Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 25, 2015	2015_401616_0014	018921-15	Resident Quality Inspection

Licensee/Titulaire de permis

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD P.O. BOX 219 SMOOTH ROCK FALLS ON P0L 2B0

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

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD P.O. BOX 219 SMOOTH ROCK FALLS ON P0L 2B0

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

JENNIFER KOSS (616), LISA MOORE (613)

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): August 11-13, 17-20, 2015

The inspectors conducted a daily walk through of resident care areas, reviewed residents' health care records, reviewed policies and procedures, and observed staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with the Long-Term Care Coordinator (LTCC), Registered Nurses (RNs)and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nutrition Manager, Food Service Worker, Activity Coordinator, Physiotherapy Assistant, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home 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.

In an interview with S#103, they reported to Inspector #616 that resident #006 had no teeth, had previously worn upper and lower dentures, and added that staff attempt to provide oral care three times a day after meals. S#100 stated that the resident has upper and lower dentures but reported they do not always wear them, and they receive oral care by staff in the morning and at night. S#102 and the Long-term Care Coordinator (LTCC) stated the resident has not worn their dentures in years.

The resident's Daily Nursing Flow Sheets related to the provision of oral care for July and August 2015 had no staff signature under the D-day shift and/or N-night shift. There were 13 dates where it was unclear whether the resident received oral care at minimum, twice a day.

S#100 reported blanks in the documentation on the Daily Flow Sheets indicated that the care had not been provided. The LTCC stated a blank on a night shift indicated the night staff did not provide care because the resident is known to go to bed after supper.

The home's policy titled 'Dental Care' (reviewed November 2014) stated each resident's mouth, teeth and/or dentures shall be cleaned twice daily or more frequently as required, with assistance provided according to the resident's ability manage his/her own care.

The LTCC confirmed the current Daily Flow Sheet related to oral care does not clearly indicate if the resident has received oral care provided by staff in the morning, after lunch and supper as per resident #006's plan of care (August 4, 2015).

The home has not ensured that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening. [s. 34. (1) (a)]

2. The licensee has failed to ensure that each resident of the home receives an offer of an annual dental assessment and other preventive dental services.

Inspector #613 reviewed resident #009's most recent care plan that is available to staff (July 30, 2015) which identified that the resident requires assistance with set up and verbal cueing to clean own teeth each morning, afternoon and after each meal. The inspector reviewed the resident's medical records, paper and electronic form but was unable to locate an annual dental assessment. The LTCC confirmed resident #009 did not receive an annual dental assessment in 2014 or 2015. [s. 34. (1) (c)]

3. Inspector #613 reviewed resident #007's most recent care plan that is available to staff (July 5, 2015) which identified that this resident requires assistance with daily cleaning of teeth, mouth and tongue each morning, afternoon and after each meal. The inspector reviewed the resident's health records, paper and electronic form but was unable to locate an annual dental assessment. The LTCC confirmed resident #007 did not receive an annual dental assessment in 2014 or 2015. [s. 34. (1) (c)]

4. A dental assessment was not located in resident #006's health record. The LTCC confirmed resident #006 had not been offered an annual dental assessment.

Inspectors #613 and #616 reviewed the home's policy titled 'Dental Care' (reviewed November 2014) that identified a dental assessment shall be offered annually or as required by qualified dental personnel.

Residents #009, #007, and #006 had not been offered an annual dental assessment and other preventative dental services. [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 mouth care in the morning and evening, including the cleaning of dentures, and are offered an annual dental assessment and other preventative dental services, to be implemented voluntarily.

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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #007's condition had been reassessed and the effectiveness of the restraining evaluated by a registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

During the RQI inspection, inspector #613 observed resident #007 with an assistive

device. The inspector reviewed resident #007's health records that indicated a physician's order was received for the assistive device as a restraint. As the resident was unable to provide written consent, verbal consent for the restraint was received from the resident on the same date.

Inspector #613 reviewed a form titled 'Smooth Rock Falls Restraints Record' located in the Daily Nursing Flow Sheet binder. The sheet was dated August 3 to 8, 2015. The inspector could not locate a sheet for dates after Aug 8, 2015, or the initials of registered staff assessing the use of restraint at least every eight hours on this sheet.

Inspector #613 met with the LTCC to determine if registered staff were expected to sign the restraint flow sheet to demonstrate they are assessing the effectiveness and need for the restraint. The LTCC confirmed registered staff do not sign on the Restraints Record Sheet, that they initial on the resident's Medication Administration Record (MAR). The LTCC showed the inspector the MARs for resident #007 that identified the registered staff had signed twice daily for use of the restraint at 1000hrs and 2100hrs from the beginning to mid August 2015.

The inspector reviewed the home's policy titled 'Least Restraint Policy' (revised January 2015) #8 which stated to reassess (physician, RNEC or registered nursing staff only) the resident's condition, effectiveness of the restraint, need for ongoing restraint, potential to employ a less restrictive restraint. Policy titled 'Guideline for Restraint Record' (revised January 2009) was reviewed which stated all restraints must be reassessed on every shift by a registered staff and signed on the MAR if restraints are still required. The policy did not identify a time frame for completion or reassessment.

The licensee did not ensure that resident #007's condition had been reassessed and the effectiveness of the restraining evaluated at least every eight hours. [s. 110. (2) 6.]

2. The licensee failed to ensure that the documentation on the restraint record identifies the person who applied, repositioned, and removed the device for resident #007.

Inspector #613 observed resident #007 with an assistive device during the course of the RQI inspection. The inspector reviewed resident #007's health records which identified that a physician's order was received for the assistive device as a restraint. Verbal consent for use of the restraint was received by the resident.

Inspector #613 reviewed a form titled 'Smooth Rock Falls Hospital Restraints Record' for

the beginning of August 2015. The inspector could not locate a form for dates after August 8, 2015 to the date of inspection. The columns on the form for one particular date at the beginning of August 2015 did not have any documentation or staff signatures. The inspector reviewed the electronic progress notes for this time period and could not locate documentation in relation to restraint application or why no documentation had occurred. Documentation on the restraint record for two specific dates at the beginning of August indicated the use of the restraint and that the resident was calm but did not identify if the restraint was applied or removed. As well, there was no staff signature on the form. This form does not identify the designation of the staff member whom initialed the form.

On August 19, 2015, the inspector met with the LTCC. They confirmed any staff (PSW or RPN) can sign the Restraint Record. The inspector showed the LTCC the Restraint Record that had not been consistently signed by staff on a daily basis. The LTCC confirmed the missing signatures by staff and also confirmed staff should have signed the form if the restraint was in use. They added if the restraint was not in use, the staff should have documented in the nursing progress notes that the restraint was not applied and explain the reason why it was not applied.

Inspector #613 reviewed resident #007's current plan of care that is accessible to staff, dated July 5, 2015 which indicated that staff must check and reposition the resident every hour when restraining device in use. The plan of care identified that the registered staff will sign the Restraint Record accordingly while the device is in use.

On August 20, 2015, the inspector informed the LTCC that the Restraint Record could not be located from August 9, 2015 to present date. The LTCC confirmed that the current Restraint Record was not in the Daily Flow Sheet binder where it should be. There was no documentation for restraint use located from August 9, 2015 to present date, August 20, 2015.

The inspector reviewed the home's policy titled 'Guideline for Restraint Record'. The policy stated that the purpose of the Restraint Record is used as a documentation and information record. It provides information as to the type of restraint, repositioning, hourly check, application time, removal time, resident's response to restraints application, and staff initial. The Nursing staff member (RN or RPN) are responsible for the documentation of the hourly checks.

For resident #007, the licensee failed to ensure there was documentation that identified

which staff applied the restraint and time of application for 15 days throughout August 2015. [s. 110. (7) 5.]

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 a resident is being restrained by a physical device, the resident's condition is reassessed and the effectiveness of the restraining is evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. In addition, the licensee is required to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: The person who applied the device and the time of application, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there 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.

On August 18, 2015, resident #003 was observed rubbing an affected extremity and complained to inspector #616 of pain to the area. In an interview with S#101 they stated the resident is known to have pain in both extremities, however more to one extremity. S#100 and S#103 both reported knowledge of resident's pain in one extremity. The LTCC reported the resident's pain is in the other extremity.

The Pain focus on the electronic care plan dated July 20, 2015 identified the resident has chronic pain to one particular extremity. The Comfort focus identified alteration in comfort related to the other extremity.

The resident's written plan of care did not set out clear directions to staff and others who provide direct care related to pain and comfort. [s. 6. (1) (c)]

2. S#103 reported resident #006 had no teeth, previously wore upper and lower dentures and added that staff attempt oral care three times a day after meals. S#100 stated that the resident had upper and lower dentures but did not always wear them, and they receive oral care in the morning and at night. S#102 and LTCC stated the resident has not worn their dentures in years.

The inspector reviewed the resident's electronic care plan dated August 4, 2015 with S#100 which stated under the Dentition/Oral focus that mouth care and denture care will be provided by staff; has dentures and/or removable bridge; daily cleaning of teeth or dentures, or daily mouth care by Client or staff; staff to clean dentures Freq-3 times a day; staff to soak denture at night and make sure all debris are remove from mouth; clean mouth and tongue each morning, evening and after meals with a frequency of 3 times a day.

The home's policy titled Dental Care (reviewed November 2014) stated individualized oral care shall be provided to maintain tissue integrity and to observe for problems.

Inspector reviewed resident #006's current care plan with the LTCC where it states they have dentures, and for staff to soak at hs (night). The LTCC confirmed the care plan is not clear or individualized to the resident's needs as they do not wear dentures. [s. 6. (1)

(c)]

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

On August 13, 2015 resident #005 was observed by Inspector #616 to be laying in bed and the communication response system (push button call bell) was clipped to the cord above bedside table, out of resident's reach.

S#105 confirmed to the inspector that the resident is unable to use call bell, although staff still provide it to them when in bed. S#103 reported the resident has been unable to use the call bell for a long time and added they would expect the care plan to indicate they do not use call bell.

The resident's CCRS Assessment:Quarterly Review in MDS completed by Registered staff on June 30, 2015 identified a communication problem for resident making self understood and problem understanding others related to cognitive loss. A review of the electronic care plan section Aids to Daily Living, dated August 4, 2015, identified the intervention that staff are to provide the resident with the call bell when in bed.

Resident #005's plan of care was not reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

4. On August 13, 2015 resident #004 was observed by Inspector #616 laying in bed and the communication response system (push button call bell) was hanging on the wall, out of the resident's reach.

S#103 stated to the inspector that the resident cannot use their call bell as they do not understand what it is for and added that staff do not make sure the call bell is within reach as they do not use it. S#100 reported the resident always has call bell when in bed although they do not have cognitive ability to use it.

The resident's CCRS Assessment:Quarterly Review in MDS completed by Registered staff on July 30, 2015 identified a communication problem for resident making self understood and problem understanding others related to cognitive loss. A review of the electronic care plan section Aids to Daily Living, dated July 30, 2015 identified the

intervention that staff are to provide the resident with the call bell when in bed. [s. 6. (10) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

During inspector #616's interview with resident #003, they reported pain in one particular extremity and were observed to be rubbing the area. Their concern was reported by the inspector to a Registered staff member for assessment.

S#101 reported to the inspector that the resident has a PRN (as needed) medication ordered for pain which was administered on three dates in August 2015 as per resident's Medication Administration Record (MAR). S#101 stated PRN medication effectiveness is documented on the resident's individual Pain Flow Sheet (PFS) however this resident's PFS was blank. Both S#101 and S#102 confirmed the PRN medication administration on those dates should have been documented.

The home's Pain Management Program Policy (June 2015) stated that a pain monitoring flow sheet will be used to monitor pain and determine the effectiveness of the pain management strategies over time. This sheet will be placed with the resident's MAR for PRN medication.

The LTCC confirmed staff are expected to monitor the effectiveness of PRN pain medication on the individual resident's PFS, recently initiated on August 7, 2015 as a component of the pain program. They reviewed and confirmed the resident's PRN MAR for pain medication administration on two of the three dates was not documented or monitored as per policy.

The home did not ensure the pain policy is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

On August 18, 2015, at 1230hrs Inspector #613 observed S#101 administer a regularly scheduled narcotic to resident #003. S#101 removed the narcotic out of the second drawer of the medication cart. The narcotic medication was observed in a single labelled Dispill compliance package on a tray along with non-narcotic medications.

The inspector met with S#101 for clarification of the narcotic count process and storage practice. S#101 stated it is not the home's practice to store narcotic medication in a double locked container in the medication cart. They added that only PRN (as needed) medications are counted at shift change (0700hrs and 1900hrs) and written on the Narcotic Control Sheet. S#101 confirmed the regularly scheduled narcotics and controlled substances are not counted.

The inspector met with two other registered staff S#102 and S#105 who both confirmed scheduled narcotics and controlled substances are signed (initialed) by the registered staff on the MAR only. They reported that registered staff do not sign on the yellow narcotic count control sheet nor do they count regularly scheduled narcotics and controlled substances at end of shift.

The inspector met with the LTCC who confirmed only PRN controlled substances are counted on the yellow narcotic sheets. Scheduled controlled substances are signed by the registered staff on the MAR only, it is not signed on the yellow narcotic count control sheets.

The inspector reviewed the home's policy titled 'Ward Narcotic Control' (Revised January 2015) that stated in the Long-term Care (LTC) Unit, the drug count is performed twice a day at 0700hrs and at 1900hrs by two nurses and recorded on the white sheet. All narcotics and controlled drugs administered are recorded on yellow narcotic control

sheets. All narcotics/controlled drugs are kept in the medication cart in a double locked container. The cart is kept in the LTC medication room. The LTC Coordinator and the RPN working on the floor have keys to the medication cart. The administration of narcotics must be recorded and signed for on the medication administration record and the narcotic/controlled drug sheet.

The home did not ensure the policy related to narcotic/controlled drug administration was complied with. [s. 8. (1) (b)]

WN #5: 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. (1).
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 failed to ensure that the following rules are complied with: 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.

During the initial tour of the residents' home area on August 11, 2015 an unlabeled door next to a resident room was observed ajar. The door knob was locked but the inspector was able to open the door freely. Observed along the back wall of the small room, was an open floor with ladder for lower lever access. S#106 confirmed this door should be locked and closed at all times. They proceeded to push the door closed and checked it was locked.

The door leading to a non-residential area was not kept closed and locked to restrict unsupervised access by residents. [s. 9. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On August 13, 2015, Inspector #616 observed resident #008's call bell hanging over the bedside table with it's cord dangling between their table and the wall. The call bell was inaccessible to resident while they were in bed.

On August 18, 2015, Inspector #613 observed resident #008's call bell hanging across the bedside table between their table and the wall as previously observed. Inspector asked resident #008 if they could reach their call bell if needed and the resident stated they could not reach the call bell.

Inspector #613 reviewed the resident's most recent care plan that is available to staff (June 27, 2015) which identified that resident #008's call bell is to be with in reach at all times.

On August 19, 2015, the inspector met with the LTCC who confirmed that staff are expected to attach the call bells to the resident's bed, around their side rails. The call bell is to be placed so that it is in the resident's reach at all times. [s. 17. (1) (a)]

2. Inspector #616 observed resident #003's communication response system (push button call bell) on August 13, 2015 and noted the call bell cord wrapped around the right bed rail, in the upright position, to be near the floor. The call bell in the current position on the bed rail would be inaccessible to the resident.

Inspector #616 reviewed the resident's electronic care plan dated July 20, 2015 which identified as a Falls intervention: 2 bed rails up when in bed and call bell within reach at all times.

During an interview with resident #003 on August 18, 2015, they were observed laying in bed, with two bed rails in upright position with the call bell attached to right bed rail. The resident demonstrated they were unable to reach the call bell from their position in bed as it was wrapped around the rail, hanging low to floor.

S#103 confirmed the resident uses the call bell and staff are to ensure it is within reach when in bed. [s. 17. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home on August 11, 2015 and then on August 20, 2015 in the company of the LTCC, observations of unlabelled personal care products in the bathroom adjacent to the dining room included: Soothe and Cool perineal wash no rinse; Wellskin barrier cream tube x 2; blue container with clear lid - cornstarch as identified by the LTCC; lubrication jelly tube; Coconut body wash; Infazinc container; and Natura body lotion.

S#107 confirmed the bathroom is used by any resident and the products are available for staff assisting residents in the bathroom. The LTCC also confirmed the products stored on the shelf are used by all staff for any resident. On exiting the room, the LTCC disposed of the unlabelled vaseline tube in the garbage. [s. 37. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #004's Pressure Ulcer Risk Evaluation Tool identified the resident as HIGH risk for impaired skin integrity. The most current electronic care plan indicated under Skin Integrity focus, that staff are to provide care after each incontinence and apply treatment cream to the affected area.

S#101 reported to inspector #616 that the ordered treatment cream for resident #004 is applied to the affected area BID (twice a day) until clear as per the physician's order. A review of the resident's Treatment Administration Record (TAR) showed consistent documentation that the cream was applied as ordered from the end of July 2015 to date however, S#101, S#100, and S#102 confirmed there is no weekly assessment of the effectiveness of the treatment cream.

The LTCC confirmed to the inspector the home's expectation of registered staff that they are to document "once in a while" in the nurse's notes if the treatment cream is not improving. With the inspector, the LTCC reviewed the resident's progress notes from the end of July 2015 and identified one note related to treatment cream in early August and no further documentation related to skin integrity from that date to August 20, 2015. They confirmed there was no weekly assessments for the effectiveness of the ordered treatment.

Resident #004 exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds and was not reassessed at least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

WN #9: 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. The licensee failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

On August 18, 2015, Inspector #613 met with the Vice President of the Residents' Council who informed the Inspector that they have never received a response letter from the licensee.

On August 19, 2015, inspector reviewed the home's policy titled 'Residents' Council' (revised September 2014), which stated "if the Resident's Council has advised the Administrator of concerns or recommendations, the Administrator shall, within 10 days of receiving the advice respond to the residents council in writing".

The inspector reviewed the Resident Council minutes from September 25, 2014 to July 30, 2015. It was noted in the February 26, 2015 and June 25, 2015 Residents' Council minutes, that the Council had recommended pan fried fish to be served. In the minutes of March 26, May 28, and June 25, 2015 the Council had recommended homemade bread to be provided more often for lunch and supper meals.

The inspector interviewed S#100 who stated Residents' Council's request was verbally brought to the Nutrition Manager's attention. S#100 followed up with the Nutrition Manager to ensure Council's requests were received. The inspector interviewed the LTCC who confirmed that a bread maker had been purchased to provide more homemade bread, but the pan fried fish was only one resident's request. The LTCC confirmed that there has never been a written response provided to the Residents' Council. [s. 57. (2)]

WN #10: 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. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

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. The licensee has failed to ensure that assistance in the establishment of a Family Council within 30 days of receiving a request is provided.

During an interview with the LTCC they reported the home does not currently have a Family Council. They stated two family members expressed interest in response to a letter encouraging the establishment of a Family Council which the home distributed by mail to all families in November of 2014. However, they reported that due to the limited interest, their response to the families was that a Council of only two members was insufficient and stated their names would be retained for future reference when three or four family members expressed interest in the establishment of a Family Council.

Assistance to establish a Family Council within 30 days of receiving a request from a family member or person of importance to a resident was not provided. [s. 59. (3)]

2. The licensee has failed to ensure that they convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The LTCC confirmed they have no record of semi-annual meetings related to Family council as there have not been meetings offered.

Semi-annual meetings are not held to advise residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #616 observed lunch service in the dining room on August 12 and August 18, 2015. The 3-week menu cycle posted outside the dining room listed pasta salad when potato salad was served on August 12, 2015. Chinese food was served on August 18, 2015 when the posted menu listed chicken pate with mix pepper salad or egg salad sandwich with bread and butter pickles, with blueberry pie or banana loaf for dessert. On this day the dessert observed offered to residents was blueberry pie or banana puree. S#100 confirmed they only received the blueberry pie and the puree, not banana loaf.

S#104 confirmed the potato salad was supposed to be pasta salad. The LTCC confirmed the Chinese food was not posted on the menu board, and the Nutrition Manager confirmed the substitutions on August 12 and 18, 2015 were not communicated to the residents on the menu board outside the dining room. [s. 71. (4)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On August 18, 2015, Inspector #613 observed narcotics in three different drug counter boxes in the locked narcotic box in the medication cart. Each drug counter box had a hand written label. S#101 informed the inspector that the LTCC dispenses the medication from the hospital stock supply into the counter boxes.

Inspector met with the LTCC who confirmed they fill the narcotics into the drug counter boxes.

Inspector reviewed the home's 'Medication Charting Procedure' (Revised January 2015) that states, 1. Narcotics used are supplied by the hospital pharmacy in specific number for specific residents. To facilitate distribution, control and drug count, a supply of the drug will be kept in a drug counter box in the locked narcotic box in the medication cart. 2. Narcotics will be filled by the DON or LTC Coordinator.

Although the home has a medication charting procedure, they did not ensure that all drugs remain in their original labelled container or package by the pharmacy service provider. [s. 126.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances 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.

On August 18, 2015, inspector #613 was informed by S#101 that regular daily scheduled narcotic and controlled substances are not stored in the locked narcotic storage bin in the medication cart. Only PRN narcotics and controlled substances are stored in the locked storage bin in the medication cart. Daily regular narcotics and controlled substances are stored in an individual labelled compliance Dispill package, located on a tray in the second drawer of the medication cart. S#101 showed Inspector #613 that this drawer was not locked.

Daily regular scheduled narcotics and controlled substances are not double locked.

Inspector #613 reviewed the home's policy titled 'Pharmacy Narcotics and Controlled Drugs' (Reviewed December 2014) which stated that all narcotics/controlled drugs are kept in the medication cart in a double locked container. The medication cart is locked and in the locked medication room when not in use; however, when the medication cart is in use, the narcotics and controlled substances are not double locked.

On August 18, 2015, the inspector met with the LTCC who confirmed that regularly scheduled narcotics and controlled substances are kept in individual labeled packages on the daily tray in the second drawer of the medication cart and are not double locked. [s. 129. (1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered.

On August 19, 2015, the inspector met with the LTCC who confirmed that monthly audits are not done on the daily count sheets. The LTCC stated that as the registered staff count narcotics and controlled substances twice daily, they are ensuring accuracy so the audit is not done monthly.

Inspector reviewed the home's policy titled, 'Pharmacy Narcotics and Controlled Drugs' (revised December 2014) and could not locate information regarding the requirement of monthly narcotic audits on the daily count sheets.

A monthly audit has not been undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. [s. 130. 3.]

Issued on this 29th day of October, 2015

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

Original report signed by the inspector.