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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 10, 2018	2018_395613_0014	001843-18	Resident Quality Inspection

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Northwood Lodge
51 Highway 105 P.O. Box 420 RED LAKE ON P0V 2M0

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

LISA MOORE (613), KATHERINE BARCA (625), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 4 - 8 and June 11 - 15, 2018.

The following intakes were were inspected during this Resident Quality Inspection:

One Follow up related to CO #001 from Inspection report #2017_435621_0006, s. 15 (2) of the Long-Term Care Homes Act (LTCHA), 2007, for ensuring that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair;

One Critical Incident (CI) report the home submitted to the Director regarding resident to resident abuse;

One CI report the home submitted to the Director regarding a fall resulting in an injury.

During the course of the inspection, the inspector(s) spoke with Administrator (ADM), Director of Care (DOC), Resident Assessment Instrument Coordinator (RAI Coordinator), Maintenance Team Lead, Maintenance staff, Housekeeper, Registered Dietitian, Food Nutrition Team Lead (FNTL), Dietary Aides (DAs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, various licensee policies, procedures and programs, the home's internal investigation files and resident council meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **21 WN(s)**
- **13 VPC(s)**
- **2 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During an family interview with Inspector #625, resident # 007's family member identified that the resident's room was unkept.

On three separate days the Inspector observed bits of refuse on the resident's floor, an accumulation of dust on surfaces, and dirty discoloured flooring.

During an interview with Housekeeper #109, they acknowledged the accumulation of dirt under resident #007's toilet, brown staining under the resident's bathroom sink, and accumulation of dust on many areas observed by the Inspector.

A review of the home's policy title, "Housekeeping - Daily Routine" last revised December 2014, with a focus on cleaning of resident rooms and personal washroom, identified:

- a daily housekeeping routine in resident rooms included: dust mopping floors including under beds, in corners and closets; spot washing; washing floors as needed; dusting only as necessary;
- a daily housekeeping routine in personal washrooms included: cleanings wash basins and fixtures; replenishing paper towels, toilet paper and soap;
- a weekly housekeeping routine that included the daily cleaning tasks as well as: dusting all surfaces in rooms including all furniture, light fixtures, pictures, knick knacks, etc.; wiping down chairs (legs and under cushions); wiping down window, ledges and tracks; wiping bathroom vanity cabinets inside and out; washing the floor completely;
- a monthly housekeeping routine that included all daily and weekly cleaning tasks as well as: moving all furnishings away from the walls; sweeping and damp mopping behind; and
- a yearly housekeeping routine that included: moving all furnishings from rooms if possible; dusting ceilings; washing all walls in rooms, bathrooms and closets; cleaning windows and ledges; cleaning and sanitizing the toilet, sink and bathtub; cleaning and sanitizing floors and baseboard and completing additional floor maintenance as required.

The Administrator acknowledged that the identified areas in resident #007's room were unclean and required cleaning. [s. 15. (2) (a)]

2. During the inspection, Inspector #625 observed a soiled recliner chair in a home area, soiled walls in two separate areas, soiled table legs, a soiled window ledge in an area, and a soiled door.

Housekeeper #109 attended the specific areas with the Inspector and acknowledged the following unclean areas: wood walls in a specific area were soiled with visible splatter marks; walls in a specific area were also soiled with splatter marks; black table legs and wood table legs in specific areas were soiled.

A review of the home’s policy titled "Housekeeping - Daily Routine" last revised December 2014, identified that Housekeeping staff were to damp wipe tables, remove marks from walls and windows, dust mop and damp mop the lounge floor, and wipe chairs as required, in the lounge areas, on a daily basis.

The Administrator toured the home with the Inspector and acknowledged that the areas were not clean and required cleaning. [s. 15. (2) (a)]

3. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

The licensee has failed to comply with the following compliance order CO #001 from inspection #2017_435621_0006 served on March 13, 2017, with a compliance date of April 28, 2017.

The licensee was specifically ordered to ensure that cosmetic fixes in resident rooms and common areas, including but not limited to, drywall repairs, painting, baseboard and trim repairs, and repair or replacement of missing flooring were addressed.

The Inspector toured the areas of disrepair, in the locations previously identified in the order, with Maintenance Team Lead#111 and the Administrator. The Maintenance Team Lead and the Administrator discussed the current condition of the areas previously observed by the Inspector.

In a resident's room:
- Inspector #625 had observed three nails protruding from the trim and two areas of drywall had been scratched by the nails. The Maintenance Team Lead stated that the resident’s chair would have caused the nails to pull and the trim to loosen. The Administrator stated that the repair made would have been safe at that time that it had

been completed but, since then, they believed the resident's chair had dislodged the trim from the wall causing the protruding nails and damage;

- Inspector #625 had noted the condition of the drywall on the left corner wall, located at the entrance to the room to be in poor condition. The Maintenance Team Lead and the Administrator stated that the ordered repair had been completed, but the wall had been damaged since the repair was made; and

- Inspector #625 had observed the left corner wall adjacent to the resident's closet to contain visible repairs which left the surface of the wall uneven. The Maintenance Team Lead identified that the area had been sanded once during the repair process, but the corner had not been painted.

In another resident's room:
- Inspector #625 had observed a portion of damaged wood trim along the wall, behind the headboard of the resident's bed. The Administrator stated they believed the trim had been replaced. The Maintenance Team Lead stated that the trim had been sanded, but they couldn't recall if it had been replaced and identified that it needed to be repaired or replaced at that time;

-The Inspector had observed sections of baseboards were missing on each side of closet. The Maintenance Team Lead and the Administrator both acknowledged there were two pieces of baseboard missing on both sides of the closet; and

-The Inspector had noted multiple gouges in the drywall. The Maintenance Team Lead and the Administrator acknowledged the gouges were present.

In a dining room:
- Inspector #625 had observed the wall on the left side of exit door to the patio having drywall disrepair. The Administrator acknowledged a large gouge in the drywall in this area that required repair; and

-The Inspector had noted the metal frame of the exit door located on the exterior wall had paint missing. The Maintenance Team Lead and the Administrator both acknowledged that the painting of the door had not been completed and was required.

2. During tours of the home, Inspector #625 noted disrepair in common areas including: missing and/or damaged baseboard, door surfaces, wall and floor coverings, a cracked

wheel chair ramp at the home's entrance, and damaged brickwork to an entrance pillar.

During tours of the home with Inspector #625, Maintenance Team Lead #111 acknowledged the home had areas of disrepair. The Maintenance Team Lead acknowledged the front entrance pillar bricks required repair and stated they had identified the wood inner portion of the pillar was rotting; and the home had plans for a new wheelchair ramp for the front entrance as the current ramp had a large crack which now required repair for the third time.

During tours of the home with the Administrator, they acknowledged the home had areas that required repair. The Administrator indicated that the brick work on the pillars at the front entrance, the cracked wheelchair ramp and the flooring in front of the nursing station, in an area frequented by residents, all required repair or replacement.

3. During resident observations, Inspector #625 observed the following areas of disrepair in resident rooms and washrooms:

- in a room, the wall behind the television had been patched, but not painted in areas;

- in a room's washroom, paint was chipped off and the drywall was damaged exposing drywall screws;

- in a shared room entrance, the wall between the two rooms had paint chipped of and drywall gouges, some areas appeared to have been patched, but not painted;

- in a room, the floor under the bed had multiple squares of damaged flooring, there were patched, but not painted areas on the walls in the bedroom and there was a phone jack hanging from the wall close to an uncovered empty electrical box;

- in a room's washroom, the walls had been patched, but not painted;

- in a room, the walls near the headboard and in the washroom had paint missing where it appeared adhesive items had been ripped off;

- in a room, the washroom had multiple areas where paint had been peeled off from the wall; and

- in a room , the pot light protruded from the ceiling above the entrance to the room.

During an interview with RPN #122, they indicated that staff were to enter any items that required repairs in the Northwood Lodge Maintenance Communication/Work Order Sheet binder.

A review of the Northwood Lodge Maintenance Communication/Work Order Sheet binder identified an entry dated June 2018, for a specific room that read “Bathroom floor is lifting looks like it is rotting” and the corresponding maintenance comment to address the flooring stated, "Needs new".

On June 8, 2018, the Inspector observed the bathroom flooring in the room. The front of the resident's toilet, the side and the back were damaged, discoloured, disintegrating, lifting and breaking off.

Maintenance Team Lead #111 attended the room with the Inspector and acknowledged the poor condition of the flooring around the toilet.

During an interview with the Administrator, they attended rooms where disrepair had previously been observed by Inspector #625 and acknowledged that the rooms observed by the Inspector had areas of disrepair.

4. During a tour of the home on June 4, 2018, Inspector #625 observed that the call bell in the resident shower room did not activate the resident-staff communication and response system when pulled. The alarm did not sound and the light outside the tub/shower room did not illuminate identifying the source of the alarm from the hallway.

During resident observations on June 5 and 8, 2018, the Inspector observed that the call bell by the bed in resident #007’s room, did not illuminate in the hallway when activated.

During an interview with PSW #110, they confirmed that the call bell in the resident's shower room did not activate when the cord was pulled, including not sounding or illuminating.

During an interview with Inspector #625, the Administrator tested and acknowledged that the call bell in the shower room did not activate when pulled, and the call bell in resident #007’s room did not illuminate when activated.

5. On June 5, 2018, during a family interview with Inspector #613, resident #002's family member reported that the ceiling had a leak in a specific room. The Inspector observed a crack present on the ceiling above the closet. The family member stated they reported the leaking ceiling in May 2018, by notifying the Administrator. They further commented that Maintenance Employee #112 had attended to the room and stated it could not be repaired at that time and left a pail to catch water in the room, which remained in the room.

On June 8, 2018, Inspector #625 observed the damaged ceiling and a white plastic bucket on the floor near the window in the room.

Inspector #625 reviewed the,"Northwood Lodge Maintenance Communication/Work Order Sheets," from April to June 2018, and could not locate an entry related to the leaking ceiling in the room.

On June 8, 2018, Maintenance Team Lead #111 attended the room with the Inspector and stated they had been unaware of the ceiling leak as the Maintenance staff had not informed them of it. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that, for the purposes of section 35 of the Act, the following devices were not used in the home: sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

Inspector #625 conducted a census record review of resident #021's progress notes which identified that:

- the resident had returned from hospital in February 2018, with a sheet tied around their torso to maintain a more upright position;
- the DOC directed the staff to wrap a bed sheet in a wide area around the resident's torso, as the hospital staff had done; and
- the home's staff wrapped a bed sheet across the resident's torso to keep the resident sitting upright for supper.

A review of the home's policy titled, "Minimizing Restraint - PASD Use - (NUR 400)" last revised November 2015, identified that it was important that staff of the Home understood that only approved devices could be used to restrain residents. The policy indicated that the Home would not use devices that limited movement including sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

During an interview with the Director of Care (DOC), they stated that they were aware of the home's policy and legislation that identified sheets could not be used to limit or inhibit a resident's movement. The DOC commented that the home was challenged with monitoring residents at meals, which was why the resident was not returned to bed to be fed; but instead, a sheet was used to keep the resident upright in their wheelchair over a couple of days to feed that resident. [s. 112. 7.]

Additional Required Actions:

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

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear direction to staff and others who provided direct care to the resident.

Resident #007 was identified as having potential bed rail restraints during a resident observation.

Inspector #625 observed resident #007's bed rails, one was in the guard position and

one was in the transfer position. The Inspector observed the bed rails to be in these positions during multiple observations throughout the inspection.

A review of resident #007's care plan, last updated in March 2018, listed "bed rails used for bed mobility or transfer" as an intervention. The care plan did not identify the type or the position of the bed rails in use.

A review of resident #007's, "Resident Care and Safety Routines sheet," dated March 2018, did not indicate that the resident used bed rails, although bed rails were listed on the sheet as an option to choose under the safety equipment category.

A review of resident #007's, "Bed Rail Assessment Sheet (NUR 145)," contained options for staff to identify which bed rails were in use [toilet (T) or window (W) side]. The assessment completed in December 2016, did not list which bed rail(s) were in use. The assessments completed March, August and September 2017; and March and June 2018, identified that the only bed rail in use.

During an interview with PSW #106, they identified that resident #007 used one bed rail in a horizontal position and the one bed rail in a vertical position. The PSW identified that the Resident Care and Safety Routines sheet did not have the bed rails checked off as in use and the care plan did not list the position of the bed rails. PSW #106 stated that it was not clear from the two documents that the resident used bed rails and how the bed rails were positioned.

During an interview with Resident Assessment Instrument Coordinator (RAI Coordinator) #102, they stated that resident #007 used bed rails as identified in their care plan and identified that the use of bed rails was not reflected in the resident's Resident Care and Safety Routines sheet. The RAI Coordinator stated they would not know how the bed rails were to be positioned and that the resident's plan of care was not clear with respect to the resident's use of bed rails or the positioning of the bed rails.

During an interview the Director Of Care (DOC), they acknowledged that resident #007's plan of care, specifically the resident's care plan and Resident Care and Safety Routines sheet, were not clear in identifying that the resident used bed rails or in what position the bed rails were to be placed in. [s. 6. (1) (c)]

2. Resident #007 was identified as having no Activities of Daily Living (ADL) assistance during a family interview.

During an interview with Inspector #625, resident #007's family member stated that resident #007 did not receive assistance with cleaning their dentures, which they required.

A review of the progress notes identified the resident had dentures at the time of their admission to the home.

A review of resident #007's Resident Care and Safety Routines sheet, dated March 2018, indicated the resident wore dentures under the Oral Care section, but did not have denture use checked off under the Daily Care Requirements section.

A review of the care plan, last updated March 2018, identified resident #007 did not wear dentures.

During an interview with PSW #113, they stated that the resident had dentures. The PSW acknowledged that the resident's Resident Care and Safety Routine sheet identified that the resident used dentures in one section, but did not reflect that the resident used dentures in another section.

During an interview with RAI Coordinator #102, they stated that they were unaware that resident #007 used dentures. The RAI Coordinator identified that the resident's care plan did not reflect the resident's use of dentures, although it was listed in one section of the Resident Care and Safety Routines.

During an interview with the DOC, they stated that resident #007's care plan did not indicate that the resident used dentures. The DOC acknowledged that resident #007's plan of care was not clear with respect to their use of dentures. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During a dining observation, resident #010 informed Inspector #625 that they did not eat a specific food and had changed their diet for the past few years for ethical reasons. The resident stated that the staff were aware and provided the resident with their specific diet.

A review of resident #010's care plan, last updated in May 2018, identified that the resident had adopted a specific diet in approximately 2016 and "disliked a specific food

unless hidden with sauce or pasta".

A review of the resident diet list posted in the server identified resident #010 as a specific diet and identified, "doesn't like any specific food unless you disguise it with sauce or pasta".

During an interview with Dietary Aide #120, they stated that the resident's diet list was updated by the home's Administrator and acknowledged that it identified resident #010 with a specific diet, and indicated that the resident "doesn't like any specific food unless you disguise it with sauce or pasta".

During an interview with Registered Dietitian (RD) #115, they stated that they were aware that resident #010 did not eat a specific food. They stated that they had previously spoken to the resident who had informed them that they did not eat a specific food as they had made a decision not to eat a specific food any longer. They reviewed the resident's care plan and acknowledged that it was not in accordance with the resident's preferences, as it identified that they disliked a specific food and that it could be hidden with sauce or pasta. The RD acknowledged that it was not the resident's preference to have staff hide a specific food in their meals.

During an interview with the Food Nutrition Team Lead #116, they identified that resident #010 was not a specific diet, but was classified as one by the home and further commented that the resident did not like a specific food on their plate, but if it was hidden or disguised they were okay to eat it. The Food Nutrition Team Lead attended resident #010's room with the Inspector to inquire about the resident's preferences related to the specific food.

During an interview with resident #010, they stated that they did not want to eat the specific food, even when it was hidden. The resident stated that they had realized they did not want to eat the specific food two years prior.

Following the conversation with the resident, the Food Nutrition Team Lead acknowledged that the care plan's direction to disguise a specific food in the resident's food was not according to their preference.

During an interview with the Administrator, they stated that all residents' care plans should be reflective of their preferences. The Administrator indicated that resident #010 was capable of deciding what they wanted to eat, that their choices should be included in

their care plan, and that disguising or hiding a specific food was not consistent with the resident's previously expressed preference. [s. 6. (2)]

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

During an interview with Inspector #625, resident #007's family member expressed concerns about the frequency of the resident's baths.

The Inspector reviewed the current, "Northwood Lodge Weekly Bath Schedule" and resident #007's current, "Resident Care & Safety Routines" sheet, dated March 8, 2018. Both documents identified that resident #007 had a bath on two evenings during the week..

A review of resident #007's, "Northwood Lodge Bath Assessment," indicated "on bath day, the PSW who assisted the resident with the bath completed the bath documentation. This was mandatory." The Inspector identified that the bath assessments did not contain documentation identifying bathing resident #007 on three days in May 2018, two days in April 2018, two days in March 2018, two days in February 2018, and two days in January 2018, or 23 per cent of the scheduled bath dates.

During interviews with RPN #103 and RN #117, they confirmed that documentation was missing for scheduled bath dates in 2018 on resident #007's Northwood Lodge Bath Assessment sheet. They both stated that staff had failed to document if a bath was given or refused, as they were required to do.

During an interview with RAI Coordinator #102, they stated that staff had not documented the care they had provided to resident #007, whether the bath was given or refused, as they were required to on the bath assessment sheet.

During an interview with the DOC, they stated that staff were required to document each bath, whether given or refused, on the Northwood Lodge Bath Assessment sheets and acknowledged that staff had failed to document the bathing of resident #007. [s. 6. (9) 1.]

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

During an interview with Inspector #625, resident #007's family member stated that resident #007 did not receive the routine oral care assistance from staff, that they required. They commented that the resident needed staff assistance with oral care, but staff may have felt the resident could do it on their own.

A review of resident #007's care plan, last updated in March 2018, which identified "ORAL CARE: Independent- may need cueing, staff ensure supplies are in room to complete oral care".

A review of resident #007's," Resident Care and Safety Routines sheet" dated in March 2018, indicated the resident performed "self-care" for oral care.

During an interview with PSW #114, they stated that staff provided oral care for resident #007. The PSW commented that the care plan reflected the resident performed oral care independently or with cueing, but that was not accurate as the resident was not able to complete oral care on their own. The PSW also identified that the resident's Resident Care and Safety Routines sheet, which identified the resident completed oral "self-care", was not accurate as staff completed oral care for the resident. The PSW stated that the two documents were not reflective of the resident's current care needs with respect to oral care.

During an interview with RAI Coordinator #102, they stated that the resident's care plan, which identified the resident was independent and may require cueing for oral care, was not reflective of the resident's current oral care needs, if staff completed oral care for the resident. The RAI Coordinator also acknowledged that the resident's Resident Care and Safety Routines sheet identified the resident performed oral "self-care", which was also not reflective of their needs, if staff completed oral care for them.

During an interview with the DOC, they reviewed the resident's care plan and Resident Care and Safety Routines sheet and commented that the documents would not reflect the resident's current oral care needs, if staff completed oral care for the resident, as the documents identified the resident was independent, required cueing or performed "self-care" with respect to their oral care. [s. 6. (10) (b)]

6. Resident #010 was identified as having potential restraints during a resident observation.

On June 5, 2018, Inspector #625 observed that resident #010 had bed rails in the

transfer position.

Inspector #543 reviewed the resident's most recent care plan, specifically related to the use of bed rails. There was no focus in the resident's care plan to identify the use or need for bed rails.

On June 11 and 12, 2018, Inspector #543 observed resident #010 lying in bed with bed rails engaged.

During an interview with PSW #107, they verified that the resident utilized bed rails, but were unsure of the reason for the use of the bed rails.

During an interview with RAI Coordinator #102, they verified that the resident's care plan did not identify the use of bed rails. They indicated that the care plan should identify the use and the need for the bed rails. They verified that the resident's care plan needed to be updated to address the care needs of the resident. [s. 6. (10) (b)]

7. Resident #002 was identified as having potential bed rail restraints during observations of the resident.

Each day of the inspection, resident #002 was observed to be lying in their bed with bed rails engaged.

A review of resident #002's care plan did not indicate the use of the bed rails or their purpose.

A review of the most current MDS assessment dated May 2018, identified that resident #002 required total dependence with staff assistance for bed mobility.

A review of the policy titled, "Care Plans" last revised February 2010, identified that the care plan would reflect the resident's current strengths, abilities, preferences, needs, goals, safety /security and advance directives."

During an interview with PSW #104, they stated that they thought the use of the bed rails was to prevent resident #002 from falling out of bed, then they stated they were not sure. PSW #104 showed the Inspector on the flow sheets that there was an area that stated "2 side rails" and the PSW's check it off each shift.

During an interview with RAI Coordinator #102, they stated that the resident's bed rails were used for bed mobility, if resident #002 had them on their bed. The RAI Coorodinator reviewed resident #002's most recent assessment and care plan and stated that the resident was total bed mobility and required assistance from staff. RAI Coordinator #102 verified that the care plan did not identify why resident #002 used bed rails while in bed and that the care plan needed to be updated to address the care needs of the resident.

During an interview with ADM, they confirmed that the use of resident #002's bed rails should have been identified in the residents care plan. [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Act or Regulation required the

licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

The licensee was required to have a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

During a census record review, it was identified that several residents did not have monthly weights completed.

On June 5, 2018, during an interview with Inspector #625, RAI Coordinator #102 identified that residents #007, #014, #015, and #016 had not had monthly weights taken in May 2018.

A review of the health care records for residents #007, #014, #015 and #016 did not contain monthly weights for May 2018.

A review of the home's policy titled "Nutrition Resident Care - (NUR 135)" last revised February 2010, indicated that, on admission, and monthly thereafter, the PSW was required to measure residents' weights.

A review of the home's policy titled "Weighing Residents - (NUR 405)" last revised February 2010, indicated that the Registrant was required to enter the weights into the residents' computer records in Vital Signs on the day(s) they were taken.

During an interview with the DOC, they stated that residents' weights were to be taken monthly. The DOC reviewed resident's #007, #014, #015 and #016 on GoldCare health care records and acknowledged that they did not have monthly weights completed for May 2018. [s. 8. (1) (b)]

2. The Long-Term Care Homes Act, 2007, c. 8, s. 87 (1) requires every licensee to ensure that there are emergency plans in place for the home that comply with the regulations.

Ontario Regulation 79/10, s. 230 (4) (i) requires the licensee to ensure that emergency plans provide for dealing with fires.

During a tour of the home on June 4, 2018, Inspector #625 observed that fire

extinguishers near three resident rooms did not reflect that monthly inspection of the extinguishers had occurred in May 2018. The punch cards on these extinguishers had last been punched in April 2018.

During a tour of the home on June 7, 2018, the Inspector noted that, in addition to the extinguishers previously identified as not reflecting monthly testing was completed, the fire extinguisher outside of a specific room did not indicate that it had been tested monthly in March, April or May 2018, and the fire extinguisher in one of the hallways did not reflect that it had been inspected in May 2018.

A review of the home’s,"Fire Safety Plan" last revised November 2016, identified that the Fire Department upon request, and that the Hospital Engineer was to inspect all portable fire extinguishers monthly as part of the “Maintenance Schedule for Fire Protection Equipment”.

A review of the monthly fire extinguisher testing log titled, "Northwood Lodge 2018 Weekly Maintenance Duties- Emergency Power System" identified that 19 fire extinguishers had been checked off as tested from January to May 2018. The Inspector noted that each fire extinguisher had a serial number listed and corresponded with a location. The months of January, February, April and May 2018 were signed off as completed by Maintenance Employee #118, March 2018 was signed off as completed by Maintenance Employee #118 and a community fire protection service representative #119.

During an interview with PSW #114, they confirmed that the fire extinguishers near the three rooms did not show that they had been inspected in May 2018, and the extinguisher near one room did not show that it had been inspected in March, April or May, 2018.

During an interview with the Administrator, they confirmed that the fire extinguishers near the three rooms, and the extinguisher in one of the hallways, had not been punched to indicated that they had been inspected monthly as previously observed by the Inspector.

On June 7, 2018, the Inspector toured the five fire extinguishers of concern with the Administrator and Maintenance Lead #111. The Maintenance Lead acknowledged that the five fire extinguishers had not been punched to reflect that they had monthly testing completed as observed by the Inspector.

During an interview with the Administrator, they acknowledged that the home's Fire Safety Plan identified that monthly inspection of fire extinguishers was required, and that the policy had not been complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where the Act or 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, that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's "Skin and Wound Program (NUR 035) " was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Residents #009 and #010 were identified as having areas of altered skin integrity during resident census record reviews.

Inspector #543 reviewed the home's policy titled, "Skin and Wound Program (NUR 035) " last revised August 2012. The policy indicated that residents with pressure ulcers would have interventions and treatments outlined in their plan of care. The resident would be be assessed weekly using a clinically appropriate assessment instrument.

The Inspector requested the licensee's written record of the "Skin and Wound Program" evaluation from the Administrator, who was unable to provide the same, and indicated to speak with the DOC.

During an interview with the DOC, they verified that they had never completed an annual evaluation of the program as they were not aware an evaluation had to be completed. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's "Skin and Wound Program" (NUR 035) is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #009 was identified as having areas of altered skin integrity during a census record review.

Inspector #543 reviewed the home's "Skin and Wound Care Program (NUR 035)" last revised August 2012. The policy indicated that residents with altered skin integrity would have interventions and treatments outlined in their plan of care. The resident would be assessed weekly using a clinically appropriate assessment instrument.

A review of resident #009's health care record identified that resident #009 had areas of altered skin integrity.

A review of resident #009's Medication/Treatment Administration record identified that there were no weekly skin assessments being completed for the resident's areas of impaired skin integrity.

During an interview with RPN #108, they verified that every resident who had altered skin

integrity would be "checked" daily and a skin assessment would be completed weekly.

During an interview with the DOC and the Administrator, they verified that every resident with impaired skin integrity must have a weekly skin assessment completed. [s. 50. (2) (b) (iv)]

2. Resident #010 was identified as having areas of altered skin integrity during a census record review.

Inspector #543 reviewed resident #010's health care record, and identified that the resident had areas of altered skin integrity.

A review of resident #010's Medication/Treatment Administration record identified that there were no weekly skin assessments being completed for the resident's areas of altered skin integrity.

During an interview with RPN #108, they verified that every resident who had a wound would be "checked" daily and a skin assessment would be completed weekly.

During an interview with the DOC and the Administrator, they verified that every resident with impaired skin integrity must have a weekly skin assessment completed. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs.

During an interview with Inspector #625, RAI Coordinator #102 stated that resident #004 received range of motion services from the nursing staff, as the home did not have on-site physiotherapy services.

A review of resident #004's inactivated care plan titled, "Physiotherapy," last updated in October 2017, identified that the resident was to receive passive range of motion exercises with the physiotherapy assistant on certain days during the week. An outcome note, dated January 2018, indicated that the care plan was inactivated, as the home currently had no physiotherapy assistant.

A review of resident #017's progress notes identified, in February 2018, that the resident required a referral to physiotherapy and would be made once it became available at the home. The notes also indicated that, in February 2018, the DOC attempted to secure temporary physiotherapy services for the resident. In February 2018, the DOC was working with the hospital to secure interim physiotherapy services until a community physiotherapy service provider resumed, but that the resident had not yet received physiotherapy services.

During an interview with the DOC, they identified that resident #017 required physiotherapy services. The DOC stated that the home had not had on-site physiotherapy services for six months. The DOC indicated that the hospital physiotherapist did not have the capacity to provide ongoing physiotherapy services to the home's residents due to their own client work load.

During an interview with the Administrator, they stated that the home had not had on-site physiotherapy services since December 2017, when the physiotherapy assistant left, and they had not yet been replaced by the contracted physiotherapy service provider. [s. 59. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that therapy services for residents of the home is arranged or provided under section 9 of the Act that included on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs, to be implemented voluntarily.

WN #8: 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 home's Nutrition Care and Hydration Programs included a weight monitoring system to measure and record with respect to each measurement, body mass index and height upon admission and annually thereafter.

During census record reviews, it was identified that several residents did not have annual height measurements completed.

During an interview with Inspector #625, RAI Coordinator #102 identified that the following residents had not had annual height measurements completed as follows:

- Residents #006, #022, and #023's most recent height were completed in January 2015;
- Residents #015 and #024's most recent height were completed in February 2015;
- Resident #003's most recent height was completed in December 2015;
- Resident #018's most recent height was completed in January 2016;
- Residents #002, #013, #019, #020's most recent height were completed in August 2016; and
- Residents #005 and #007s most recent height were completed in December 2016.

A review of the health care records for the above mentioned residents confirmed that they had not had annual heights entered into GoldCare as detailed above. In addition, the Inspector noted that:

- Resident #003 was admitted in December 2015, and the only height measurement for the resident was entered on a later date in December 2015;
- Resident #018 was admitted in December 2015, and the only height measurement for the resident was entered in January 2016;
- Resident #013 was admitted in August 2016, and the only height measurement for the resident was entered on their admission date; and
- Resident #007 was admitted in December 2016, and their admission height, identified by the RAI Coordinator as being completed in December 2016, but had not been entered into GoldCare in the Vitals Signs section.

A review of the home's policy titled "Nutrition Resident Care -(NUR 135)" last revised February 2010, indicated that, residents' heights were to be taken and recorded on admission and annually thereafter.

During an interview with the DOC, they stated that residents' heights were required to be taken on admission and annually and confirmed this was not done for all residents. The DOC identified that the home did not have a system in place to take annual heights and indicated that the home would be implementing a system which would include obtaining admission and annual height values. [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 the home's Nutrition Care and Hydration Programs includes a weight monitoring system to measure and record with respect to each measurement, body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #9: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, the communication of the seven-day and daily menus to residents.

During dining observations, Inspector #625 noted that for seven days in June 2018, the daily menu posted did not include pureed menu items. In addition, for six days in June 2018, the daily menu posted did not include vegetarian menu items.

The Inspector noted that the seven-day menu posted for two weeks in June 2018, did not include pureed and vegetarian menu items.

During an interview with Dietary Aides #120, #121 and #123, they stated that the daily menu posted did not include pureed or vegetarian menu items.

During an interview with the Food Nutrition Team Lead #116, they stated that the pureed and vegetarian diets differed from the regular texture diets and non-vegetarian diets, respectively. They stated that the home did not post vegetarian or pureed menu items on the daily or seven-day menus. [s. 73. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that included, at a minimum, the communication of the seven-day and daily menus to residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

During resident observations, Inspector #625 observed cracks in sinks in the washrooms for six rooms, toilets running in the washroom for two rooms, and a toilet seat and lid missing from the washroom in one room.

A review of the home's form titled, "Northwood Lodge Maintenance Communication/Work Order Sheets," included entries, dated May 2017, that "In one room, the toilet leaks & tries to flush" with a maintenance response written "All good in May 2018"; and "an identified room, needs a toilet seat" with no maintenance response to the work order noted.

Maintenance Team Lead #111 attended the rooms with the Inspector and confirmed the sinks were cracked and required repair. They also indicated that the sink in a room had silicone applied with putty on the bottom of the sink in an attempt to seal the crack. The Maintenance Team Lead confirmed that the toilet was running in a room.

During an interview with the DOC, they acknowledged that the sinks in the rooms were cracked. They also acknowledged the toilets were running in two rooms and that one room did not have a toilet seat and lid, but it should have been in place. [s. 90. (2) (d)]

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, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

During a tour of the home on June 4, 2018, Inspector #625 observed two EnviroSolutions 64 Disinfectant containers, containing consumer product labels identifying that the substance was corrosive, with a written warning that it was corrosive to eyes, kept in an unlocked Housekeeping closet. In addition, barbicide disinfectant/fungicide/viricide was observed in the unlocked hair salon.

On June 7, 2018, the Inspector observed the same EnviroSolutions 64 Disinfectant containers in the unlocked Housekeeping closet, at 1123 and 1550 hours. On June 11, 2018, the Inspector again observed barbicide in the unlocked hair salon in a container that read "corrosive – causes eye damage and skin burns". Staff were not present in the area during any of the observations.

During an interview with PSW #106, they stated that the Housekeeping closet should have been locked and confirmed that the hazardous substances were present in the unlocked Housekeeping closet.

During an interview with PSW #110, they acknowledged that the Housekeeping closet had been unlocked, was unsupervised and that hazardous chemicals were accessible to residents in the unlocked closet.

During interviews with the DOC, they stated that the Housekeeping closet contained hazardous substances and should have been kept closed and locked when not in use and that the barbicide was a hazardous substance and should have been kept in the locked hair salon. The DOC acknowledged that some residents in the home wandered and would have access to the hazardous substances in the home, which should not be accessible to them. [s. 91.]

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 hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area with in the locked medication cart.

During an observation of the medication storage room, Inspector #613 observed that that the only one type of controlled substance was being stored in the locked storage bin in the bottom drawer of the locked medication cart.

During an interview with RPN #103, they stated that narcotics and controlled substances were stored in two separate locked storage bins in the bottom drawer of the medication cart, one locked storage bin was for narcotics and the other locked storage bin was for controlled substances. The RPN stated that only one controlled substance was kept in the locked storage bin and that it was counted at shift change. RPN #103 informed the Inspector that other controlled substances were kept in the resident's individual plastic strips with their other scheduled non-narcotic medications.

RPN #103 showed the Inspector that resident #005 and #006 had a controlled substance packaged in plastic strips with their regular scheduled medications. RPN #103 confirmed that these controlled substances were not double locked in the locked medication cart.

During an interview with the Administrator and DOC, they stated they were unaware that not all controlled substances were stored in a separate locked area within the locked medication cart and confirmed they should have been. [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 with in the locked medication cart, to be implemented voluntarily.

WN #13: 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 has failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

During an observation of the medication storage room, RPN #103 showed the Inspector that resident #005 and #006 had a controlled substance packaged in plastic strips with their regular scheduled medications

RPN #103 stated that narcotics and controlled substances were stored in two separate locked storage bins in the bottom drawer of the medication cart, one locked storage bin was for narcotics and the other locked storage bin was for controlled substances. The RPN stated that only one type of controlled substance was kept in the locked storage bin and that it was counted at shift change. RPN #103 informed the Inspector that other controlled substances were kept in the resident's individual plastic strips with their other scheduled non-narcotic medications and were not being counted at shift change.

A review of the home's policy titled, "Medication Program - Narcotic & Controlled Drug Maintenance" last revised February 2010, identified that all narcotic and controlled drugs entering the Home would be monitored in accordance with provincial and Ministry regulations and standards. All Homes registrants must apply diligent accounting practices for narcotic medications and document accordingly. The policy identified that prior to turning over controlled drugs to the next shift, two registrants would count all control drugs and complete the key exchange/Narcotic Unit Drug Count Record.

A review of the resident count sheets titled, "Individual Record for Count Control & Narcotic Drug Administration", did not indicate that resident #005 and resident #006's controlled substance medications were being counted and monitored, as per the home's policy. In addition, they did not identify that a monthly audit had been undertaken of the daily count sheets of controlled substances.

During an interview with the Administrator and the Director of Care, they stated that management had been unaware that all controlled substances were not being counted at shift change and monitored as per the home's policy. The Administrator further stated that they had started the process for completing a monthly audit of the daily count sheets of controlled substances, but it had dwindled down recently and that a monthly audit of the daily count sheets had not been done since December 2017. [s. 130. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all benzodiazepines are counted daily on each shift and that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there is any discrepancies and that immediate action is taken, if any discrepancies are discovered, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #613 reviewed the home's medication incidents from January 2018 to June 2018, which identified that three medication errors had occurred. The Inspector noted that on all of the forms titled, "District of Kenora Homes for the Aged – Northwood Lodge Medication Incident/Discrepancy Report," that three out of the three medication incident forms did not identify documentation that the medication incidents had been reported to the resident or their substitute decision-maker, or the prescriber of the medication and that the pharmacy service provider had not been notified on two out of three incident reports.

A review of the GoldCare electronic progress notes did not identify documentation to indicate that the medication incidents had been reported to the resident or their substitute decision-maker, the prescriber of the medication or the pharmacy service provider.

A review of the policy titled, "Medication Incidents", last revised February 2010, identified the RN would notify the physician and pharmacist of the medication incident/discrepancy by telephone. Where the matter constituted significant risk to the resident, the DOC was to be immediately notified by telephone. The policy did not make any reference to the notification of the resident or their SDM.

During an interview with the DOC, the Inspector showed the DOC the homes, "Medication Incident/Discrepancy Reports" that indicated the resident/SDM or the prescriber of the medication had not been notified on three out of three incident reports and that the pharmacy service provider had not been notified on two out of three incident reports. The DOC confirmed that there was no documentation to indicate this had been done.

During an interview with the Administrator, they stated the policy titled, "Medication Incidents" and the form titled, "District of Kenora Homes for the Aged – Northwood Lodge Medication Incident/Discrepancy Report," was going to be updated to reflect the legislation and to ensure the medication incident reports identified areas for the registered staff to sign that they reported the medication incidents to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director,

the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review were implemented, and (c) a written record was kept of everything provided for in clause (a) and (b).

A review of the Pharmacy and Therapeutic Pharmacy and Therapeutic Professional Advisory Committee Meeting minutes from November 2017 and February 2018, did not identify analysis review of medication errors for the quarter and changes implemented.

During an interview with the DOC, they confirmed that a quarterly review of all medication incidents and adverse drug reactions had not been done and there was no written documentation of the changes and improvements implemented. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On June 4, 2018, during a dinner dining observation, Inspector #625 observed RN #105 feed one resident, assist a second resident to use their spoon, go to the medication cart, push a third resident's wheelchair closer to the dining table and repositioned their glasses, hold the spoon of a fourth resident and feed the resident, assist a fifth and a sixth resident to stand up. The RN had not performed hand hygiene before or after contact with the residents or their environments until after they had come into contact with the sixth resident.

On June 12, 2018, during a lunch dining observation, the Inspector observed PSW #113 feed resident #017 wearing gloves, remove the gloves and place a new pair of gloves on without performing hand hygiene. The PSW then touched a dining room chair wearing the new pair of gloves and fed resident #017. The PSW removed their gloves, took a new pair of gloves in their hand, rubbed resident #023's arm and applied the new gloves. The PSW removed the gloves, performed hand hygiene, touched their hair and applied new gloves while sitting down beside resident #017 again. The PSW carried a dish away from resident #017, took off their gloves and put on a new pair without performing hand hygiene. The Inspector observed the PSW sit down beside resident #025, carry a dish away from the resident, remove their gloves and put on a new pair without performing hand hygiene. The PSW then sat near resident #017 and then approached resident #014 and used their utensils to cut the resident's food.

On June 12, 2018, Inspector #625 observed RN #105 administer medications to residents in the dining room. The RN provided medications to several residents, signed the eMAR and touched the medication cart without performing hand hygiene before or after administering medications to each resident.

A review of the home's policy titled "Infection Prevention and Control: General Practices" original date February 2018, identified that health care workers were required to adhere

to stringent hand hygiene practices at all times; the Four Moments of Hand Hygiene included before initial resident or resident environment contact and after resident environment contact; and that health care workers were required to practice hand hygiene prior to and after removal of gloves, before preparing or handling food and before feeding a resident.

During an interview with PSW #113, they stated that they should have been doing a better job of performing hand hygiene in between helping residents and acknowledged that they had not completed the required hand hygiene in between assisting the residents.

During an interview with RN #105, they stated that they did not wash their hands if they just handed residents a medicine cup. After reviewing the home's infection prevention and control policy with the Inspector, including the Four Moments of Hand Hygiene, and discussing the RN's contact with the computer, medication cart and other surfaces in between administering each resident's medications, the RN stated that they should have washed their hands in between administering medications to each resident.

During interviews with the Administrator and DOC, they stated that staff should perform hand hygiene according to the home's policy "Infection Prevention and Control: General Practices", specifically with respect to the Four Moments of Hand Hygiene, which included before and after contact with a resident or their environment, and when using gloves. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's "Zero Tolerance of Abuse and/or Neglect" policy was complied with.

Inspector #543 reviewed a Critical Incident (CI) report that was submitted to the Director in April 2017. The CI report indicated that the incident had occurred one day earlier in April 2017, whereby the resident was in a specific area and staff heard a resident screaming. Resident #012 abused resident #013, resulting with an injury.

A review of the home's policy titled, " Zero Tolerance of Abuse and/or Neglect policy (ADM 450) " last revised September 2014, indicated that all staff, volunteers, contractors and affiliated personnel were required to fulfill their legal obligation to immediately and directly report any witnessed or alleged incident of abuse to the Ministry of Health and Long-Term Care.

During an interview with the Administrator, they verified that all alleged or witnessed incidents of abuse must be reported immediately. They indicated the incident was not reported immediately, because they were not made aware of the incident until the following day, and informed staff that the incident should have been reported. They verified that the incident was not reported until the next day. [s. 20. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

During an interview with Inspector #625, resident #007's family member stated that the home did not accommodate the resident's preferences on how they were dressed. The family member identified that the staff dressed the resident in other residents' clothing when they ran out of clean laundry for the resident or the laundry didn't make it back on a long weekend. The family member identified that the home would dress the resident in other residents' pants, although the resident had enough pants to be worn for one week.

A review of resident #007's care plan last updated March 2018, identified the resident required assistance of staff with dressing.

During an interview with PSW #114, they stated that, if the home did not have clean laundry returned, resident #007 would sometimes wear other residents' clothes over a weekend. The PSW identified that the adjacent hospital washed the home's laundry and, if the resident did not have any clean pants to wear, the PSW would borrow a pair from another resident for resident #007. The PSW identified that, if soiled personal clothing items were collected on a Friday and over a weekend, the resident's cleaned personal laundry would not be returned to the home until Wednesday or Thursday of the following week.

During an interview with the DOC, they stated that the adjacent hospital had been contracted to provide the home with laundry services and acknowledged that the laundry return could be slow at times. The DOC confirmed that the home had received complaints about the laundry service and identified that there was no one in the laundry department on weekends which did result in soiled personal laundry not being returned to the home until the Tuesday of the following week, or the following Wednesday after a long weekend. The DOC stated that residents should be dressed in their own clothing and that the home should speak with family if there had been a problem with this. [s. 40.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternative choices of entrees, vegetables and desserts at lunch and dinner.

Inspector #625 overheard staff speaking about resident #010's lack of an alternate choice for their dinner meal. The staff stated that the specific diet options were pasta with cheese sauce or fish, and resident #010 did not eat one of the options and would not have a choice of what to eat.

During an interview with Dietary Aide #120, they stated that the main food production sheets did not list an alternative option for the dinner meal for resident #010 on the specific date in June 2018, as they did not eat one of the options.

During an interview with resident #010, they stated that they did not have a second option for dinner that day.

A review of resident #010's Nutritional Care care plan last updated May 2018, and the resident diet list posted in the dining room servery, both indicated the resident followed a specific diet.

A review of the food production sheets titled, "Main Production Sheets" with a focus on alternative meal options for resident #010 for two weeks in June 2018, identified that the specific diet dinner options were a food option that the resident did not eat.

During an interview with the Food Nutrition Team Lead #116, they reviewed the Main

Production Sheets with the Inspector for two weeks in June 2018, and stated the second specific diet option for resident #010 was an option that the resident did not eat.

The Inspector and Food Nutrition Team Lead met with resident #010, who stated they did not eat the specif diet option. The Food and Nutrition Team Lead informed the Inspector that they had not been aware that the resident did not eat the specific diet option.

During an interview with the Administrator, they stated that all residents should have alternate choices of entrees, vegetables and desserts at lunch and dinner. [s. 71. (1) (c)]

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

During an interview with Dietary Aide #120, they identified that the Main Product Sheet listed lentils as a vegetarian option, but that the home did not have lentils to cook with. The Dietary Aide stated they did not know why lentils were listed on the menu as staff were required to substitute other foods in its place.

A review of the Main Production Sheets with a focus on use of lentils and identified that lentils were listed as a vegetarian lentil rice casserole lunch option.

During an interview with Food Nutrition Team Lead #116, they acknowledged that the home did not have lentils to provide to residents and lentils listed on the Main Production Sheet should be removed and replaced with another food item. The Food Nutrition Team Lead reviewed the Main Production Sheets and identified lentils listed in a lentil rice casserole during the lunch service that occurred on June 6, 2018. They acknowledged that the lentil dish listed had not been available in the home. [s. 71. (4)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On June 13, 2018, Inspector #543 interviewed the president of the Residents' Council who stated, "I don't believe they do" when asked the licensee sought the advice of the council in developing and carrying out the satisfaction survey.

A review of the meeting minutes from previous Residents' Council meetings, did not identify any documentation to identify that the licensee sought the advice of the council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the Administrator, they verified that they did not seek the advice of the Residents' Council in the developing and carrying out the satisfaction survey. [s. 85. (3)]

WN #20: 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 has failed to ensure that, as part of the organized program of laundry services under clause 15 (1) (b) of the Act, residents' personal items and clothing were labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

During an interview with Inspector #625, resident #007's family member had concerns about the resident's clothing.

The Inspector observed two unlabeled clothing in resident #007's closet. The Inspector also observed an article of clothing present with resident's #007's name written in blue ink on a label that had another name crossed out in ink.

During an interview with PSW #113, they identified that the unlabeled clothing belonged to resident #007 and was not labeled; as well the other article of clothing was not labeled and they were not sure if it belonged to resident #007; and one article of clothing had the name of a deceased resident crossed out with resident #007's name written on the old label.

During an interview with RAI Coordinator #102, they stated that all residents' clothing should be labeled, and that the labeling was done by the home's staff.

During an interview with the DOC, they stated that all residents' personal clothing should be labeled by staff, and that the labeling should be done with the home's labels, not blue pen ink. [s. 89. (1) (a) (ii)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff permitted a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if: (a) The staff member had been trained by a member of the registered nursing staff in the administration of topicals (b) The member of the registered nursing staff who was permitting the administration was satisfied that the staff member could safely administer the topical; and (c) The staff member who administered the topical did so under the supervision of the member of the registered nursing staff.

During an interview with RPN #103, they informed the Inspector that PSWs were permitted to administer topical creams to the residents. RPN #103 was not sure if the PSWs had been trained by a member of the registered nursing staff and if they were supervised by a member of the registered nursing staff.

During an interview with PSW #104, they stated they applied topical creams to the residents and that they had not received any training from registered staff on how to apply topical creams. The PSW stated registered staff had not watched them apply a cream.

During an interview with RN #105, they stated that sometimes PSWs apply topical creams; registered staff provide the cream, which is stored in the locked medication room; registered staff tell the PSW where to apply the cream on the resident but do not go with the PSW to observe how they apply the cream. The RN stated they were not sure if the PSWs were trained by registered staff and stated they had not trained any PSW to apply topical creams.

During an interview with the DOC, they stated that PSWs apply over the counter and medicated topical creams to the residents; registered staff kept the creams in the medication room or medication cart, then provided the topical cream to the PSW and provide them with direction on application, the PSW applied the cream to the resident and then returned the cream to the registered staff. The DOC stated they they did not have a record that identified that the PSW had been trained and supervised on the application of topical creams. DOC was not sure if there was a formal process at the home for training PSW and monitoring by registered staff on the application of topical creams. [s. 131. (4)]

Issued on this 11th day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), KATHERINE BARCA (625), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2018_395613_0014
Log No. / No de registre :	001843-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 10, 2018
Licensee / Titulaire de permis :	Board of Management of the District of Kenora 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	Northwood Lodge 51 Highway 105, P.O. Box 420, RED LAKE, ON, P0V-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kandice Henry

To Board of Management of the District of Kenora, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_435621_0006, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 15 (2) (c).

The licensee shall prepare, submit and implement a plan to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The plan must include but is not limited, to the following;

a) A detailed description how the licensee will ensure that cosmetic fixes in resident rooms and common areas, including but no limited to, furnishings, call bells, drywall repairs, painting, baseboard and trim repairs and repair or replacement of missing flooring are addressed, repaired and maintained.

b) Detailing how the licensee will review the organized program of maintenance services to ensure the procedures are in place for routine, preventative and remedial maintenance of the home, furnishings and equipment. This plan is to state how the licensee plans to ensure that the organized program of maintenance services is reviewed, how often and who will participate in the review. The review shall be documented and shall include any changes made to the organized program.

c) A detailed description how the licensee will develop and implement an audit tool to ensure tracking of all maintenance requests and tasks are documented, completed and followed up.

Please submit the written plan for achieving compliance for #2018_395613_0014 to Lisa Moore, LTC Homes Inspector, MOHLTC, by email to SudburySAO.moh@ontario.ca by September 7, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

The licensee has failed to comply with the following compliance order CO #001 from inspection #2017_435621_0006 served on March 13, 2017, with a compliance date of April 28, 2017.

The licensee was specifically ordered to ensure that cosmetic fixes in resident rooms and common areas, including but not limited to, drywall repairs, painting,

baseboard and trim repairs, and repair or replacement of missing flooring were addressed.

The Inspector toured the areas of disrepair, in the locations previously identified in the order, with Maintenance Team Lead #111 and the Administrator. The Maintenance Team Lead and the Administrator discussed the current condition of the areas previously observed by the Inspector.

In a resident's room:
- Inspector #625 had observed three nails protruding from the trim and two areas of drywall had been scratched by the nails. The Maintenance Team Lead stated that the resident's chair would have caused the nails to pull and the trim to loosen. The Administrator stated that the repair made would have been safe at that time that it had been completed but, since then, they believed the resident's chair had dislodged the trim from the wall causing the protruding nails and damage;

- Inspector #625 had noted the condition of the drywall on the left corner wall, located at the entrance to the room to be in poor condition. The Maintenance Team Lead and the Administrator stated that the ordered repair had been completed, but the wall had been damaged since the repair was made; and

- Inspector #625 had observed the left corner wall adjacent to the resident's closet to contain visible repairs which left the surface of the wall uneven. The Maintenance Team Lead identified that the area had been sanded once during the repair process, but the corner had not been painted.

In another resident's room:
- Inspector #625 had observed a portion of damaged wood trim along the wall, behind the headboard of the resident's bed. The Administrator stated they believed the trim had been replaced. The Maintenance Team Lead stated that the trim had been sanded, but they couldn't recall if it had been replaced and identified that it needed to be repaired or replaced at that time;

-The Inspector had observed sections of baseboards were missing on each side of closet. The Maintenance Team Lead and the Administrator both acknowledged there were two pieces of baseboard missing on both sides of the closet; and

- The Inspector had noted multiple gouges in the drywall. The Maintenance Team Lead and the Administrator acknowledged the gouges were present.

In a dining room:
- Inspector #625 had observed the wall on the left side of exit door to the patio having drywall disrepair. The Administrator acknowledged a large gouge in the drywall in this area that required repair; and

- The Inspector had noted the metal frame of the exit door located on the exterior wall had paint missing. The Maintenance Team Lead and the Administrator both acknowledged that the painting of the door had not been completed and was required.

2. During tours of the home, Inspector #625 noted disrepair in common areas including: missing and/or damaged baseboard, door surfaces, wall and floor coverings, a cracked wheel chair ramp at the home's entrance, and damaged brickwork to an entrance pillar.

During tours of the home with Inspector #625, Maintenance Team Lead #111 acknowledged the home had areas of disrepair. The Maintenance Team Lead acknowledged the front entrance pillar bricks required repair and stated they had identified the wood inner portion of the pillar was rotting; and the home had plans for a new wheelchair ramp for the front entrance as the current ramp had a large crack which now required repair for the third time.

During tours of the home with the Administrator, they acknowledged the home had areas that required repair. The Administrator indicated that the brick work on the pillars at the front entrance, the cracked wheelchair ramp and the flooring in front of the nursing station, in an area frequented by residents, all required repair or replacement.

3. During resident observations, Inspector #625 observed the following areas of disrepair in resident rooms and washrooms:

- in a room, the wall behind the television had been patched, but not painted in areas;

- in a room's washroom, paint was chipped off and the drywall was damaged exposing drywall screws;

- in a shared room entrance, the wall between the two rooms had paint chipped of and drywall gouges, some areas appeared to have been patched, but not painted;

- in a room, the floor under the bed had multiple squares of damaged flooring, there were patched, but not painted areas on the walls in the bedroom and there was a phone jack hanging from the wall close to an uncovered empty electrical box;

- in a room's washroom, the walls had been patched, but not painted;

- in a room, the walls near the headboard and in the washroom had paint missing where it appeared adhesive items had been ripped off;

- in a room, the washroom had multiple areas where paint had been peeled off from the wall; and

- in a room , the pot light protruded from the ceiling above the entrance to the room.

During an interview with RPN #122, they indicated that staff were to enter any items that required repairs in the Northwood Lodge Maintenance Communication/Work Order Sheet binder.

A review of the Northwood Lodge Maintenance Communication/Work Order Sheet binder identified an entry dated June 2018, for a specific room that read "Bathroom floor is lifting looks like it is rotting" and the corresponding maintenance comment to address the flooring stated, "Needs new".

On June 8, 2018, the Inspector observed the bathroom flooring in the room. The front of the resident's toilet, the side and the back were damaged, discoloured, disintegrating, lifting and breaking off.

Maintenance Team Lead #111 attended the room with the Inspector and acknowledged the poor condition of the flooring around the toilet.

During an interview with the Administrator, they attended rooms where disrepair had previously been observed by Inspector #625 and acknowledged that the

rooms observed by the Inspector had areas of disrepair.

4. During a tour of the home on June 4, 2018, Inspector #625 observed that the call bell in the resident shower room did not activate the resident-staff communication and response system when pulled. The alarm did not sound and the light outside the tub/shower room did not illuminate identifying the source of the alarm from the hallway.

During resident observations on June 5 and 8, 2018, the Inspector observed that the call bell by the bed in resident #007's room, did not illuminate in the hallway when activated.

During an interview with PSW #110, they confirmed that the call bell in the resident's shower room did not activate when the cord was pulled, including not sounding or illuminating.

During an interview with Inspector #625, the Administrator tested and acknowledged that the call bell in the shower room did not activate when pulled, and the call bell in resident #007's room did not illuminate when activated.

5. On June 5, 2018, during a family interview with Inspector #613, resident #002's family member reported that the ceiling had a leak in a specific room. The Inspector observed a crack present on the ceiling above the closet. The family member stated they reported the leaking ceiling in May 2018, by notifying the Administrator. They further commented that Maintenance Employee #112 had attended to the room and stated it could not be repaired at that time and left a pail to catch water in the room, which remained in the room.

On June 8, 2018, Inspector #625 observed the damaged ceiling and a white plastic bucket on the floor near the window in the room.

Inspector #625 reviewed the,"Northwood Lodge Maintenance Communication/Work Order Sheets," from April to June 2018, and could not locate an entry related to the leaking ceiling in the room.

On June 8, 2018, Maintenance Team Lead #111 attended the room with the Inspector and stated they had been unaware of the ceiling leak as the Maintenance staff had not informed them of it

The severity of this issue was a level two as there was potential for actual harm to the residents. The scope was a level two as their was a pattern of floor and wall damage in resident rooms and home areas. Compliance history was a level three as there was related non-compliance that included:

- Compliance Order (CO) made under s. 15 (2) (c) of the Regulations, March 13, 2017, (#2017_435621_0006) with a compliance date of April 28, 2017;
-Voluntary Plan of Correction (VPC) issued December 13, 2016 (#2016_433625_0010). (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 05, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 112. For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Order / Ordre :

The licensee must be compliant with r. 112 (7) of the LTCHA.

Specifically the licensee must:

a) Ensure that prohibited devices that limit a resident's movement are not used in the home: sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

Grounds / Motifs :

1. The licensee has failed to ensure that, for the purposes of section 35 of the Act, the following devices were not used in the home: sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

Inspector #625 conducted a census record review of resident #021's progress notes which identified that:

- the resident had returned from hospital in February 2018, with a sheet tied around their torso to maintain a more upright position;
- the DOC directed the staff to wrap a bed sheet in a wide area around the resident's torso, as the hospital staff had done; and
- the home's staff wrapped a bed sheet across the resident's torso to keep the resident sitting upright for supper.

A review of the home's policy titled, "Minimizing Restraint - PASD Use - (NUR 400)" last revised November 2015, identified that it was important that staff of the Home understood that only approved devices could be used to restrain residents. The policy indicated that the Home would not use devices that limited movement including sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

During an interview with the Director of Care (DOC), they stated that they were aware of the home's policy and legislation that identified sheets could not be used to limit or inhibit a resident's movement. The DOC commented that the home was challenged with monitoring residents at meals, which was why the resident was not returned to bed to be fed; but instead, a sheet was used to keep the resident upright in their wheelchair over a couple of days to feed that resident

The scope of this issue was a level two as the same resident had been affected by repeated occurrences of the same deficient practice. The home had no previous history of non-compliance with this section of the LTCHA; however, the severity of this issue was determined to be a level two as there was potential for actual harm to the resident. (625)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 20, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector /
Nom de l'inspecteur : Lisa Moore

Service Area Office /
Bureau régional de services : Sudbury Service Area Office