Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 9, 2016	2016_214146_0004	002291-16	Resident Quality Inspection

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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

BARBARA NAYKALYK-HUNT (146), IRENE SCHMIDT (510a), KELLY CHUCKRY (611), KELLY HAYES (583), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 2, 3, 4, 5, 8, 9, 10, 11, 12, 17, 18, 19, 22, 2016.

Other inspections conducted concurrent with this RQI included: CI inspections #008065-15, 008229-15, 029918-15 and 033569-15 related to alleged abuse and falls; complaint inspections #025929-15, 026989-15 and 029964-15 related to care concerns, complaints process, pain management and falls; and Follow-up inspections #035232-15, 035233-15, 035234-15, 03235-15, 035236-15, 035237-15. During the course of the inspection, the inspectors toured the home; reviewed health records, policies and procedures, home's internal investigation notes; and observed resident care and dining and snack service.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Manager (FSM), Registered Dietitian (RD), Environmental Services Manager (ESM), Recreation Manager, registered staff, Personal Support Workers (PSW's), housekeeping staff, maintenance staff, dietary staff, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #006	2015_323130_0007	146
O.Reg 79/10 s. 26. (3)	CO #003	2015_323130_0007	583
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_323130_0007	146
O.Reg 79/10 s. 68. (2)	CO #005	2015_323130_0007	583

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 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 this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, (b) was complied with.

Previously issued July 27, 2015 as a CO.

A) A review of the clinical record for resident #016 confirmed that the resident was sent to hospital on a date in September 2015. The home was requested to provide the home's policy for treating residents with hypoglycemia. The ADOC provided a one page document entitled "Medical Directives for Hypo/Hyperglycemia".

The home's Medical Directives for Hypo/Hyperglycemia gave specific directions for interventions to provide when a resident's blood glucose was abnormal. A review of the health record and staff interviews indicated that the policy was not complied with in September 2015 for resident #016.
Interview with the ADOC confirmed that the licensee failed to ensure that the home's Medical Directives for Hypo/Hyperglycemia were complied with for resident #016 in September 2015. (511)

B) The organized program of nutrition care and hydration, specifically the homes system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration was reviewed.
The home's "Documentation" policy CN-D-19-1, created on April 2011, stated "PSW

must document intake of food and fluid for all meals and snacks on Nutritional Flow Chart" and "It is important to complete these accurately and in detail to ensure accurate accounting of resident intake". The Registered Dietitian (RD) referral form identified an example of a reason to refer the RD was, oral intake of fluid routinely below 1000 milliliters per day for more than five consecutive days or oral intake of food below 50 percent for more than five consecutive days.

In an interview with the Food Service Manager (FSM) on a date in February 2016, it was shared that education was provided to Personal Support Workers (PSW) related to completing the new food and fluid sheets in August 2015. The written procedure identified that night staff would total the resident's daily fluid intake and inform the registered staff if a resident's fluid intake was routinely below 1000 milliliters for more than five days. The FSM confirmed that direction on when to refer the RD related to low food intake was not provided.

A review of the "Nutritional Flow Chart" was completed from February 1 to February 16, 2016. It was documented that resident #040, #550, #701, #702 and #703's total volume of fluid consumed was less than 1000 milliliters per day for more than five consecutive days. It was documented that resident #040, #702, and #703 oral intake of food was below 50 percent for more than five consecutive days. In an interview with the FSM on February 18, 2016, it was confirmed that the RD had not received any referrals for resident #040, #550, #701, #702 or #703 for low food or fluid intake.

In an interview with registered staff #124, #128, #129, #130 and #131 on February 18, 2015, it was shared that they did not know that an RD referral was to be sent based on the assessment of the "Nutritional Flow Chart" if oral intake of fluid routinely below 1000 milliliters per day for more than five consecutive days or oral intake of food below 50 percent for more than five consecutive days. Staff shared that they did not recall being provided education in the past six months related to the home's system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A review of the electronic RD referrals from December 17, 2015 to February 17, 2016, showed that there were no resident referrals for oral intake of fluid routinely below 1000 milliliters per day for more than five consecutive days or oral intake of food below 50 percent for more for more than five consecutive days.
In an interview with the Administrator on February 19, 2016, it was confirmed that the homes system to monitor and evaluate the food and fluid intake of residents with

identified risks related to nutrition and hydration was not complied with. (583)

C) The Home's policy #CN-P-09-1, entitled "Pain Management" and dated January 2013, directed that the interdisciplinary team would assess residents for pain on admission, re-admission, quarterly or with a change in condition that impacts pain or causes pain using Resident Assessment Inventory-Minimum Data Set (RAI-MDS) tool. Item #5 of the policy directed that, for residents who have pain, the pain flow record or 'PACLSAC' record would be completed.

i) Resident #031 experienced chronic pain for which they received long acting analgesics. Review of the clinical record for resident #031 revealed that the quarterly RAI-MDS pain assessments were completed. All assessments reported that the resident experienced moderate pain. The ADOC confirmed that there were no corresponding pain flow records or PACSLAC records completed as required by the home's policy.

ii) Resident #031 was readmitted to the home on a date in June 2015. A pain assessment using the RAI-MDS tool was not completed at the time of re-admission, as confirmed by the DOC.

iii) A review of the clinical record indicated that resident #600 was admitted on a date in March 2015. The admission notes indicated that the resident had intermittent pain. There was no evidence of a pain assessment on admission as per the home's policy until three months after the resident's admission.
The home's policy for pain management was not complied with. (510)

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

Previously issued July 27, 2015 as a CO and December 23, 2014 as a VPC.

A) Resident #031 had impaired skin integrity. The document the home referred to as the plan of care for resident #031 directed that the resident would be turned and positioned every two hours. On a date in February 2016, resident #031 was observed to be positioned on their right side between the hours of 1045 and 1320. The PSW confirmed the resident had been on their right side for longer than two hours. On another date in February 2016, the resident was observed to be positioned on their right side between the hours of 1000 and 1500. The resident's roommate confirmed that the resident had not been repositioned that day. Review of the turning and repositioning record for the resident revealed that on seven out of ten days in February 2016, the resident had not been consistently turned and positioned every two hours.
The ADOC confirmed that the resident had not been turned and positioned every two hours.

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

On a date in February 2016, resident #550 was observed to be using an identified apparatus. The apparatus was observed to be in standby mode and not functioning. When staff were asked what the settings on the apparatus should be for the specific resident, the registered staff assigned to the floor did not know how to work the machine and did not know what the settings should be for the resident.
The ADOC then observed the apparatus and confirmed that the standby setting was an error but did not know how to adjust the setting to the preferred setting for the resident. There were no directions for staff who provided direct care to the resident in the resident's room or in the plan of care related to the use of the apparatus. This was confirmed by the staff, the ADOC and the Administrator. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On a date in November 2015, cognitively impaired resident #022 was transferred from the room the resident had occupied for several years to another room. The SDM was not given an opportunity to participate in the decision to make the move and was not informed until the move was done. This information was confirmed by the SDM, the health record and the ADOC. [s. 6. (5)]

3. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the plan of care and had convenient and immediate access to it.

Registered staff confirmed that staff who provide direct care to residents obtain direction for that care from the resident specific kardex kept on each unit.
Resident #016 was readmitted from hospital on a date in September 2015. The care plan was updated. Registered staff confirmed that the kardex, printed January 12, 2016, was the current kardex available to direct care staff for resident #016 and that the kardex did not contain the updates added after readmission from the hospital. Staff who provided direct care to the resident were not kept aware of the contents of the plan of care. This was confirmed by the health record and registered staff. [s. 6. (8)]

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

A) Review of clinical records for resident #031 revealed they were readmitted to the home from hospital on a date in June 2015. Progress note documentation from the RD dated in June 2015 outlined changes to the resident's feeding protocol related to a specific risk. The document referred to by the home as the care plan was not updated to provide a focus and interventions related to the risk until more than two months later. The above was confirmed by the ADOC. The plan of care was not reviewed and revised when the resident's care needs changed.

B) Resident #016 was readmitted to the home from hospital and returned on a date in September 2015. The care plan was not updated until one week after re-admission. Registered staff confirmed the resident's care plan was not revised when the residents care needs changed. [s. 6. (10) (b)]

5. The licensee has failed to ensure that when a resident was reassessed and the plan of care reviewed and revised b) if the plan of care was being revised because care set out in the plan was not effective, different approaches were considered in the revision of the plan of care.

On a date in February 2016, resident #029 reported that they always had pain. Documentation in the progress notes supported the resident's ongoing pain. Pain assessments confirmed the presence of ongoing pain. Registered staff confirmed that different approaches to the resident's pain were not considered in the revision of the plan of care when the resident was reassessed. (510a) [s. 6. (11) (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:
1. there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident;
8. staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it; and
10. the resident's plan of care is reviewed and revised at least every six months and at any other time when, (b) 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

An initial tour of the home was conducted on February 2, 2016. While touring a non residential area of the home in the southwest wing, the mechanical electrical room was observed with the door closed but unlocked and accessible to residents of the home.

An interview with the Administrator confirmed that this door should have been locked when not being supervised by staff and was immediately locked. [s. 9. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: 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 (a) the home, furnishings and equipment were kept clean and sanitary; (c) the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) On February 2, 3, 4, 5, 2016 and further into this inspection, inspectors observed built up debris and soiling on the floor along baseboards of multiple resident rooms in all wings, on the baseboards of resident rooms, in corners of resident rooms, under beds and on the walls of resident rooms, in dining rooms and a build up of debris and soiling along hallway baseboards and under the heating radiators:

i. room 105 - observed blackened substance on baseboard approximately 1 metre long and also brown spots which appeared to be spilled dried liquid on wall;
ii. room 109 -observed dust and debris on floor along baseboards and in corners;
iii. hallways - observed dust and debris on floor along baseboards
iv. room 110 - observed blackened substance on baseboard;
v. resident lounge Garden Room with debris and crumbs on floor under the table during the first week of the inspection and soiling on floor along baseboards on all dates of this inspection
vi. dining room for 500 wing residents with food debris and paper on floor just prior to lunch at 1155 hours on February 18, 2016.

B) The family of resident #019 reported on February 4, 2016 that the resident's bedroom floor frequently has debris and food crumbs on it. When the resident's room was observed on February 5, 2016, debris and crumbs were noted on the floor under the bed.

C) Damaged walls and baseboards were observed throughout the home during this inspection:
i. room 108 - loonie sized hole in sliding door of closet where room door handle touches it
ii. room 110 - piece of baseboard torn off in bathroom at corner ; plaster chipped from the walls
iii. room 202 - hole in wallboard
iv. room 203 - damaged walls
v. room 206 - damaged walls and hole in closet door from door handle, and
vi. room 207 - broken baseboard behind toilet

The Administrator stated that housekeeping audits had not been completed in past year. A walk through with the ESM and a maintenance worker confirmed that the home was not kept clean and that the walls and some baseboards were not in a good state of repair. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #6: 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 where there was a written policy that promoted zero tolerance of abuse and neglect of residents that it is complied with.

The home's "Abuse - Prevention, Reporting and Elimination of Abuse and Neglect" policy dated June 2010, indicated that sexual abuse was "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person other than a staff member". The policy also indicated that on any alleged, suspected or witnessed abuse, the following procedures and interventions would occur:
1. Police would be contacted immediately
2. MOHLTC would be notified immediately
3. Where sexual abuse has occurred or is suspected, the attending physician was to be contacted to arrange for a medical assessment
4. Abused resident would be offered counselling and support services from management, staff and or chaplain

A review of a MOHLTC Critical Incident report (CIS), dated in October 2015, indicated that an incident of resident to resident abuse was witnessed by a staff member. The physician was not contacted. A review of the clinical record did not indicate a physical assessment of the resident occurred after the incident. An MDS-RAI skin assessment was not completed until greater than nine days after the incident. Interview with the two RPN's (#128 and #129) working the day of the incident and on the day following the incident confirmed that they did not complete an assessment of the resident nor notify the home's attending physician. Both RPN's confirmed that they would be required to complete a head to toe assessment on any alleged, suspected or witnessed abuse. Interview with the Administrator confirmed that the licensee had failed to ensure that the home's "Abuse -Prevention, Reporting and Elimination of Abuse and Neglect" policy, dated June 2010 , was complied with when the attending physician was not notified and an assessment of the resident was not completed on any alleged, suspected or witnessed abuse. [s. 20. (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 where there is a written policy that promotes zero tolerance of abuse and neglect of residents that it is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A review of resident #031's plan of care identified that they were at high nutrition risk and required specific interventions related to intake. A review of the intake record identified that the total volume of intake was to be documented each shift, days, evenings and night. During an audit of the intake record from January 1 to January 31, 2016, the intake total was not documented on 14 shifts. From February 1 to 15, 2016, the intake total was not documented on five shifts. When intake volumes were not documented, no responses were provided in the comment section of the intake record form.

B) A review of resident #700's plan of care identified that they were at high nutrition risk and required specific interventions related to intake. A review of the intake record identified the total volume of intake was to be documented each shift, days, evenings and night. During an audit of the intake record from January 1 to January 31, 2016, the intake total was not documented on 17 shifts. From February 1 to 15, 2016, the intake total was not documented on six shifts. When intakes were not documented no responses were provided in the comment section of the intake record.

In an interview with the ADOC on February 17, 2016, it was confirmed that not all of resident #031's and resident #700's interventions were documented. It was shared that it was the homes expectation that documentation would be provided in the comment section if the interventions were not able to be administered as ordered. (#583) [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) On a date in February 2016 resident #200 was observed being transferred. During this observation, staff #108 was the only staff member with the resident. Staff #108 transferred this resident alone. Resident #200's care plan indicated that the resident was to be transferred using two persons.

An interview with staff #108, the Administrator and Director of Care confirmed that two staff members should have been present to assist with the transfer of resident #200. Safe transferring techniques were not used with resident #200 in this instance. [s. 36.]

2. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

B) According to the health record resident #550 had requested, in July 2015, to have a specific positioning device used. On a date in December 2015, the positioning device was not used by the PSW and the resident fell with no serious injury. This information was confirmed by the health record, the DOC's notes, the RAI back-up registered staff and the ADOC. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an interdisciplinary falls prevention and management program implemented in the home, with the aim to reduce the incidence of falls and the risk of injury

A) Policy #CN-F-05-1 titled "Fall Prevention and Management Program" and dated June 2010, directed that fall risk assessments be conducted for each resident at a minimum on admission, quarterly and with any significant change in condition that impacts fall risk.

Resident #016 was admitted to the home on a date in September 2014. Review of clinical records revealed that a falls risk assessment was completed on admission and the resident was identified as high risk. The next fall risk assessment was dated September 2015, and again, the resident identified as high risk for falls. Registered staff confirmed that the resident did not have quarterly fall risk assessments completed in December 2014, March 2015 or June 2015. The home's policy was not implemented.

B) The home provided a Fall Prevention and Management Program document for review. The document was dated June 2010 and included the following four components of the Fall preventions program:
Assessment, Intervention, Evaluation and Education.

A review of resident #600's health record indicated that the first falls risk assessment had been completed on a date in October 2015 on readmission from hospital.

Assessment: The Falls Prevention Program, under assessment, indicated the safety risk assessment would be conducted for each resident, at a minimum, on admission and quarterly. Interview with the ADOC confirmed the home's falls risk assessment was the tool the home used for the safety risk assessment for fall risk and that resident #600 had not had a risk assessment completed on admission nor on the next two quarters as directed by the home's Fall Prevention and Management Program.

Intervention: The Falls Prevention Program, under intervention, indicated to use alert messaging to identify residents at high risk for falls. Interview with the ADOC confirmed that the home had not implemented an alert messaging to identify resident #600 as a high risk for falls.

Evaluation: The Falls Prevention Program, under evaluation, indicated a number of strategies that included tracking and analysis of monthly falls in order to determine the success of the program. Interview with the ADOC confirmed that the home had not tracked, reviewed or analyzed monthly falls for resident #600 or any other resident that sustained a fall in 2015 until October 2015.

The ADOC confirmed that the licensee had failed to ensure that the home's falls prevention and management program was implemented. The ADOC stated that the program was implemented in October 2015, eight months after the admission of resident #600 who had been identified with a high risk for falls. (511) [s. 48. (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 following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #600, according to the health record sustained a fall in July 2015. Further review of the health record indicated a post falls assessment had not been completed. The home's Fall Prevention and Management Program required a post falls evaluation to be completed on residents who had fallen. Interview with the ADOC confirmed that the home had failed to ensure that when resident #600 had fallen a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

B) On a date in April 2015 resident #021 sustained a fall. A post-fall assessment was not completed for resident #021 for this identified fall. An interview conducted with registered staff and the ADOC confirmed that a post fall assessment should have been completed. 611 [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of the clinical record indicated resident #600 was admitted on a date in March 2015 and complained of intermittent pain. The resident was on routine analgesic for mild to moderate pain. The pain was still present in August. The PACSLAC was identified by RPN #111 as the pain assessment tool to be used for residents with cognitive impairment. On a date in October 2015 the resident developed pain in a different body area that became severe and uncontrolled. An order was received from the treating doctor for a stronger analgesic as needed. The PACSLAC was not completed until three days after the resident had complained of severe pain. The resident continued to complain of pain. Documentation on the medication flow sheet indicated that the stronger pain medication had been effective; however the progress note indicated that the resident had pain at 10 out of 10 and had continued to have pain at a level of 8-9 out of 10. Two weeks after the stronger medication was ordered, the order was changed to the milder medication even though the resident continued to experience pain that at times became severe. A week later the resident continued to complain of pain and was documented as being quite distressed. The resident was hospitalized for treatment. A pain assessment (PACSLAC) was not completed during the two weeks that the resident complained of moderate to severe pain. The pain assessment was completed upon return from hospital. The plan was to have pain medication control the resident's pain.

Interview with the ADOC confirmed the resident was not assessed using a clinically appropriate assessment instrument (PACSLAC) specifically designed for this purpose when the resident's pain as described above was not relieved by initial interventions. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council was sought in developing and carrying out the survey.

The Residents' Council was not consulted in the development of the satisfaction survey as confirmed by the Resident Council, the minutes and the Director of Therapeutics and Recreation Services. [s. 85. (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 advice of the Residents' Council and the Family Council, if any, is sought in developing and carrying out the survey, and in acting on its results, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for, (d) addressing incidents of lingering offensive odours.

The home had a lingering odour of urine in the hallways 100, 200, 300, 400 and 600 on February 2, 2016 at 0930 during the initial tour of the home. Lingering odours of feces were found to be pervasive on a daily and continuous basis on February 2, 3, 4, 5, 9, 10, 16, and 17, 2016 in the 200 and 500 hallways. On February 12, 2016, it was observed that the 500 hallway had an extremely strong urine odour. The soiled laundry bins in the hallway did not have the lids in place on February 12, 2016.
The odour of urine was frequently present in hallways of the home throughout this inspection. The Administrator confirmed that the home did not have a written procedure developed to address lingering offensive odours. [s. 87. (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 procedures are developed and implemented for, (d) addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #019 was observed on February 10, 2016 at 1315 hours to be wearing a lapbelt labelled as a Personal Assistance Service Device (PASD) very loosely around the hips. The belt was loose enough to be pulled away from the resident at least six inches. The manufacturer's instructions, according to the ADOC, stated that the belt should be no more than two fingers away from the resident. The ADOC confirmed that the belt had been applied too loosely on this occasion. [s. 111. (2) (b)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review of the health record indicated that resident #600 received medication for pain on several occasions in October 2015 but the effectiveness of the medication was not documented.

Interview with the ADOC confirmed that the home failed to ensure that when resident #600 was taking any drug or combination of drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs. [s. 134. (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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 8. continence, including bladder and bowel elimination.

An MDS assessment for resident #039 reported a decline for continence. Review of the document the home referred to as the care plan indicated that the intervention for bowel incontinence was containment. The above was confirmed by the RAI coordinator. Resident #039 reported that they were aware when they needed to defecate. They put the call bell on for staff who then put the resident in bed and provided a bed pan. Personal support staff confirmed this is the process used for toileting this resident. The plan of care was not based on, at a minimum, an interdisciplinary assessment of bowel elimination. [s. 26. (3) 8.]

2. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of, with respect to the resident risk of falls. O. Reg. 79/10, s. 26 (3).

Resident #016 was admitted to the home in September 2014 and assessed as high risk for falls. As confirmed by registered staff and the ADOC, the care plan did not include any interventions to minimize the risk of falls for resident #016 until one year after the resident had been admitted and identified at high risk for falls. The plan of care was not based on interdisciplinary assessment of the resident's risk of falls. [s. 26. (3) 10.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that a resident or the resident's substitute decision-maker was notified when, (a) the resident's personal aids or equipment were not in good working order or required repair; or (b) the resident required new personal belongings.

Resident #550 had personal equipment damaged in August 2015. The resident's substitute decision maker (SDM) was not notified that the resident required new or repaired equipment and found out about it when visiting 20 days after the equipment was damaged. This information was confirmed by the family member, the home's complaint log and the administrator. [s. 38. (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

A review of resident #016's MDS assessment for September 2015 identified them with difficulty finding words or finishing thoughts, unclear speech with slurred, mumbled words and although they were usually understood they may miss some part or intent of the message. The Resident Assessment Protocol (RAP) for the same period indicated that the resident's communication needs would be addressed in the plan of care. A review of the resident's plan of care did not include the resident's communication needs or strategies developed to address these needs.
Interview with two PSW's (#125,#126) confirmed resident #016 had slurred speech and had difficulty communicating with staff. PSW #126 had worked with the resident and confirmed the resident would become frustrated with new staff when trying to communicate. Interview with the ADOC confirmed the licensee had failed to ensure that strategies were developed and implemented to meet the resident's communication needs as identified in the RAP. [s. 43.]

WN #19: 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 nutrition care and hydration program included a weight monitoring system to measure and record with respect to each resident, (ii) body mass index and height upon admission and annually thereafter.

Health records of thirteen (13) residents were reviewed. Resident #016, 019, 020, 022, 024, 025 and 027 did not have a height measured and recorded annually or within the last year.

An interview with staff #106 confirmed that the home measures and records heights on admission only, and height is not monitored annually.

An interview with the DOC confirmed that heights are only measured and recorded upon admission. [s. 68. (2) (e) (ii)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Interview with staff member #125 confirmed that they observed resident to resident abuse. The staff member stated they intervened immediately.
A review of the clinical record indicated the substitute decision-maker (SDM) was upset when they were notified of the incident more than 24 hours after the incident.
Interview with the Administrator confirmed the home failed to ensure that the resident's SDM was notified within 12 hours upon the home becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. Where an incident occurs that causes an injury to a resident for which the resident was taken to a hospital, (b) where the licensee determined that the injury resulted in a significant change in the resident's health condition or remained unsure whether the injury resulted in a significant change in the resident's health condition, the licensee has failed to inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Resident #016 sustained a fall with injury on a date in September 2015 with admission to hospital. On readmission to the home, the resident had new care and treatments required and the care plan was updated.
The administrator confirmed that a critical incident was not submitted related to this hospitalization and change in condition. [s. 107. (3.1) (b)]

Issued on this 10th day of March, 2016

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BARBARA NAYKALYK-HUNT (146), IRENE SCHMIDT (510a), KELLY CHUCKRY (611), KELLY HAYES (583), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2016_214146_0004
Log No. / Registre no:	002291-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 9, 2016
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	OAKWOOD PARK LODGE 6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LeAnne Ryan

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

To MARYBAN HOLDINGS LTD, 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_323130_0007, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the home's policies, including the documents entitled "Medical Directives for Hypo/Hyperglycemia"; the "Documentation" policy to monitor food and fluid intake CN-D-19-1; and the "Pain Management" policy" CN-P-09-1 are complied with; specifically, ensure that interventions for hypoglycemia are implemented as per the policy; ensure that the resident's, including residents #040, 702 and 703's food and fluid records are completed and reviewed daily with referrals to the dietitian as per the policy; and, ensure that pain assessments are completed as per the policy for residents , including resident #031

The licensee shall provide training and education to staff related to the identified policies.

The licensee shall audit and evaluate the effectiveness of the training provided and the compliance with the specified policies.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, (b) was complied with.

Previously issued July 27, 2015 as a CO.

A) A review of the clinical record for resident #016 confirmed that the resident was sent to hospital on a date in September 2015. The home was requested to provide the home's policy for treating residents with hypoglycemia. The ADOC provided a one page document entitled "Medical Directives for Hypo/Hyperglycemia".

The home's Medical Directives for Hypo/Hyperglycemia gave specific directions for interventions to provide when a resident's blood glucose was abnormal. A review of the health record and staff interviews indicated that the policy was not complied with in September 2015 for resident #016.
Interview with the ADOC confirmed that the licensee failed to ensure that the home's Medical Directives for Hypo/Hyperglycemia were complied with for resident #016 in September 2015. (511)

B) The organized program of nutrition care and hydration, specifically the homes system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration was reviewed.
The home's "Documentation" policy CN-D-19-1, created on April 2011, stated "PSW must document intake of food and fluid for all meals and snacks on Nutritional Flow Chart" and "It is important to complete these accurately and in detail to ensure accurate accounting of resident intake". The Registered Dietitian (RD) referral form identified an example of a reason to refer the RD was, oral intake of fluid routinely below 1000 milliliters per day for more than five consecutive days or oral intake of food below 50 percent for more than five consecutive days.

In an interview with the Food Service Manager (FSM) on a date in February 2016, it was shared that education was provided to Personal Support Workers (PSW) related to completing the new food and fluid sheets in August 2015. The written procedure identified that night staff would total the resident's daily fluid intake and inform the registered staff if a resident's fluid intake was routinely below 1000 milliliters for more than five days. The FSM confirmed that direction on when to refer the RD related to low food intake was not provided.

A review of the "Nutritional Flow Chart" was completed from February 1 to February 16, 2016. It was documented that resident #040, #550, #701, #702 and #703's total volume of fluid consumed was less than 1000 milliliters per day for more than five consecutive days. It was documented that resident #040,

#702, and #703 oral intake of food was below 50 percent for more than five consecutive days. In an interview with the FSM on February 18, 2016, it was confirmed that the RD had not received any referrals for resident #040, #550, #701, #702 or #703 for low food or fluid intake.

In an interview with registered staff #124, #128, #129, #130 and #131 on February 18, 2015, it was shared that they did not know that an RD referral was to be sent based on the assessment of the "Nutritional Flow Chart" if oral intake of fluid routinely below 1000 milliliters per day for more than five consecutive days or oral intake of food below 50 percent for more than five consecutive days. Staff shared that they did not recall being provided education in the past six months related to the home's system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A review of the electronic RD referrals from December 17, 2015 to February 17, 2016, showed that there were no resident referrals for oral intake of fluid routinely below 1000 milliliters per day for more than five consecutive days or oral intake of food below 50 percent for more for more than five consecutive days.
In an interview with the Administrator on February 19, 2016, it was confirmed that the homes system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration was not complied with. (583)

C) The Home's policy #CN-P-09-1, entitled "Pain Management" and dated January 2013, directed that the interdisciplinary team would assess residents for pain on admission, re-admission, quarterly or with a change in condition that impacts pain or causes pain using Resident Assessment Inventory-Minimum Data Set (RAI-MDS) tool. Item #5 of the policy directed that, for residents who have pain, the pain flow record or 'PACLSAC' record would be completed.

i) Resident #031 experienced chronic pain for which they received long acting analgesics. Review of the clinical record for resident #031 revealed that the quarterly RAI-MDS pain assessments were completed. All assessments reported that the resident experienced moderate pain. The ADOC confirmed that there were no corresponding pain flow records or PACSLAC records completed as required by the home's policy.

ii) Resident #031 was readmitted to the home on a date in June 2015. A pain

assessment using the RAI-MDS tool was not completed at the time of re-admission, as confirmed by the DOC.

iii) A review of the clinical record indicated that resident #600 was admitted on a date in March 2015. The admission notes indicated that the resident had intermittent pain. There was no evidence of a pain assessment on admission as per the home's policy until three months after the resident's admission.
The home's policy for pain management was not complied with. (510) (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_323130_0007, CO #004;

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee shall ensure that residents, including resident #031, who are dependent on staff for repositioning are repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.
The licensee shall provide training to staff related to repositioning every two hours.
The licensee shall audit and monitor the effectiveness of the training.

Grounds / Motifs :

1. The licensee has failed to ensure that (d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.O. Reg. 79/10, s. 50 (2).

Previously issued July 27, 2015 as a CO and December 23, 2014 as a VPC.

A) Resident #031 had impaired skin integrity. The document the home referred to as the plan of care for resident #031 directed that the resident would be turned and positioned every two hours. On a date in February 2016, resident #031 was observed to be positioned on their right side between the hours of 1045 and 1320. The PSW confirmed the resident had been on their right side for longer than two hours. On another date in February 2016, the resident was observed to be positioned on their right side between the hours of 1000 and 1500. The resident's roommate confirmed that the resident had not been repositioned that day. Review of the turning and repositioning record for the resident revealed that on seven out of ten days in February 2016, the resident had not been consistently turned and positioned every two hours.
The ADOC confirmed that the resident had not been turned and positioned every two hours. (510a)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 02, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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