Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 9, 2014	2014_211106_0009	S-000007-14	Resident Quality Inspection

Licensee/Titulaire de permis

KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT
35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4

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

PRINCESS COURT
PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4

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

MARGOT BURNS-PROUTY (106), DEBBIE WARPULA (577), KARI WEAVER (534)

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): April 28, 29, 30, May 1, 2, 5, 6, 7, 8, 2014

The following Logs were reviewed as part of this inspection: Log# S-000007-14, S-000076-14, S-000107-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistance Directors of Care (ADOC), Administrative Clerk, Program Services Coordinator, Dietary Supervision, Environmental Services Manager, Adjuvant, Day Care Aide/Geriatric Recreationist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapy Assistant (PTA), Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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. 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. On May 5, 2014, one of the ADOC's in the home told inspector #106 that the home does not currently have a Skin and Wound Care program implemented in the home. Registered staff that were interviewed during this inspection reported to the inspector that currently, RPN will document on wound care when they complete dressing changes on the "Wound & Skin Management – RPN Additional Charting" or "pink sheets" and some wounds are referred to St. Joseph's Care Group, but that is all that is done.

On May 6, 2014, inspector #577 interviewed one of the home's ADOCs, staff member S-103 about the home's Skin and Wound Program. The ADOC reported that currently the home doesn't have a Skin and Wound Program in place nor an assessment tool. The ADOC reported that the "Wound and Skin Management-RN Weekly Assessment" documentation form isn't being utilized and wounds are not being assessed weekly. [s. 48. (1) 2.]

2. On May 6, 2014, staff member #S-110, reported to inspector #106, that RNs no longer conduct weekly wound assessments, which had once been the home's process, now RPNs document on the pink wound care sheets what dressing changes were done and there is no other wound assessment of documentation completed regarding residents' wounds.

The licensee failed to ensure that the following interdisciplinary program is developed and implemented in the home: 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. [s. 48. (1) 2.]

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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. Inspector #534 reviewed the manufacturer's recommendations for the use of a restraint used by resident #400. Resident #400 was observed by the inspector on May 7, 2014, to be restrained in a manner that was contraindicated in the manufacturer's instructions.

The licensee failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions. [s. 110. (1) 1.]

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 O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. During the course of this inspection inspector #106 observed staff speak to residents in a disrespectful manner and 2 residents reported to the inspector that some staff are verbally rough or disrespectful to them. Inspector #106 reviewed Policy # ADM 450, titled "Zero Tolerance of abuse and/or Neglect", with a revision date of December 2013, and found that, the home's written policy to promote zero tolerance of abuse and neglect of residents does not identify the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

Previously issued non-compliance regarding O. Reg. 79/10, s. 96 (e) (i) & (ii):
-a Written Notification (WN) and Voluntary Plan of Correction (VCP) was previously issued on December 4, 2013, during inspection # 2013_246196_0010
-a WN and VPC were previously issued on February 28 , 2013, during inspection # 2012_211106_0003

The Licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On April 30, 2014, at 0900hrs, inspector #106 overheard a staff member, say in an angry voice "you don't need any help, go sit down". The inspector looked in the direction of the voice and saw resident #505 standing outside an activity room. The inspector went into the room and saw staff member #S-128, with an angry look on their face. The inspector asked the staff member if they were the one who was just speaking to resident #505, they stated that they were and that they were not an employee of the home and work as a Physiotherapy Assistant (PTA) for an outside agency.

The licensee failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality was fully respected and promoted. [s. 3. (1) 1.]

2. During stage 1 resident interview and on May 6, 2014, resident #075 told inspector #106 that staff will often begin to assist them with am care and then will leave to answer bells or assist other residents and they are left waiting for them to return. Resident #075 indicated that this makes them very upset and has caused them to cry in the past. On May 6, 2014, the inspector observed that the resident's call bell was ringing at 0650hrs and a PSW responded immediately, but only stayed in the resident's room a very short time before leaving. At 0655hrs, five minutes later the

PSW returned to the resident's room. Later that morning the inspector asked resident #075 if staff had left them while assisting with care that day. The resident confirmed that staff had left them while assisting with their care. The licensee failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality was fully respected and promoted. [s. 3. (1) 1.]

3. While resident #500 was talking to staff member #S-129, they (S-129) turned to their co-worker and said "If you didn't know any better you would think they (resident #500) knew what I was talking about". The staff member, at the nursing station in front of the inspector and one other resident began discussing whether the resident should be changed or not. The licensee failed to ensure that the resident's right to be treated with dignity and respect was fully respected and promoted. [s. 3. (1) 1.]

4. On May 7, 2014, the inspector observed resident #029, who is dependent on staff for locomotion, in their chair outside the dining room, pushed very close to the wall, so close that their arm nearest the wall was directly under the handrail on the wall. The inspector brought this the attention of the RN and they agreed that it was not an appropriate place to place the resident and relocated the resident to the TV lounge. The licensee failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted. [s. 3. (1) 1.]

5. During the RQI, inspector #534 observed the supper meal service on 2 separate occasions. The inspector noted on the 1st observation on April 28, 2014, that resident #400 was displaying specific responsive behaviours and was disturbing many residents.

Resident #402 was visibly upset with resident #400's disruptive responsive behaviours. During the course of the meal, the inspector counted that the resident displayed specific responsive behaviours and staff attempted to redirect at least 6 times in the 1st 10 minutes of the meal observation. Staff attempts at redirection were noted to be 1:1 at the resident's side on some occasions and other times they were speaking in a loud tone from a few tables away while assisting another resident with their meal. At times, multiple staff were attempting to redirect the resident unsuccessfully.

Resident #068 waved the inspector over at one point during the meal to complain about the resident #400's disruptive behaviour. At the end of the meal staff #S-108

commented to the inspector "you picked our worst meal to watch".

On May 7, 2014, the inspector watched a 2nd supper meal service. During this observation resident #400 was noted to be inappropriately restrained.

The home failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

6. April 29, 2014, at approximately 1203 hrs, the inspector observed, staff member # S-130 administering a medication by injection to resident #506 at the nursing station. Staff member #506 pushed the resident's clothing aside to administer the medication, in front of the inspector and other residents that were near the nursing station. The licensee failed to ensure that the resident's right to be to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted. [s. 3. (1) 8.]

7. May 5, 2014, at approximately 1130 hrs, the inspector observed staff member #S-131, in front of the nursing station pulling the back of a female resident's shirt down. Staff member #S-131 was holding a container of what appeared to be a treatment cream; the inspector asked the staff member what they were doing.

Staff member S-131 stated that they was putting a treatment cream on the resident's back. The inspector asked if they, put the cream only on the lower back and staff member #S-131 stated that they put it all over the resident's back and up near their shoulders. Other residents were nearby at the time staff member #S-131 was applying the cream to the resident's back. The licensee failed to ensure that the resident's right to be to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted. [s. 3. (1) 8.]

8. On May 6, 2014, while the inspector was observing morning care the inner door to resident #055's room was left open and only the door to the hallway was closed while the PSWs assisted the resident with am care. The resident's roommate was still in their room and walked by the resident #055's open door on the way to their shared washroom, and then left the room. The licensee failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was not fully respected and promoted. [s. 3. (1) 8.]

9. During stage 1 resident interview, resident #011 told the inspector that they are afraid to ask staff to toilet them during meals. On May 7, 2014, registered staff member #S-132 told the inspector that they had observed the resident asking to be toileted by PSWs after meals and they have on multiple occasions told resident #011 that they have to wait. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [s. 3. (1) 15.]

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 that the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted, specifically in regards to resident #505, 075, 500, 029, 506, 055, 400, and 011, to be implemented voluntarily.

WN #5: 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. (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. (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 plan of care for resident # 011 was reviewed by the inspector. The care plan document, indicates, in regards to personal hygiene, resident #011 requires the assistance of 2 staff members and resident will help as much as physically possible. The RAI MDS assessment for the resident, indicated that the resident requires extensive assistance and a one person physical assist for personal hygiene.

The worksheet that the PSWs use to organize care, indicates that staff are to complete resident #011 some am care for the resident and then the resident will complete the rest once set up. On May 6, 2014, the inspector asked staff member #S-133 what am care was provided for the resident. Staff member # S-133 stated that they completed some am care for the resident and then they set the resident up to complete the am care.

The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The behaviour progress notes for resident #500 were reviewed by inspector 106. There were 20 different notes that indicated the resident displayed specific responsive behaviours.

The care plan document for resident #500 was reviewed and no interventions were found that direct staff on how to manage the resident's specific responsive behaviours. The licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Throughout the Resident Quality Inspection (RQI), that occurred in the home from April 28 to May 8, 2014, the inspector observed resident #501 displaying specific responsive behaviours. Residents #011 and #075 both told the inspector that when resident #501 exhibits these behaviours it disturbs them and they do not like it.

On April 28, 2014, during the initial tour of the home the inspector observed resident #501 display specific responsive behaviours and overheard resident #075 attempt to redirect resident #501. No staff were present to manage resident #501's responsive behaviours and eventually left the area.

A progress note reviewed, indicated that resident #501 continues to display specific responsive behaviours. The note also indicated that the resident became resistive when staff attempted to redirect resident #501. The care plan document for resident #501 was reviewed, it does not set out clear direction for staff on how often to monitor the resident, how to manage resident #501's behaviours to prevent or minimize the specific responsive behaviour and what to do it the resident becomes resistive while redirecting them. The licensee failed 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. [s. 6. (1) (c)]

4. On May 7, 2014, inspector #577 reviewed resident #017 Heath Care Record (HCR). On the printed PWS worksheet for resident #017, under falls prevention the following was found, "resident requires both side rails while in bed", this information is not documented in the care-plan binder (resident's written plan of care). 3 PSWs confirmed with the inspector that side rail use should be documented in the care-plan binder. During the record review for resident #017, inspector #577, could not find documentation in resident's plan of care concerning the use of 2 bed rails for safety. The inspector also observed the resident lying in bed with both side rails in the up position.

The licensee failed 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. [s. 6. (1) (c)]

5. A "Wound & Skin Management - RPN Additional Charting" sheet for resident # 060 was reviewed, the sheet indicated how often the resident's dressing was to be changed. During this inspection a ADOC, RN and RPN all reported to the inspector that all wound care documentation is recorded on the "Wound & Skin Management - RPN Additional Charting" sheet. There was no documentation to indicate the dressing for resident #060 was changed on a specific day. The licensee failed to ensure that the following are documented, the provision of the care set out in the plan of care. [s. 6. (9) 1.]

6. The "Wound & Skin Management – RPN Additional Charting" or "pink sheets", dated April 27 to May 7, 2014, for resident #020 found in the wound care binder on 2nd floor. The St. Joseph's Care Group "Wound and Ostomy Consultation Form" were also reviewed. Both documents indicate that the resident's dressing is to be changed daily.

Registered staff reported to the inspector that all dressing changes are documented on the "Wound & Skin Management – RPN Additional Charting" or "pink sheets". There is no dressing change documented for resident #020 on April 30, 2014. The licensee failed to ensure that the provision of the care set out in the plan of care is documented. [s. 6. (9) 1.]

7. The "Wound & Skin Management – RPN Additional Charting" found in wound care binder reviewed by inspector, indicates the resident's #503 dressing is to be changed daily. Multiple registered staff members told the inspector that the only place that dressing changes/wound care is documented is on the "Wound & Skin Management – RPN Additional Charting" sheet.

There are was no documentation to indicated that resident's #503 dressing was changed on the following days: March-21, 24, 25, 26, 27, 28, 30, 31, April 1, 2, 6, 7, 10, 11,13, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, May 7, 2014. The licensee failed to ensure that the provision of the care set out in the plan of care is documented [s. 6. (9) 1.]

8. The behaviour progress notes for resident #500 were reviewed by inspector #106. There were 34 different behaviour notes found that indicated the resident had displayed specific responsive behaviours that could impact other residents. Family and staff members both told the inspector that the resident is continually displaying specific responsive behaviours that could affect the safety of co-residents.

The care plan document for resident #500, was reviewed and the following intervention was found, Monitor Resident for behaviours - and redirect from the specific behaviour. Monitoring the resident and redirecting has not been effective in managing the resident's behaviour, yet the plan of care has not been revised. The licensee failed to ensure a resident is reassessed and the plan of care reviewed and revised, 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. [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 the plan of care sets out clear directions to staff and others who provide direct care to residents # 011, 500, 501, and 017; the provision of the care set out in the plan of care is documented for residents # 020, 060 and 501; and that resident #500 is reassessed and the plan of care reviewed and revised, 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, to be implemented voluntarily.

WN #6: 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:
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.

Findings/Faits saillants :

1. During the course of the inspection, inspector #534 noted that 3 residents within the home had keys and locked their room doors to prevent wandering residents from entering into their rooms. According to staff and the residents, each resident has been provided with a key with the understanding that the doors are to remain unlocked when the resident is in their room and at night. It was reported by staff #S-113 that sometimes resident #401 forgets to leave their door unlocked at night but staff check the doors nightly to ensure they are unlocked. The locks on the residents' doors were noted to not have any type of quick release mechanism so that the doors could be easily released from the outside in an emergency if the resident had forgotten to leave their door unlocked. The doors could only be unlocked with the use of a key.

The licensee failed to ensure that any locks on bedrooms, washrooms, and toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. [s. 9. (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 any locks on bedrooms, washrooms, and toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. Inspector # 534 looked into complaints related to missing personal items such as clothing, books, and a collection of money that were reported missing by residents # 011, 029, and 049. The inspection focused on the process that the home uses to report and investigate missing personal resident property within the home. The inspector conducted interviews with staff #S-104 PSW, #S-109, #S-110, the DOC, and the administrator of the home. Through the various interviews with the home's management, unregistered, and registered staff the inspector was told that no process with policies and procedures existed in the home for reporting and investigating missing resident property.

A PSW stated they would report it to the RPN, the RPN stated they would notify the RN, and the RN stated they would notify the DOC or someone from the management team. The only documentation that would occur would be in the progress notes of the resident's computer chart. The staff within the home stated that they try to encourage residents' to not keep valuable items such as jewellery or money in the home as a method to prevent missing items. The home's management team stated that a corporate policy for missing property may exist but that the procedure and policy was not known or used within the home.

The licensee failed to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. [s. 21.]

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 ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. On May 8, 2014, inspector asked the administrator if the home had forwarded a copy of the written complaint letter dated March 8, 2014, to the Ministry of Health and Long-Term Care (MOHLTC). The administrator stated the home did not forward a copy of the complaint letter dated March 8, 2014, as by the time the home had received the letter all of the complainant's concerns had been addressed and a response letter had be sent to the complainant on March 14, 2014. The licensee failed to ensure that when a long-term care home receives a written complaint concerning the care of a resident or the operation of the long-term care home, the licensee shall immediately forward it to the Director. [s. 22. (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 when a long-term care home receives a written complaint concerning the care of a resident or the operation of the long-term care home, the licensee shall immediately forward it to the Director, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On May 6, 2014, inspector #577 interviewed resident #057 who reported their teeth were not brushed. The resident's teeth appeared unclean and unbrushed. Interviews conducted with staff members #S-118 and S-119, both confirmed that resident #057 requires assistance of 1 staff to clean their teeth. Staff member # S-120 confirmed that they brushed residents teeth on May 6, 2014.

On May 7, 2014, the inspector was approached by staff member #S-120, who reported they were dishonest, and did not perform oral care for resident on May 6, 2014. Staff member #S-120 reported they were urged by a co-worker to answer 'yes' to questions, asked by the inspector. The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures. [s. 34. (1) (a)]

2. The Home does not provide an annual dental assessment and other preventative dental services. Resident #057, had a 'Dental and Gum care' assessment done on admission in 2011. During an interview staff member #S-102 reported to inspector #534 that the home does not offer an annual dental assessment or other preventive services to all the residents in the home. The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1). [s. 34. (1) (c)]

3. Inspector # 534 interviewed resident #010 regarding their oral care within the home. The resident stated they had a hard time eating without dentures and that their gums were sore. The inspector asked the resident when their last dental exam was and it was reported to the inspector that they had not seen a dentist in 2 years. Staff member #S-102 was asked about the home's oral care policy and whether dental assessments are offered to residents within the home. The staff member stated that oral care concerns are discussed in annual care conferences with residents and their families who participate in the conferences but the home does not offer an annual dental assessment or other preventative services to all the residents' in the home. The staff member explained that the responsibility of this is left up to the residents' who have families. An oral exam is completed by a registered practical nurse on admission and repeated by the RPN if any concerns are noted for the resident. The concerns would be relayed to resident's family to arrange for a dental exam.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

4. Inspector # 534 interviewed resident #020 regarding their oral care within the home. The resident stated they had problems with painful gums and had not seen a dentist in a long time. The resident's chart was reviewed and no notes were found by the inspector to indicate that any oral health professionals had been offered to assess the resident. Staff member #S-102 was asked about the home's oral care policy and whether dental exams are offered to residents within the home. The staff member stated that oral care concerns are discussed in annual care conferences with residents and their families who participate in the conferences but the home does not offer an annual dental assessment or other preventative services to all the residents' in the home. The staff member explained that the responsibility of this is left up to the residents' who have families. An oral exam is completed by a registered practical nurse on admission and repeated by the RPN if any concerns are noted for the resident. The concerns would be relayed to resident's family to arrange for a dental exam.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being

authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

5. On May 8, 2014, Inspector confirmed through interview with staff member # S-102, that the Home does not offer an annual dental assessment and other preventative dental services. The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, specifically for residents # 057, 010, and 020, to be implemented voluntarily.

WN #10: 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. On various days, during this inspection, inspector #106 asked a ADOC, a RN and a RPN, if residents exhibiting altered skin integrity, are assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. All staff members reported that the only documentation regarding wounds or altered skin integrity is done by the RPNs on the "Wound & Skin Management - RPN Additional Charting" sheets.

A "Wound & Skin Management - RPN Additional Charting" sheet for resident #060 was found in the wound care binder and reviewed by the inspector. The sheet provided direction to staff, regarding the treatment/ procedure staff are to follow when caring for the resident's wound and the RPNs charted the dressing changes on the sheet. There was no assessment of the wound documented on this sheet that indicates the size or stage of the wound. [s. 50. (2) (b) (i)]

2. On May 8, 2014, inspector 106 reviewed, a "Wound and Ostomy Consultation Form" from St. Joseph's Care Group, for resident #20 and it indicated the size and stage of the resident's wound.

A "Wound & Skin Management - RPN Additional Charting" sheet for resident # 020 was found in the wound care binder was reviewed by the inspector. The sheet provided direction to staff, regarding the treatment/ procedure staff are to follow when caring for the resident's wound and the RPNs charted the dressing changes on the

sheet. There was no assessment of the wound documented on this sheet. [s. 50. (2) (b) (i)]

3. On May 07, 2014, inspector #577 reviewed the Heath Care Record for resident #048. On the Wound and Skin Management form for resident #048, instructions were found on how to care for the wound. The most recent OTN wound assessment describes the wound and how to care for it. [s. 50. (2) (b) (i)]

4. On May 5, 2014, inspector #577 reviewed the Health Care Record for resident # 017 and noted that the documentation indicated that the resident's skin integrity and treatment.

Inspector #577 spoke with staff member #S-125 about Homes Skin and Wound Management Program and they reported, that staff follow the physician orders and the orders of the Ontario Telehealth Network (OTN) skin care nurse, but there is no formalized procedure within the Home. Staff member #S-125 also reports that PSW's monitor the resident's skin on bath day, daily and RPN's will perform dressing changes as ordered, but there is no current clinically appropriate assessment instrument that is specifically designed for skin and would assessment being used in Home.

On May 6, 2014, inspector #577 interviewed ADOC # S-103, concerning the home's Skin and Wound Program and a current skin and wound assessment instrument. The ADOC reported that the home does not have a Skin and Wound Program in place nor an assessment tool, and wounds are not being assessed weekly. The "Wound and Skin Management-RN Weekly Assessment" documentation form, which the home previously used to assess altered skin integrity, is no longer being utilized by staff.

The licensee failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, specifically in regards to residents # 060, 020, 048, 017, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. Inspector # 534 reviewed resident #400's current care plan that identifies the resident's documented specific responsive behaviours and the interventions currently being used. The care plan states that staff in the home are to follow the home's program on minimizing the use of restraints but no additional interventions are listed to guide staff on other methods to avoid these potential harmful interactions or identify triggers for the resident. The only intervention listed is the use of a restraint.

The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, specifically in relation to resident #400's responsive behaviours, to be implemented voluntarily.

WN #12: 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. Inspector #534 was looking into resident complaints related to the home's food not being served at proper temperatures. The inspector interviewed the Dietary Supervisor regarding the temperatures of food served, reviewed the homes food temperature policy "DTY 075: Food Temperatures", and examined the documentation practices for food temperatures "Princess Court Nutrition & Food Service Temperature Audit" sheets.

The inspector determined that the temperatures of the home's food occurred twice before it was served to the resident. Documentation of the temperatures was completed and documented 95% of the time before the food left the kitchen. The 2nd temperature that was to occur was on the unit just prior to the resident being served the food. This 2nd temperature was not consistently recorded as being measured and was confirmed by the Dietary Supervisor. On some of the documentation sheets reviewed by the inspector and the Dietary Supervisor, an entire day's worth of meal temperatures were absent. The home's policy and audit sheet clearly stated that the temperatures were to be tested and documented just prior to serving the food to the residents.

The home failed to ensure that the Nutrition Care and Hydration Programs include, 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. [s. 68. (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 the Nutrition Care and Hydration Programs include, 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, specifically in regards to taking and documenting all required food temperatures, to be implemented voluntarily.

WN #13: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. On April 28, 2014, during the supper meal service staff member #S-134 was observed, by inspector #106, to stand while assisting resident #029 and resident #501. During the same meal service the inspector also observed staff member #S-135 standing while feeding resident #059.

On May 5, 2014, during the lunch meal service, inspector #106 observed staff member #S-134 to stand while feeding resident #059. The licensee failed to ensure that proper techniques are used to assist resident with eating, including safe positioning of residents who require assistance. [s. 73. (1) 10.]

2. On April 28, 2014, resident #059 was observed to have their meal sitting in front of them at 1705hrs and did not receive assistance with eating until 1714hrs. On April 30, 2014, at 1715, when the inspector came into the dining room resident #059 had their supper meal sitting in front of them and no one was available to assist them with eating until 1722hrs. On May 5, 2014, at 0817hrs, the inspector observed a PSW, place a bowl of oatmeal in front of the resident and no one was available to assist them with eating until 0825hrs. The licensee failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, specifically in regards to resident #059, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. In the Fall of 2013, the home received a complaint letter from a family member of resident #502, that had multiple areas of concern. In October 2013, the home sent a response letter to the POA and in December 2013 the same letter was sent to the complainant.

The inspector reviewed a copy of the response letter and it did not contain any details in regards to what the licensee had done to resolve the complaint or if the licensee believed that parts of the complaint to be unfounded and the reasons for the belief. During a May 7, 2014, meeting with the POA for resident #502, they reported that in March 2014, they had again asked the administrator for information regarding the results of the September 2013 complaint letter and still had not received a satisfactory response.

On May 8, 2014, the inspector asked the administrator if the home had provided information to resident #502's POA and family member regarding what the licensee had done to resolve the complaint or if the licensee believes the complaint to be unfounded and the reasons for the belief. The administrator reported to the inspector other than the original response letter they did not share any other details in regards to the home's investigation into the concerns/complaints that were identified in the original complaint letter.

The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response has been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. [s. 101. (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 for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response has been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #15: 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. On May 7, 2014, at approximately 1945hrs, the inspector found an unlocked and unattended medication cart in the hall outside a resident room. The inspector could hear the registered staff member assisting the resident in the room. The inspector noted that individual medication packs were sitting on top of the cart as well as crushed medications mixed with what appeared to be pudding.

The inspector waited by the cart for approximately 1 or 2 minutes until the registered staff member was finished assisting the resident and came back to the cart. The inspector asked the registered staff member if it was their regular practice to leave the medication cart unattended when medications are left on top of the cart. The registered staff member stated that they normally take the cart into resident rooms but they had forgotten to this time. The licensee failed to ensure that drugs are stored in a area or a medication cart that is secure and locked. [s. 129. (1) (a)]

2. On May 7, 2014, during a review of a medication room it was found that the controlled substances are kept in a separate stationary cupboard that does not have a lock. Staff member # S-125 told the inspector that the controlled substance cupboard is supposed to be getting a lock and that there had been a lock on the cupboard previously, but the lock does not currently work. The licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [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 drugs are stored in a area or a medication cart that is secure and locked and that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. On May 7, 2014, the inspector interviewed the home's administrator to discuss the Quality Improvement (QI)) System. The administrator reported that the home does have a QI System that is informal in nature and the QI processes are reviewed regularly during management team meetings. The administrator stated that the home does not currently have any written description of the QI system. The licensee failed to ensure that there is a written description of the QI utilization and review system that includes its goals, objective, policies, procedures and protocols and a process to identify initiatives for review. [s. 228. 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 there is a written description of the Quality Improvement and Utilization Review system that includes its goals, objective, policies, procedures and protocols and a process to identify initiatives for review, to be implemented voluntarily.

WN #17: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. On April 28, 2014, during the supper meal service inspector observed staff member #S-135, remove dirty dishes from the dining room and then assist resident #059 with eating. The staff member did not practice hand hygiene before assisting the resident after handling other resident's dirty dishes.

On May 5, 2014, during the lunch service, the inspector observed staff member #S-134 to stop feeding resident #059, to assist with boosting another resident up in their wheelchair, then pat another resident on their shoulders, and then feed resident #059. The staff member did not practice hand hygiene after assisting and touching the other residents before returning to feed resident #059.

On May 6, 2014, during the breakfast meal service, the inspector observed staff member #S-135, serve residents' their meals, pick up their dirty dishes while at the table, return the dirty dishes to the servery and then serve the next residents' their

meals. The staff member was observed to repeat this multiple times and was not observed to practice hand hygiene during the dining service.

On May 6, 2014, during the 0800hrs medication pass the inspector observed staff member #S-132 administer an injection to a resident. The inspector did not observe the staff member practice hand hygiene prior to giving the injection nor were they observed to practice hand hygiene after the injection or before administering medications to other residents.

The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program. [s. 229. (4)]

2. During the course of the inspection, inspector #534 noted various instances of hand hygiene and infection control principles not being followed by the staff in the home. Multiple instances of this were noted during the supper time meal observation on May 7, 2014 by 3 separate staff members.

The inspector noted the following:

Registered staff #S-109 was noted to administer crushed oral medications by spoon to 3 separate residents. No hand hygiene was noted between each of the residents before or after receiving medications. The staff member at was noted to leave the dining room and enter into the nursing station care area, walked by 2 hand sanitizer pumps during the transition between the 2 care areas, and failed to sanitize their hands.

Staff #S-111 was noted to transition between multiple tasks without performing hand hygiene. For example, the staff member was noted to clear dirty dishes from tables, scrape plates, document meal consumption amounts, provide a resident with a tissue box, and then assist a resident with eating without practicing hand hygiene before assisting the resident with eating.

During the same meal observation a third staff member, #S-104 was noted to assist a resident with their meal at one of the tables, get up and walk over to a 2nd resident at another table and offer that 2nd resident meal assistance, all without washing their hands between the 2 residents at the 2 separate tables.

With regards to the Infection Prevention and Control Program and hand hygiene, the

licensee failed to ensure that all staff participate in the implementation of the program. [s. 229. (4)]

3. On May 6, 2014, inspector interviewed one of the home's ADOCs, about the homes Infection Prevention and Control program. The ADOC reported to the inspector that the home does not offer residents immunization for tetanus and diphtheria. The licensee failed to ensure that the following immunization and screening measures are in place: tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 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 staff participate in the implementation of the Infection Prevention and Control Program, specifically in regards to hand hygiene and that the following immunization and screening measures are in place: tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. Inspector # 534 interviewed the home's Residents' Council President about the Residents' Council role within the home. They were asked if the home responded to the council in writing when any concerns or recommendations were brought forth to the home from the council. They stated that sometimes the home did respond back in writing to the council if it was an urgent matter. This was further clarified though an interview with the Program Services Coordinator who assists the council within the home. The staff member explained that most of the communication between the council and the home was verbal and that the home did not routinely respond back to the council within 10 days in writing of receiving concerns or recommendations.

The licensee failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. [s. 57. (2)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. On May 7, 2014, inspector #534 conducted an interview with staff #S-107 regarding the home's Family Council. According to the staff member the home has not had a Family Council in place since September 2013. The home has been trying to re-establish the Family Council by advertising for council membership on the home's TV screen and resident newsletters. No semi-annual meetings have been organized to date to advise such persons of the right to establish a Family Council, since the dissolution of the home's Family Council 8 months ago.

The licensee failed to ensure that if there is no Family Council, the licensee shall convene semi-annual meetings to advise such persons of the right to establish a Family Council. [s. 59. (7) (b)]

WN #20: 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. Inspector # 534 interviewed the home's Residents' Council President about the Residents' Council's role within the home. They were asked if the home had sought advice on the development of the home's annual resident and family satisfaction surveys used in the home. The Residents' Council President responded that the council was not involved with the survey development but the results have been shared at family care conference meetings. This was further clarified though an interview with staff #S-107, Program Services Coordinator who assists the council within the home. The staff member explained that the Residents' Council is not involved with the development of the survey. The home's administrator mails the survey out to the resident and their families and results are shared with the councils. The managers are involved with the process but the Residents' Council is not.

The licensee failed to ensure that home seeks 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. [s. 85. (3)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (5) The licensee shall ensure,
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

Findings/Faits saillants :

1. On May 7, 2014, the DOC told the inspector that the home has been recently reviewing the home's drug destruction and disposal system and have had verbal meetings with their pharmacy. It was identified that there are no written records that document the home has been conducting annual audits and that any changes identified in the audits has been implemented. The licensee failed to ensure that in regards to drug destruction, a written record of annual audits or any changes identified in the audits were kept. [s. 136. (5) (c)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #534 interviewed staff #S-105 regarding trust accounts in the home due to concerns of trust account written statements not being provided to residents. During a stage 1 family interview, the POA for resident #029, indicated that statements are not automatically provided to the home's residents but are provided when requested. The staff member confirmed that statements are not routinely mailed out to residents or family members/SDM. Most communication is centered on monthly rent and cable bill balances. Some family members stop at the front office and hand written trust account balances are provided upon request. Staff #S-105 acknowledged that the home should be sending out quarterly itemized written statements for trust account money to all residents and family/SDMs.

The licensee failed to ensure that a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement are provided to the resident, or to a person acting on behalf of a resident. [s. 241. (7) (f)]

Issued on this 6th day of October, 2014

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

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) :	MARGOT BURNS-PROUTY (106), DEBBIE WARPULA (577), KARI WEAVER (534)
Inspection No. / No de l'inspection :	2014_211106_0009
Log No. / Registre no:	S-000007-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 9, 2014
Licensee / Titulaire de permis :	KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT 35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4
LTC Home / Foyer de SLD :	PRINCESS COURT PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PATRICK BERREY

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 KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
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.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee will comply with O. Reg. 79/10, s. 48 (1) 2 and ensure that the following interdisciplinary program is developed and implemented in the home: 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.

Grounds / Motifs :

1. On May 6, 2014, staff member #S-110, reported to inspector #106, that RNs no longer conduct weekly wound assessments, which had once been the home's process, now RPNs document on the pink wound care sheets what dressing changes were done and there is no other wound assessment of documentation completed regarding residents' wounds.

(106)

2. On May 5, 2014, one of the ADOC's in the home told inspector #106 that the home does not currently have a Skin and Wound Care program implemented in the home. Registered staff that were interviewed during this inspection reported to the inspector that currently, RPN will document on wound care when they complete dressing changes on the "Wound & Skin Management – RPN Additional Charting" or "pink sheets" and some wounds are referred to St. Joseph's Care Group, but that is all that is done.

On May 6, 2014, inspector #577 interviewed one of the home's ADOCs, staff member S-103 about the home's Skin and Wound Program. The ADOC reported that currently the home doesn't have a Skin and Wound Program in place nor an assessment tool. The ADOC reported that the "Wound and Skin Management-RN Weekly Assessment" documentation form isn't being utilized and wounds are not being assessed weekly.

The licensee failed to ensure that the following interdisciplinary program is developed and implemented in the home: 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. [s. 48. (1) 2.] (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2014

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. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee will comply with O. Reg. 79/10, s. 110 (1) 1 and ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, specifically in regards to resident #400.

Grounds / Motifs :

1. Inspector #534 reviewed the manufacturer's recommendations for the use of a restraint used by resident #400. Resident #400 was observed by the inspector on May 7, 2014, to be restrained in a manner that was contraindicated in the manufacturer's instructions.

The licensee failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions. (534)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Order / Ordre :

The licensee will comply with O. Reg. 79/10, s. 96 (e) (i) & (ii) and ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

Grounds / Motifs :

1. During the course of this inspection inspector #106 observed staff speak to residents in a disrespectful manner and 2 residents reported to the inspector that some staff are verbally rough or disrespectful to them. Inspector #106 reviewed Policy # ADM 450, titled "Zero Tolerance of abuse and/or Neglect", with a revision date of December 2013, and found that, the home's written policy to promote zero tolerance of abuse and neglect of residents does not identify the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

Previously issued non-compliance regarding O. Reg. 79/10, s. 96 (e) (i) & (ii):
-a Written Notification (WN) and Voluntary Plan of Correction (VCP) was previously issued on December 4, 2013, during inspection # 2013_246196_0010
-a WN and VPC were previously issued on February 28 , 2013, during inspection # 2012_211106_0003

The Licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2014

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 September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARGOT BURNS-PROUTY

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