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

Division de la responsabilisation et de la performance du système de santé
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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
Sep 30, 2015	2015_380593_0018	015788-15	Resident Quality Inspection

Licensee/Titulaire de permis

675412 ONTARIO INC
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

NORTHVIEW NURSING HOME
77 RIVER ROAD P.O. BOX 1139 ENGLEHART ON P0J 1H0

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

GILLIAN CHAMBERLIN (593), SHEILA CLARK (617), SYLVIE LAVICTOIRE (603)

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): July 6 - 10, 13 - 15, 2015

One complaint (#015788-15) was also inspected during the RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Nutrition Manager, Registered Nursing Staff, Registered Dietitian, Dietary Staff, Activation Staff, Housekeeping Staff, Personal Support Workers (PSW), residents and family members.

The inspectors also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dining Observation
Family Council
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
Safe and Secure Home
Skin and Wound Care

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

11 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #002.

On July 8, 2015, Inspector #603 reviewed the electronic care plan which indicated that resident #002 required, option ONE an additional safety device to be applied or option TWO a modification to their current safety device. On the paper care plan which was located in the resident's file, it was indicated a safety device was to be applied when sitting. There was no mention of the modification to their current safety device or a difference in options.

On review of the electronic care plan, the safety device and modification of the the safety device were all indicated as restraints, however in the resident's health care record, they were identified as PASDs. During a discussion with #S-102 and #S-103, they stated that it was not clear why the safety devices were necessary. Both staff members indicated

that the plan of care was unclear. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care for resident #010 set out clear directions to staff and others who provided direct care to the resident.

Inspector #617 reviewed the health care record for resident #010 which indicated a specific disease diagnosis. Resident #010's current Resident Assessment Protocol (RAP) for Activity of Daily Living (ADL), Functional Rehabilitation Potential, indicated that the resident was very independent with ADLs but required cueing for personal care and would become responsive if asked frequently. Resident #010's current care plan, for a specific type of care identified several interventions indicating that staff are to ensure good hygiene and cue resident to complete a specific personal care task. The care flow sheet for resident #010 indicated that for a seven day period, on the day and evening shifts, staff have marked "R". The "R" indicated that resident #010 had refused a specific type of care.

Inspector #617 interviewed #S-110 who reported that resident #010 would not let staff assist with a specific type of care. #S-110 reported that resident #010 displayed responsive behaviours with attempts of care provision. #S-110 reported that they were not aware if resident #010 had any problems related to this type of care as the resident would not let the staff member check. #S-110 confirmed that resident #010's care flow sheet signed for the seven day period, indicated that resident #010 had refused and did not receive a specific type of care.

#S-110 reviewed the care plan for resident #010 and confirmed that the care plan had no direction for the staff to manage the resident, who was constantly refusing a specific type of care.

Inspector #617 interviewed the Administrator/DOC who reported that specialist external resources had been in the home to develop strategies to assist staff to manage residents experiencing responsive behaviours. The Administrator/DOC confirmed that some of the strategies offered had not been successful in providing care to residents who refused. The care plan for resident #010 did not indicate strategies for managing the responsive behaviours to successfully provide care. [s. 6. (1) (c)]

3. The licensee has failed to ensure that there was a written plan of care for resident #009 that set out clear directions to staff and others who provided direct care to the resident.

Inspector #617 reviewed the health care records for resident #009 which indicated multiple diagnoses. The current care plan for resident #009, indicated that staff were to remind them to complete a specific care task and schedule regular specialist visits related to this care. Resident #009's care flow sheet indicated that for a seven day period, for both day and evening shifts, either an "X" or "R" had been signed by the staff. Inspector #617 interviewed #S-111 who confirmed that the signed "X" and "R" indicated that resident #009 had been refusing a specific type of care when offered.

Inspector #617 interviewed #S-111 who reported that resident #009 did not want the specific care task completed, and would not let the staff complete this task. #S-111 confirmed that resident #009 had not been completing a specific care task despite staff attempts at cueing and offering to complete the task for them.

Inspector #617 interviewed the Administrator/DOC who reported that specialized external resources had been in the home to develop strategies in assisting staff to manage residents experiencing responsive behaviours. The Administrator/DOC confirmed that some of the strategies offered have not been successful in providing care to residents who refused. The care plan for resident #009 did not indicate strategies for managing responsive behaviours to successfully provide care. [s. 6. (1) (c)]

4. The licensee has failed to ensure that there was a written plan of care for resident #015 that set out clear directions to staff and others who provided direct care to the resident.

A written complaint to the Director was received regarding resident #015 not being provided a specific type of care because the resident felt degraded while the care was taking place. As a result resident #015 was being given an alternative type of care and they felt this was not as effective.

Inspector #617 reviewed the health care records for resident #015 which indicated numerous diagnoses. The current Resident Assessment Protocol (RAP) for Activities of Daily Living (ADL) functional rehabilitation potential, indicated that resident #015 required cueing for their ADLs, and there were responsive behaviours associated with this. The current care plan for a specific ADL, indicated that resident #015 "required limited assistance from one staff member for this task".

Inspector #617 interviewed #S-112 who was hired recently and reported that they would

find information on caring for resident #015 in the kardex at the desk. Inspector #617 and #S-112 both reviewed resident #015's kardex for a specific care task which indicated "resident requires limited assistance from one staff member for the specific care task". #S-112 confirmed that they did not know resident #015 well and that the kardex is not giving them clear direction to offer resident #015 a choice with this care task.

Inspector #617 interviewed #S-115 who reported that resident #015 had refused care several times and had become verbally responsive. #S-115 confirmed that resident #015 likes an alternate care option over the one being provided and very much wants to be independent and doesn't like when staff intervene to assist them with this care task. This information was not identified in the care plan or kardex for resident #015.

Inspector #617 interviewed the Administrator/DOC who reported that it is the expectation of the staff to update the care plans with the information that would assist the staff in being successful in completing tasks for residents. [s. 6. (1) (c)]

5. The licensee has failed to ensure that residents #010 and #011's care set out in the plans of care was provided to the resident as specified in the plan.

A review of resident #010's current care plan found that the resident had a BMI documented as significantly below the recommended range of 25-29 and this was indicative of malnutrition. It also stated that the resident's oral intake is not adequate and as an intervention, is currently on the Med Pass program.

A review of the Medication Administration Record (MAR), for a period of a month found that resident #010 had an active order of a specific oral nutrition supplement to be administered by the medication nurse three times per day. The MAR was completed by the registered staff member for 17 days of this period as either administered or not delivered. The MAR was blank for the remaining 12 days.

During the 0800h medication pass, Inspector #617 observed resident #010 and that the resident did not receive their oral nutrition supplement. #S-113 was completing the medication pass and reported to Inspector #617 that resident #010 used to receive this supplement with the medication pass, however since the weekend, this order had been removed from the MAR and they were unsure why.

During an interview with Inspector #593 July 14, 2015, #S-114 reported that resident #010 used to receive an oral nutrition supplement as part of the Medication Pass

however just recently, it was no longer in the MAR. They further reported that they did not know why this was, whether the RD removed this or if it was a computer glitch? They added that this has happened for several residents in the home and they plan on asking the RD about it when they are in the next day. #S-114 advised that they cannot administer the supplement as it is not in the MAR, they added that they could check the resident's chart for any communication from the RD, however they have not yet done so.

A review of resident #010's MAR, confirmed that the order for the oral nutrition supplement was not documented on the MAR.

A review of the home's policy Nutrition Supplement Medication Pass CD-05-21-1, found that an order to start the resident on a nutrition supplementation on the Med Pass program is written on the Physician's Order form by the Physician or the RD and the order is included as part of the medication orders on the MAR. The Registered Nursing Staff dispenses the nutrition supplement as ordered during the scheduled medication pass and documents appropriately on the MARs, specifying the amount of supplement taken by the resident, or if the supplement was refused.

A review of resident #011's health care record, found an assessment completed by the Registered Dietitian shortly after the resident was admitted to the home. The recommendation by the RD was that the resident receive a specific oral nutrition supplement at the AM nourishment pass as their BMI was below the recommended range of 25-29 and they were taking this supplement at home prior to admission and they wanted to continue with this.

On July 10, 2015, Inspector #593 observed the AM nourishment pass to residents in the home. Resident #011 was seated in the hallway. The PSW was observed to pass the resident with the nourishment cart and ask the resident if they wanted a beverage, the resident declined. The PSW was not observed to offer or provide the specific oral nutrition supplement to the resident as per the plan of care. The Inspector observed a supply of the same oral nutrition supplement on the nourishment cart at this time.

On July 14, 2015, Inspector #593 observed the AM nourishment pass to residents in the home. Resident #011 was resting in their room at this time and it was observed that the resident did not receive the specific oral nutrition supplement as per their plan of care. During an interview with Inspector #593 July 14, 2015, resident #011 said in reference to the supplement, that they "do not drink that stuff anymore as it makes me unwell".

During an interview with Inspector #593 July 16, 2015, the home's RD reported that they were made aware by staff that the oral nutrition supplement was no longer showing on the MAR for several residents. The RD advised that they believe the reason for this was because the order was prescribed by the physician one year previously for one year. As that one year had passed, the order was no longer showing in the MAR however the RD advised that these residents still required this oral nutrition supplement as part of the Medpass. The RD also reported that they were not aware that resident #011 was no longer taking the oral nutrition supplement as this had not been communicated to them by staff in the home.

A review of the home's Policy: Nutrition Supplement Medication Pass CD-05-21-1, found that the need for continued use of a nutrient dense oral supplement is reviewed by the RD or Physician and the rest of the care team on an ongoing basis, quarterly at a minimum. The supplement is re-ordered, changed or discontinued based on the resident's current nutrition and health status.

On several occasions, two residents were not provided their oral nutrition supplement as per the plan of care. As confirmed by the RD, both residents were still required to receive the supplements. [s. 6. (7)]

6. The licensee has failed to ensure that the resident was reassessed and that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change.

Inspector #603 interviewed #S-108 who explained that resident #006 had a wound. The TAR indicated that the resident received a medicated cream for the wound for a specific period of time and then as required. On review of the care plan, there was no mention of the wound. During an interview with #S-108, they explained that the wound was not on the care plan as it was fairly new. On review of the resident's health care record, the wound was discovered several weeks before this. During an interview with #S-101, all wounds and treatments are to be documented on the care plan as soon as it is identified. [s. 6. (10) (b)]

7. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Inspector #603 interviewed #S-108 who explained that resident #007 had a pressure

ulcer and that this ulcer was discovered very recently. The TAR indicated that the ulcer required a specific type of dressing and needed to be assessed daily. On review of the care plan, there was no mention of the ulcer. During an interview with #S-108, they explained that the wound was not on the care plan as it was fairly new. During an interview with #S-101, all wounds and treatments are to be documented on the care plan as soon as they are identified. [s. 6. (10) (b)]

8. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Inspector #603 interviewed #S-108 who explained that resident #002 had a wound. The TAR indicated that the staff apply a specific type of dressing to the wound. On review of the care plan, there was no mention of a wound. During an interview with #S-108, they explained that the wound was not on the care plan as it was fairly new. During an interview with #S-101, all wounds and treatments are to be documented on the care plan as soon as they are identified. [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 ensuring that the plan of care for every resident sets out clear direction to staff, that care is provided to the resident as per the plan and that the resident is reassessed and that the plan of care is revised at a minimum of every six months or more often, if the resident care needs change., to be implemented voluntarily.

WN #2: 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 has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures.

Inspector #617 reviewed the health care records for resident #009 which indicated multiple disease diagnoses. The current care plan for resident #009, for dental care indicated that staff were to remind them to brush their teeth and schedule regular dental visits. Resident #009's care flow sheet indicated that for a one week period, for both day and evening shifts, either an "X" or "R" had been signed by the staff. Inspector #617 interviewed #S-111 who confirmed that the signed "X" and "R" indicated that resident #009 had been refusing oral care when offered.

Inspector #617 interviewed #S-111, who reported that resident #009 did not want their teeth brushed, and would not let the staff use a tooth brush in their mouth. #S-111 reported that they are able to get resident #009 to smile which allows them to assess if the teeth are clean, don't have caries and are not loose. #S-111 confirmed that resident #009 has not been cleaning their teeth despite attempts at cueing and offering to brush them. #S-111 is not sure if the dentist has seen resident #009, but if the resident complains of a sore tooth or has a canker sore, they will tell the registered staff.

Inspector #617 observed resident #009 come out of the washroom after using the toilet. Resident #009 was co-operative with #S-111 when cued to place their used tissue in the garbage and wash their hands.

Conmed Health Care Group policy CN-S-13-23 last updated June 2010 indicated that oral care is to be provided at a minimum twice per day with am and pm care and as required to maintain clean teeth and mouth. Resident is to be encouraged to do this for themselves but staff are to assist either verbally or physically if resident is not able.

Despite the staff attempts at cueing or assisting resident #009 to clean their teeth, mouth care has not occurred daily in the morning or evening as per the resident's plan of care and home policy. [s. 34. (1) (a)]

2. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures.

Inspector #617 reviewed the health care record for resident #010 which indicated a specific disease diagnosis. Resident #010's current Resident Assessment Protocol (RAP) for Activity of Daily Living (ADL), Functional Rehabilitation Potential, indicated that the resident was very independent with ADLs but required cueing for personal care and would get upset if asked frequently. Resident #010's current care plan for dental care identified that the resident tends not to brush their teeth, needs cueing, and staff are to ensure good oral hygiene and cue resident to brush their teeth. The care flow sheet for resident #010 indicated that for a one week period on the day and evening shifts, staff have marked "R" for refused.

Inspector #617 interviewed #S-110 who reported that resident #010 would not let staff assist with mouth care. The staff have tried several times to attempt to cue resident #010 but they refused and became panicked. #S-110 reported that they are not aware if resident #010 has any mouth problems. #S-110 confirmed that resident #010's care flow sheet for a one week period, indicated that resident #010 had refused and had not received mouth care.

Conmed Health Care Group policy CN-S-13-23, last updated June 2010, indicated that oral care is to be provided at a minimum twice per day with am and pm care and as required to maintain clean teeth and mouth. The resident is to be encouraged to do this for themselves but staff are to assist either verbally or physically if resident is not able.

Despite attempts by staff to cue and assist resident #010, the resident has not received oral care in accordance with the care plan and the home policy. [s. 34. (1) (a)]

3. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes 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.

Conmed Health Care Group policy CN-S-13-23, last updated June 2010, indicated that an annual dental assessment and preventative services (scaling and cleaning and an assessment to ensure that dentures are properly fitted) performed by qualified dental professionals shall be offered. If a referral for dental assessment and preventative services is being considered, the resident's authorization for payment or authorization for payment from resident's Substitute Decision Maker with legal authority to make property or financial decisions is required. Response to this offer and authorization or lack of it will be documented in the resident record in the progress notes and in the resident's plan of care.

Inspector #617 reviewed the health care records for resident #002 which indicated a multiple disease diagnoses. Resident #002 is dependent for their care needs. Resident #002's current care plan did not indicate the response to any offer of dental assessment and authorization or lack of it. Inspector #617 reviewed the progress notes for resident #002, which did not indicate a response for any offer of a dental assessment.

Inspector #617 interviewed #S-116, who reported that a denturist used to visit the home and provide dental assessments for the residents but they haven't seen one for some time. #S-116 stated that they were not aware if resident #002 had been offered a dental assessment, the registered staff would know that information. Inspector #617 interviewed #S-117 and #S-113 who reported that resident #002 was not offered an annual dental assessment.

Inspector #617 interviewed the Administrator/DOC, regarding the offers of annual dental assessments performed by qualified dental professionals who confirmed that residents are not being offered this service as per the Conmed Health Group Policy CN-S-13-23. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that each resident in the home, is provided oral care or assistance with oral care in the morning and the evening to maintain the integrity of the oral tissue, and that each resident is offered a dental assessment at least annually, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

Inspector #603 interviewed #S-108 who explained that resident #006 had a wound. The TAR indicated that the resident received a medicated cream for a specific period and

then as required. According to #S-101, the registered staff utilized the Wound Tracker Tool on E-Tar to assess skin and wounds. During an interview, #S-107 told inspector #603 that they do not utilize this tool as they have not yet been trained. #S-107 explained that they simply document their observations or assessments of wounds on progress notes. Inspector #603 reviewed the progress notes over a ten day period and there was no documentation of any wound assessments. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #007 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

Inspector #603 interviewed #S-108 who explained that resident #007 had a pressure ulcer. This ulcer was discovered recently. The TAR indicated that the ulcer required a specific type of dressing and needed assessment daily. During an interview with #S-101, they reported that the registered staff utilize the Wound Tracker Tool on E-Tar to assess skin and wounds. During an interview with #S-107, they indicated that they have not utilized this tool as they have not yet been trained. #S-107 explained that they simply document their observations or assessments of the wounds on the progress notes. Inspector #603 reviewed the progress notes and there was one recent entry that indicated an old ulceration with a description and the use of a specific type of dressing applied [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that resident #002 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

Inspector #603 interviewed #S-108 who explained that resident #002 had a wound. The TAR indicated that the staff apply a specific type of dressing and that it is assessed daily. On the care plan, there was no mention of a wound. According to #S-101, the registered staff are to utilize the Wound Tracker Tool on E-Tar to assess skin and wounds. During an interview with #S-107, they do not utilize this tool as they have not yet been trained. #S-107 explained that they simply document their observations or assessments of wounds on the progress notes. [s. 50. (2) (b) (i)]

4. The licensee has failed to ensure that resident #006 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at

least weekly by a member of the registered nursing staff.

Inspector #603 interviewed #S-108 who explained that resident #006 had a wound. The TAR indicated that the resident received a medicated cream for a specific period then as required. According to #S-101, the registered staff utilize the Wound Tracker Tool on E-Tar to assess skin and wounds. During an interview, #S-107 told the inspector that they do not utilize this tool as they have not yet been trained. #S-107 explained that they simply document their observations or assessments of wounds on the progress notes. Inspector #603 reviewed the progress notes for a ten day period and there was no documentation of any wound assessments. [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 ensuring that all residents in the home exhibiting altered skin integrity, receive 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 and that they are reassessed at least weekly if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident weights are measured and recorded on a monthly basis.

A review of the home's weight record book found numerous months where multiple residents in the home did not have a weight recorded. Inspector #593 reviewed the weight records over the past 12 months and found a pattern of resident weights not being recorded during this time period:

July 2014- 4 residents were not weighed this month
August 2014- 4 residents were not weighed this month
September 2014- 4 residents were not weighed this month
October 2014- 2 residents were not weighed this month
November 2014- 3 residents were not weighed this month
January 2015- 2 residents were not weighed this month
February 2015- 8 residents were not weighed this month
March 2015- 1 residents were not weighed this month
April 2015- 9 residents were not weighed this month

June 2015- 1 resident was not weighed this month

During an interview with Inspector #593 July 15, 2015, the ADOC said that it is the responsibility of the bath PSWs to complete the weights for each resident for each month and then record it in the weights book located at the Nurses' station. The ADOC further said that if there was a weight measurement missing from this book, then it was likely that the weight measurement had not been completed.

A review of the home's policy: CN-W-02-1 Weighing Residents, found that all residents are weighed on admission and monthly thereafter.

A review of the home's policy: CN-W-04-1 Weight Change Policy, found that all residents will be weighed monthly and the weight will be recorded in the weight book. [s. 68. (2) (e) (i)]

2. The licensee has failed to ensure that the residents' heights are measured and recorded upon admission and annually thereafter.

Inspector #593 reviewed the health care records of all 47 residents in the home and found that 10 of these residents had no height measurement taken and recorded upon admission or annually thereafter.

During an interview with Inspector #593 July 15, 2015, the ADOC reported that the height for each resident is supposed to be completed annually. They stated that the height is not measured upon admission as they use the height data from the CCAC admission information, if the CCAC has not provided recent height data, then the home does complete a height measurement upon admission.

During an interview with Inspector #593 July 16, 2015, the home's Registered Dietitian (RD) reported that admission heights are not completed for residents and they usually obtain this information from the CCAC admission documentation. As far as they are aware, the height is never measured for any residents within the home.

A review of the home's policy: CN-H-09-1 Height, found that every resident admitted into the facility must have their height recorded within 24 hours of admission. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a weight monitoring system in place to ensure that every resident in the home is weighed and the value documented at a minimum monthly and that a height measurement is taken upon admission and documented and then annually thereafter, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

Inspector #603 observed the dining service for a one hour time period. During this time, four different call bells rang from residents who were in their own rooms and not attending the dining room for lunch. When the call bells rang, different staff who were feeding residents would interrupt the feeding assistance in order to attend the call bells. At one point, #S-106 interrupted feeding two residents and left for nine minutes. During this time, no other staff continued to feed the residents. Once #S-106 returned to the dining room, they continued to feed the residents. After the meal service, #S-106 explained that it was the home's expectation that any staff member can attend to the call bells during meal services. During an interview with #S-103, they explained that it was the responsibility of the staff who are not providing feeding assistance to answer the call bells during meal times. According to #S-103, the expectation is that if staff have to leave the residents in order to answer call bells, that the food will be brought back to the kitchen or at least utilize a plate cover in order to preserve the quality of the food. [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 all residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #6: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that following right was fully respected and promoted:
the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Inspector #603 interviewed resident #005 who explained that they find the staff rude at times when they position the resident equipment such as resident lifts, wheelchairs, or commodes in front of their closet, preventing access to the closet. This issue had been brought forward to administration at different times and the problem continued. On Day A, Inspector #603 observed a resident lift positioned in front of resident #005's closet. On Day B, Inspector #603 observed a resident lift and a wheelchair in front of resident #005's closet. On Day B, Inspector #603 interviewed #S-103 who explained that the resident's equipment such as lifts, wheelchairs, and geri-chairs, are not to be stored in the resident's rooms and need to be put in the hallways. On Day B, resident #005 showed Inspector #603 a chair and lift that were in front of their closet preventing access. [s. 3. (1) 1.]

WN #7: 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 when bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices or with prevailing practices to minimize risk to the resident.

Inspector #603 interviewed #S-101 who explained that once a decision is made to apply bed rails, the resident is not assessed or their bed system evaluated. During an interview with #S-109, they explained that the home's quarterly check only includes bed frame corners to ensure they are not broken. They will make sure that the mattress fits snug to the frame corners and that there is no space in between the frame and mattress. On review of the Audit for Bed Corners, it does not relate to residents but to a bed number. There was no other documentation of bed rail assessments. [s. 15. (1) (a)]

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

On July 10, 2015, Inspector #603 interviewed #S-109 who explained that the home does a quarterly check of bed frame corners to ensure they are not broken. They will make sure that the mattress fits snug to the frame corners and that there is no space in between the frame and mattress. The inspector reviewed the Audit for Bed Corners and it was up to date. #S-109 explained that the home does not check for potential zones of entrapment because they do not have the tools to perform this duty. #S-101 stated that a kit to check potential zones of entrapment has been ordered but not yet received. [s. 15. (1) (b)]

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care for resident #002 included an order by the physician or registered nurse in the extended class.

On July 8, 2015, Inspector #603 reviewed resident #002's care plan which indicated multiple restraint devices. While observing the resident, they were sitting with a specific restraint device in place and later was observed laying in bed with another specific restraint device applied. On review of the health care record, there were no physician orders or orders from a registered nurse in the extended class for any of the restraint devices utilized as a form of restraint. #S-103 agreed that there were no orders for restraints.

On review of the home's restraint policy, it indicated: The restraining of a resident by a physical device may be included in a resident's plan of care only if the following is satisfied. #4. A physician or registered nurse in the extended class has ordered the restraint. The order must clearly indicate the type of restraint, when and where it is to be used, the detailed reason for use and any special instructions for use. The order is included on the care plan. [s. 31. (2) 4.]

2. The licensee has failed to ensure that the restraint plan of care for resident #001 included an order by the physician or registered nurse in the extended class.

On July 9, 2015, Inspector #603 reviewed the care plan for resident #001 which indicated use of multiple restraint devices. Inspector #603 observed resident #001 laying in bed

with one of the restraint devices applied. Later that day, the same resident was observed sitting with another restraint device applied. During an interview with #S-104 and #S-105, both explained that the resident needs to have both restraints applied while in bed or sitting up as a safety measure. On review of the health care record, there were no physicians orders or orders from a registered nurse in the extended class for any of the devices as a form of restraint. #S-103 agreed that there were no orders for restraints.

On review of the home's restraint policy, it indicated: The restraining of a resident by a physical device may be included in a resident's plan of care only if the following is satisfied. #4. A physician or registered nurse in the extended class has ordered the restraint. The order must clearly indicate the type of restraint, when and where it is to be used, the detailed reason for use and any special instructions for use. The order is included on the care plan. [s. 31. (2) 4.]

3. The licensee has failed to ensure that the plan of care for resident #002 included the consent by the resident or if the resident is incapable, by the SDM.

On July 8, 2015, Inspector #603 reviewed resident #002's care plan which indicated the use of multiple restraint devices. While observing the resident, they were sitting with one of the restraint devices applied and later was observed laying in bed with another restraint device applied. On review of the health care record, there was no consent for any of the devices as a form of restraint. #S-103 agreed that there was no consent for restraints.

On review of the home's restraint policy, it indicated: The restraining of a resident by a physical device may be included in a resident's plan of care only if the following is satisfied: #5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. Consent must be documented in the progress notes and the consent form signed. [s. 31. (2) 5.]

4. The licensee has failed to ensure that the plan of care for resident #001 included the consent by the resident or if the resident is incapable, by the SDM.

On July 9, 2015, Inspector #603 reviewed the care plan which indicated use of multiple restraint devices. Inspector #603 observed resident #001 laying in bed with one of the restraint devices applied. Later that day, the same resident was observed sitting upright with another restraint device applied. During an interview with #S-104 and #S-105, both

explained that the resident needed to have both restraint devices applied as a safety measure. On review of the health care record, there was no consent for any of the devices as a form of restraint. #S-103 agreed that there was no consent for the restraints.

On review of the home's restraint policy, it indicated: The restraining of a resident by a physical device may be included in a resident's plan of care only if the following is satisfied: #5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. Consent must be documented in the progress notes and the consent form signed. [s. 31. (2) 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #015 was bathed, at a minimum, twice weekly by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A written complaint sent to the Director was received, regarding resident #015 not bathing. Resident #015 feels that they cannot bathe themself properly in the tub or shower.

Inspector #617 reviewed the health care records for resident #015 which indicated multiple disease diagnoses. The current care plan for bathing and shampooing indicated that resident #015 requires some assistance by staff for this task.

Jul 09, 2015, inspector #617 reviewed the bath schedule for resident #015 which

indicated that the resident was scheduled to have a bath on two specific days each week.

The bath shift notes which are paper documentation of residents receiving baths were reviewed for an 11 day period and indicated the following for resident #015:

Day 1, charted Rx3
Day 4, charted Rx2
Day 6, charted Rx3
Day 9, charted Rx3

Inspector #617 interviewed #S-115 who reported that the documentation for resident #015 of "Rx2/3" indicated that the resident was offered a bath two or three times but refused. #S-115 reviewed the bath shift notes for this period and confirmed that resident #015 did refuse a bath at those times.

On two occasions during the inspection, Inspector #617 observed resident #015 to have greasy hair.

Conmed Health Care Group policy #CN-S-13-18 under bathing requirements indicated that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by medical condition. "Bathing" includes tub baths, showers, and full body sponge baths.

Inspector #617 interviewed #S-115, who confirmed that resident #015 has not had a "bath" for an 11 day period.

Inspector #617 interviewed the Administrator/DOC who reported that the staff and family have attempted different techniques to give resident #015 a bath and were not successful. The Administrator/DOC, reported that the home has not yet addressed resident's refusal for bathing with any specialist resources. [s. 33. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 was reassessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated after a significant change in weight.

A review of resident #009's health care record found a significant weight loss over a two month period. Upon further review, there was no assessment related to this significant weight decrease by the home's Registered Dietitian (RD) or any other member of the interdisciplinary team.

During an interview with Inspector #593, July 17, 2015, the home's RD reported that they completed a full dietetic assessment of this resident when they were first admitted more than a year prior, and they do monitor the resident occasionally during meals however a full dietetic assessment has not been completed since admission. The RD confirmed that when they complete an assessment of a resident, they record the details of this assessment in the e-progress notes.

A review of the home's policy- Dietitian Consultation CN-D-06-1, found that the RD will determine cause and rectify if possible unexplained weight loss of more than 7.5% in three months and that the RD will record findings on progress notes and develop the nutritional plan of care and notify the appropriate department of the interactions to be initiated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #11: 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. (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 ensure that the documented results of the survey are made available to the Residents' Council.

During an interview with Inspector #593, July 9, 2015, resident #004 reported that the home does not provide a copy of the results of the annual satisfaction survey to them or the Council and they know that they are supposed to receive a copy of the results. Resident #004 added that they want to receive a copy of the results.

During an interview with Inspector #593, July 10, 2015, the Administrator advised that the results of the survey are reviewed with the Residents' Council however a copy of the results of the survey has not been provided to the Council. [s. 85. (4) (a)]

Issued on this 5th day of November, 2015

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

Original report signed by the inspector.