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
Aug 28, 2014	2014_226192_0024	L-000923-14	Resident Quality Inspection

Licensee/Titulaire de permis

SOUTHAMPTON CARE CENTRE INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

SOUTHAMPTON CARE CENTRE
140 Grey Street, P.O. Box 790, Southampton, ON, N0H-2L0

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

DEBORA SAVILLE (192), DOROTHY GINTHER (568), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)

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, 12, 13, 14,15, 18, 19, 2014

Inspection of Critical Incidents L-000416, 000782-14 and 000785-14 related to potential abuse and Critical Incident L-000339-14 related to Fall Prevention were completed concurrently with this inspection and the results of the inspections are on separate reports.

During the course of the inspection, the inspector(s) spoke with residents and family members, the Administrator, Director of Care, Co-Director of Care, Administrative Assistant, Resident and Family Services and Volunteer coordinator, Activity Director, Environmental Services Manager, Support Services Aides, Dietary Manager, Dietary Aides, Registered Nurses, Registered Practical Nurses, Personal Support Workers and Health Care Aides.

During the course of the inspection, the inspector(s) toured the home, observed meal service, food preparation, medication administration, medication storage areas, recreation activities and care provided to residents, reviewed relevant clinical records, reviewed relevant policies and procedures, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home

The following Inspection Protocols were used during this inspection:

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

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. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Interview with the Director of Care on August 14, 2014, confirmed that where bed rails were used residents of the home have not been assessed to minimize the risk to residents.

During observation in stage 1 of this inspection by inspectors #519, #192, #568 and #165, 30 of 40 residents were observed to have one or more bed rails in the up position.

Where bed rails were in the up position, beds were observed to have no keepers in place at the foot or head of bed, allowing the mattress to move out of place with minimal lateral pressure and creating a potential zone of entrapment.

All beds in the home were assessed for entrapment risk September 27, 2012, by a contracted service, Joerns. At the time of the assessment 36 of 86 beds assessed were identified to have failed two or more zones of entrapment.

The Environmental Manager confirmed that the mattresses from the 36 beds that were identified to have failed were replaced however, had not been reassessed. The Environmental manager reported that mattresses have moved between bed systems. Since the independent assessment conducted in September 2012 the home did not track the changes to bed systems. The Environmental Manager confirmed that where changes in the bed system occurred, bed systems were not reassessed and steps taken to prevent resident entrapment.

During stage 1 observation on August 11 and 12, 2014, several assist rails were identified to be attached to resident bed systems by Long Term Care Home Inspectors #519, #192, #568 and #165. On August 19, 2014, it was observed with the Environmental Manager that specified residents had assist rails attached to the bed system in the up position. A review of the independent assessment conducted September 27, 2012, indicated that the assist rails were not attached to the bed system at the time the assessment was conducted. The Environmental Manager

confirmed that several residents have assist rails that were added to the bed system after the independent assessment was conducted and bed systems were not reassessed and steps taken to prevent resident entrapment.

During stage one observation on August 11, 2014, a specified resident was identified to be on a therapeutic surface. The plan of care for the resident confirmed the use of two bed rails when the resident was in bed. A review of the independent assessment of all beds conducted September 27, 2012, confirmed that the bed the resident used, was not assessed.

During stage one observation on August 12, 2014, a specified resident was identified to be on a therapeutic surface and was observed by Long Term Care Home Inspector #165 to have two 3/4 rails in the up position. The plan of care for the resident confirmed the use of two bed rails when the resident was in bed. A review of the independent assessment of all beds conducted September 27, 2012, confirmed that the bed the resident used, was not assessed.

The Director of Care reported that there were currently identified resident's to be on a therapeutic surface. The Environmental Manager confirmed that for residents with therapeutic surfaces, the bed systems had not been evaluated for the risk of entrapment. [s. 15. (1) (a)]

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. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with weight changes that compromises their health status were assessed using an interdisciplinary approach and that actions were taken and outcomes evaluate.

Resident #016 had experienced weight loss [redacted]. A nutritional referral was sent to the home's Registered Dietitian, related to continued weight loss and to consider implementing the home's Food First #2 intervention to assist with the prevention of continued weight decline. The Registered Dietitian indicated that they would wait for a weight to be taken prior to taking action. The Registered Dietitian confirmed that there was no documentation since a specified date [redacted], related to an assessment of the resident's weight and there were no interventions implemented to assist with the prevention of continued weight decline. The resident was now below their goal weight range established by the home's Registered Dietitian. The Registered Dietitian confirmed that gradual weight loss was not monitored. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has 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 are respected and promoted.

A) Resident #009 had a fall [redacted] when they were attempting to transfer using a walker. No injury was identified at the time of the fall.
The progress notes identified that the resident complained of worsening pain over the next nine days and analgesic was given.
The Substitute Decision Maker (SDM) was contacted but could not take the resident to hospital. A message had been left for the Physician in the doctor book about this resident's fall by the Registered Staff.
Physiotherapy assessed the resident [redacted] for a post fall assessment and identified that the resident had limited range of motion, significant pain with grimacing and a

possible injury. The physiotherapists plan included consult with the physician for completion of an x-ray.

The Physician was notified [redacted] by Registered Staff when an abnormality was observed. Orders were received from the physician.

The Physician assessed the resident and ordered an xray at the Emergency Room. Injury was confirmed.

Upon interview with the Director of Care [redacted] it was confirmed that it was not usual for a resident to go that long without an x-ray after a fall; especially when complaining of worsening pain. She stated that normally they would send a resident for an x-ray right away if they are complaining of pain. She confirmed that the resident could have been sent by ambulance for an x-ray at the time of injury.

The licensee failed to ensure that every resident has the right to be properly cared for in a manner consistent with his or her needs [redacted]. (519)

B) Resident #014 was observed [redacted] to be unshaven. A review of documentation completed on Point of Care indicated that the resident received grooming including shaving. Resident #014 was observed on multiple occasions to be unshaven with a significant growth of facial hair. Review of the progress notes does not identify that the resident refused or was resistive to the provision of grooming.

Resident #014 was observed to have a yellow substance with white pieces on the face, hands and down the front of their tee shirt. Resident #014 was observed to have their face wiped and sweater pulled over the soiled tee shirt before they were moved into the dining room for lunch. The resident's hands were not cleaned and the soiled tee shirt was not changed prior to the resident receiving lunch. (192)

C) Resident #012 was observed for a period of two hours [redacted] and was not assisted to the bathroom prior to the lunch meal as required under their plan of care.

Record review indicated that the resident's family had expressed concern that resident #012 was not receiving care related to the established toileting routine.

[redacted] resident [redacted] told Long Term Care Homes Inspector #568 that they tell staff they need to go to the washroom and the staff disappear. They don't come back for upwards of a half hour resulting in the resident having an accident. Resident #012 indicated it is very upsetting to them.

[redacted] resident [redacted] indicated that they were awake at 0700 hours, but were not provided assistance to the bathroom until 0900 hours. During this two hour time period the resident indicated they felt pain. The resident indicted that they want to be clean, but when they have to wait so long, they have accidents and being wet or dirty causes pain and burning in the groin area.

Resident [redacted] did not have their right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs respected and promoted when they were not assisted with toileting as identified in the plan of care and when continence care was delayed. [s. 3. (1) 4.]

2. The licensee failed to ensure that every resident has the right to: (iv) have his or her personal health information within the meaning of the "Personal Health Information Protection Act, 2004" kept confidential in accordance with that Act.

During the Medication Administration Observation on August 18, 2014, it was observed that the Registered Practical Nurse administering medications left the E-MAR monitor open and visible to passers by between administering medications to three separate residents in the dining room.

Two other residents were sitting in chairs across from the medication cart at the time. The Registered Practical Nurse confirmed when questioned that the expectation of the home is to close the screen when not in attendance at the cart. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs are respected and promoted, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A) Resident #014 was observed to have a medical device in place [redacted]

The plan of care for resident #014 was reviewed and did not include the use of the medical device.

Interview with the Director of Care confirmed that the medical device was in place and was not included in the plan of care.(192)

B) The MDS assessment completed [redacted] for resident #016 indicated that the resident required extensive assistance of two staff to provide personal hygiene including combing hair, brushing teeth, shaving, washing/drying face, hands, and perineum (excluding baths and showers).

A review of Point of Care records [redacted] indicated that the resident required limited assistance on eight occasions, extensive assistance on eight occasions and total assistance on one occasion. Records indicated that the resident required one staff member on 16 of 17 occasions during a specified time in 2014.

[redacted] the resident was observed to be unshaven. The resident's written plan of care did not set out the planned care including the type and level of assistance that was required related to hygiene and grooming. [s. 6. (1) (a)]

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

A) The plan of care and point of care documentation for resident #010 indicated under hygiene and grooming that the resident required extensive assist of two staff to comb hair, shave, wash face/hands, and do teeth.

Interview with the Personal Support Worker identified that the resident did not require shaving.

Interview with the Registered Practical Nurse identified that the family had made specific requests in relation to grooming and confirmed that the plan of care was not clear in relation to resident #010's grooming needs.

The plan of care was updated following this inspection. (192)

B) Resident #007's plan of care related to oral care and personal hygiene and the Kardex indicated that staff provide the supplies and encouragement for oral hygiene every morning and evening and assist as required.

An assessment completed by the Dental Hygienist indicated that the resident had poor oral hygiene. The Dental Hygienist recommended that the resident needed help and reminders to brush teeth daily.

[redacted] a review of Point of Care records for the resident indicated that oral care was completed. Approximately one hour later, the resident's toothbrush was dry and the resident could not recall if their teeth were brushed. The PSW that provided morning care, reported that the resident was handed their supplies however, the PSW left the resident as they entered the bathroom. The PSW was unable to confirm if the

resident brushed their teeth.

The plan of care did not provide clear direction related to the level of assistance required for oral care. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

A review of Resident #001's dehydration/fluid maintenance Resident Assessment Protocol (RAP) completed by a Registered Practical Nurse indicated that the resident's fluid goal was 1600 milliliters (ml) and staff were to encourage the resident as the resident's current intake was currently 1525 ml per day.

The Registered Dietitian's nutritional status RAP indicated that the resident's fluid goal was 1350 ml and that the resident usually meets their daily fluid goal. A review of the resident's plan of care indicated that the fluid goal was re-established from 1800 ml to 1350 ml by the home's Registered Dietitian.

A review of Point of Care records during the three day look back period for fluid indicated total daily fluid intake was below the specified goal on all three days.

The Registered Dietitian reported that she completes the dehydration/fluid maintenance RAP only when the RAP was triggered by insufficient fluids during the three day look back period and Registered Nursing staff complete the dehydration/fluid maintenance RAP when triggered by all other triggers. The Registered Dietitian confirmed that there was no collaboration in the hydration assessment so that assessments were integrated and consistent with and complement each other. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A) Resident #004 has a plan of care related to risk of falls that indicated the resident's bed was to be in the lowest position at all times as the resident will attempt to transfer independently.

On two occasions [redacted] resident #004 was observed at the bedside. The bed was observed to be in an elevated position and by using the bed control it was confirmed that the bed was not in the lowest position.

On a third occasion the bed was observed to be in an elevated position, confirmed by staff member that bed was not in lowest position and the bed was repositioned.

Care set out in the plan of care was not provided to resident #004 as specified in the plan of care when the bed was not left in the lowest position.

B) Resident #012 has a plan of care related to continence that indicated the resident was on a toileting plan and was to be toileted immediately before meals, at bedtimes, once during the night and as necessary.

On a specified date in 2014 resident #012 was observed for a period of two hours. The resident was not observed to have been assisted to the bathroom, as directed in the plan of care, during this observation period.

Resident #012 was not provided care as set out in the plan of care in relation the toileting. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a written plan of care for each resident that sets out the planned care for the resident; that the plan of care sets out clear directions to staff and others who provide direct care to the resident; that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments were integrated, consistent with and complement each other and ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy titled Resident Rights, Care and Services - Required Programs - Falls Prevention and Management - Program with an effective date of September 16, 2013 indicated on page five of nine that a resident who has a fall has a follow-up progress note completed for at least three shifts following the incident and that the resident was referred to the physiotherapist who completed the post fall referral with in seven days.

A) Resident #009 had a fall on a specified date in 2014. The initial Fall Incident Report was documented. There was no fall progress note for three shifts following the fall.

The licensee failed to comply with their Falls Policy as there was no fall follow up progress note for 3 shifts following the fall. (519)

B) On a specified date in 2014, resident #013 sustained a fall. A review of the clinical health record indicated that there were no fall follow up progress notes completed for all three shifts following the fall. The Director of Care confirmed that there was no fall follow up progress notes completed however, the expectation was for Registered staff to complete the fall follow up progress notes for all three shifts following the fall.

A review of the clinical health record indicated there was no physiotherapist referral initiated by Registered staff post fall. This was confirmed by the Director of Care. (165)

C) Resident #004 sustained a fall on a specified date in 2014 with a progress noted

completed following the fall. There is no further reference to the resident's fall during the three shifts following the fall.

Resident #004 sustained a fall on a specified date in 2014 that was documented in the progress notes. There is no documentation of the residents status related to the fall for the three shifts following the fall.

Resident #004 sustained a fall on a specified date in 2014 that was recorded in the progress notes. A second fall occurred on the specified date in 2014 and was recorded. There is no fall follow-up progress note recorded for the night shift after the resident sustained two falls on the previous two shifts.

The Director of Care confirmed that progress notes should be completed for three shifts following a fall and that these notes would be recorded in the progress notes in Point Click Care.

The policy related to Falls Prevention and Management - Program was not followed when resident #004 did not have follow-up progress notes completed for at least three shifts following falls.

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy on Continence, titled "Resident Rights, Care and Services - Required Programs - Continence Care and Bowel Management - Program", Section: Required Programs, dated as revised July 24, 2014, stated Registered Staff shall ensure that Referrals and additional "assessment for continence" is completed with any decline in bowel and/or bladder continence indicated in completing RAI-MDS.

Resident #001 is incontinent of urine. [redacted] the resident had a medical device to manage their incontinence. This device was removed. After the removal of the medical device this resident was using a Continence Product and staff were monitoring the urine output once a shift and documenting it.

This was noted as a decline in the Minimum Data Set (MDS) results compared to the prior MDS results.

According to the Director of Care (DOC) it was confirmed that Resident #001 had a

Continence Assessment last completed in 2010. It was also confirmed by the Director of Care at that time that a Continence Assessment should be completed on a resident on Admission and if there is any change in their continence. It was confirmed by interview with the DOC that a Continence Assessment should have been completed when Resident #001's continence status changed. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's Oral Care policy last dated September 16, 2013, indicated that Personal Support Worker's (PSW) would document the oral care provided to the resident in keeping with the standards of documentation set by the long term care home. The Director of Care reported that the expectation of the home was that PSW staff document in Point of Care when care was provided.

A review of resident #013's Point of Care records indicated for a specified period in 2014, documentation of oral care was incomplete for 10 of the 13 days. A PSW reported that staff document in Point of Care when oral care was provided including when a resident refused care. The PSW confirmed that staff do not complete documentation when they do not have time to do so. [s. 8. (1) (a),s. 8. (1) (b)]

4. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy titled Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Point Click Care Wound Assessment and Treatment dated as effective September 16, 2013 indicated under policy that the Wound assessment and Treatment assessment shall be completed for a resident at the time of any impairment of skin integrity including pressure ulcer, vascular ulcer, bruising, skin tear, scar, surgical incision ,burn, rash, subcutaneous or intravenous port, blister, etc. and that it will be completed for any change in treatment for that impairment.

Under procedure in the same policy registered staff are to:
3. Have strategies related to maintaining skin integrity discussed with resident/substitute decision maker and document in progress notes in Point Click Care. An evaluation of prevention strategies is to be completed at least quarterly and documented in the pressure ulcer Resident Assessment Protocol (RAP) or in the progress notes if the RAP is not triggered.

4. Complete wound assessment and treatment records with the initiation of impaired skin integrity and where the altered skin integrity is other than a wound, a weekly progress note is to be completed to reflect weekly assessment of the resident related to skin status.

Personal Support Workers (PSW) are to:
- complete daily skin observation during routine care provision on each shift and document in Point of Care.
- changes in skin integrity and or abnormal or unusual skin conditions are to be reported to Registered Staff including red or open areas, blisters, bruises and scratches.
- preventative measures to promote skin integrity are to be implemented.

An identified resident was observed by Inspector #568 and #192 to have bruising.

A review of the medical record identified that there is no documentation of bruising in the progress notes for the resident.

The Director of Care confirmed that the expectation would be that a change in condition such as bruising would be included in the progress notes. The DOC confirmed that bruising to the resident had not been documented.

A review of the Plan of Care and interview with the Director of Care confirmed that altered skin integrity exhibited by the resident had not been assessed, was not included in the plan of care and interventions to prevent further injury were not recorded in the plan in spite of confirmation that the resident frequently had bruising.

Review of the Point of Care documentation failed to identify a change in the resident's skin condition. Documentation indicated that skin was intact with no reference to bruising.

The licensee failed to comply with their policy related to Skin and Wound Care when the resident was not assessed related to bruising evident during observation; failed to identify the altered skin integrity in the plan of care, and develop interventions to prevent further injury and failed to identify the change in the resident's status in the daily Point of Care record completed by PSW's providing care. [s. 8. (1) (a),s. 8. (1) (b)]

5. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's Medication Policy titled, " Resident Rights, Care and Services - Medication Management - Drug Disposal", last revised date of Oct 7, 2013 stated under "Procedure: that on an ongoing basis, the Registered Staff shall : remove from current medication supplies, medications which are discontinued, unused, expired, recalled, deteriorated, unlabeled and in containers with worn, illegible, damaged, incomplete or missing labels.

During the Medication Room observation on August 18, 2014 at 1415 hours there were 5 medications that were found to be expired. Those medications were:
- 1 expired vial of Fluviral (expired June 2014)
- 1 expired Insulin Pen refill (Novolin ge 30/70) (expired March 2014)
- 2 ampules of Stemetil 10 mg/ml vials (expired March 2014, and June 2014)
- 1 vial of Ceftriaxone Sodium 1 gm/vial (expired July 2014)

The Director of Care was present in the medication room when the expired medications were found and disposed of them. [s. 8. (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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On August 11 and 12, 2014 the mattress on an identified bed was observed to be soiled and smell of stool. A Personal Support Worker interviewed confirmed that they are to wipe the surface when it is soiled, but identified that due to frequent incontinence the urine and odour was right into the mattress and was not able to be cleaned.

B) On August 13, 2014 it was noted that there was an odour of urine. The bed in an identified room has a therapeutic surface that was observed to be soiled with liquid. Staff interview identified that staff are to wipe the surface daily and that new covers are available when the surface becomes heavily soiled. Staff indicated that the resident in the bed is frequently incontinent and the surface is frequently soaked with urine. Staff confirmed that the surface does not receive a deep cleaning to address the odour.

C) On August 15, 2014 it was observed that arm chairs in the lounge across from the large dining room have heavily soiled arms with tears noted on the arms of both chairs.

Interview with the Environmental Services Manager confirmed that the chairs are to be steam cleaned by the home and have not been cleaned since November 2013. [s. 15. (2) (a)]

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

During the Stage 1 home observations August 12, 2014 at 1554 hours, it was observed in the Team 1 Tub Room that the bottom of the wheelchair lift/scale was dirty.

During observation of the Team 1 Tub Room August 19, 2014 at 1340 hours along with the Environmental Services Manager (ESM), it was observed that the bottom of the wheelchair lift/scale was dusty with dried on brown debris.

Interview with the ESM, on August 19, 2014 at 1340 hours confirmed that the Tub Room lift/scale was dirty and that housekeeping does not clean these lift/scales. He indicated that this task will be put on the tub room list to clean along with the tub chairs . [s. 15. (2) (a)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Nutrition Care and Hydration program included the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

The home's Registered Dietitian confirmed that the home's Nutrition Manual Policies were developed corporately and implementation was not completed in consultation with the home's Registered Dietitian.

A corporate policy acceptance form last signed by the home's Dietary Manager and Administrator April 24, 2013, acknowledged the policies were developed corporately and apply to the home. [s. 68. (2) (a)]

2. The licensee has failed to ensure that the Nutrition Care and Hydration programs include, a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A nutritional referral for resident #001 was initiated in 2014, related to poor fluid intake

for three consecutive days. A response signed by the home's Registered Dietitian indicated that the food and fluid records were incomplete for the three days, the referral was not valid due to missing documentation and she was unable to complete an evaluation of the resident's fluid intake.

A review of food and fluid records for resident's indicated that several entries were consistently missing. The home's Hydration Policy revised October 7, 2013, indicated that at the end of each meal and snack the Personal Support Worker (PSW) would document the resident's daily intake on Point of Care. A PSW confirmed that if staff did not have time they did not document in Point of Care. The Director of Care was aware that PSW staff did not always record food and fluid intake.

The Registered Dietitian confirmed that she did not currently evaluate resident's fluid intake since fluid records were incomplete. The home did not implement the system in place to monitored and evaluated the food and fluid intake of residents with identified risks related to nutrition and hydration. [s. 68. (2) (d)]

3. The licensee has failed to ensure that the Nutrition and Hydration program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

Resident #050 was admitted to the home in 2013, however, there was no admission weight taken and recorded in point click care. The first documented weight was three weeks after admission.

Resident #051 was admitted to the home in 2014, however there was no admission weight taken and recorded in point click care. The first documented weight was two weeks after admission.

Resident #052 was admitted to the home in 2013, however, there was no admission weight taken and recorded in point click care. The first documented weight was 8 days following admission.

The Dietary Manager and Director of Care confirmed the weights were not taken and recorded on admission. [s. 68. (2) (e) (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 ensuring that the Nutrition Care and Hydration programs include, a system to monitor and evaluate the food and fluid intake of residents with identified risks and that the Nutrition and Hydration program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

During the lunch meal August 11, 2014, the puree textured sausage was not cohesive and ran into the other menu items on the plate. The Dietary Manager confirmed that the puree textured was too runny.
During the lunch meal August 11, 2014, the minced textured Mediterranean salad was runny and resembled puree textured. This was confirmed by the Dietary Manager.

During the supper meal August 18, 2014, the minced and puree textured menu items were not cohesive. The minced and puree textured steak and the puree textured vegetables were runny.

The altered textures compromised the taste, nutritive value, appearance and food quality of the menu items. [s. 72. (3) (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 ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes food and fluids being served at a temperature that was both safe and palatable to the resident.

On August 11, 2014, at approximately 1237 hours the puree textured egg and the hard boiled egg for the cold salad plate was 10 degrees celsius.

On August 18, 2014, at approximately 1240 hours the puree chicken salad sandwich was 12 degrees celsius and the regular chicken salad sandwich was 13 degrees celsius.

On both days the menu items were placed in the steam well on top of ice however, it is next to the steam well serving hot food. Dietary staff confirmed that ice melts from the hot steam well and the temperatures of cold menu items were not sustained during meal service.

On August 18, 2014, at approximately 1727 hours temperatures were taken of the puree textured steak, minced and puree textured riblettes, puree textured brussel sprouts, minced and puree mixed vegetable and puree rice. The altered textured menu items ranged in temperature from 48 degrees to 56 degrees celsius. The menu items were placed on top of the grill in the main kitchen during service.

The cook reported that there was not enough room in the steam table to fit the altered textured menu items and confirmed that temperatures were not maintained throughout the meal service. [s. 73. (1) 6.]

2. The licensee has failed to ensure that appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.

During the lunch meals on August 11 and 18, 2014, it was observed that there were only four feeding stools available for staff who were assisting residents to eat. At least four staff were using regular dining chairs which were not at an appropriate height to meet the needs of all residents who required staff assistance. The Director of Care confirmed that there was not enough feeding stools available for staff that are assisting residents in the small dining room. [s. 73. (1) 11.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home has a dining and snack service that includes food and fluids being served at a temperature that was both safe and palatable to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

The home failed to develop and implement a procedure for addressing incidents of lingering offensive odours as room 46, and the hallway outside of the room had a lingering offensive odour. The odour at times would permeate the hallways by the dining room and near the front entrance of the home.

The observations of lingering offensive odours were made by inspectors #519, and #192, on August 11, 13, 14 and 15, 2014 at specified locations.

During interview with the Environmental Service Manager on August 19, 2014 at 1400 hours it was explained that the housekeeping staff have Lysol and Zephr Air (Eco Lab) to assist with managing lingering offensive odours. He stated for resident #001 they have tried other ways to manage the odour which were ineffective.

The home could not produce a Policy outlining procedures and implementation of addressing incidents of lingering offensive odours. They produced a policy titled, "Indoor Air Quality", dated as revised January 1, 2008. This policy was not specific in addressing lingering offensive odours in resident areas.

The home did not seek out the source of the odours, rather attempting to cover it up with air fresheners and charcoal filters. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom.

It was observed during stage 1 of this inspection that several residents do not have a comfortable easy chair provided in the bedroom.

Room 14 has four residents residing in the room, only one resident was provided with a comfortable easy chair (bed 4).

Observation on August 19, 2014 found 17 rooms of those observed to be missing one or more comfortable easy chairs.

Interview with the Environmental Services Manager confirmed that comfortable easy chairs are not available at every resident's bed side and that some chairs were currently on order.

The licensee failed to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom. [s. 12. (2) (e)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 Centimeters (cm).

On August 11, 2014 it was observed in a specified room that the window nearest the door was open greater than 15cm. The Director of Care confirmed that the window was open greater than 15 cm and that the wire installed to restrict the window from opening greater than 15 cm was broken. It was noted the the restricting wire on the third window was also broken.

The Director of Care secured the windows closed, tagged out the windows and posted signage that the windows were not to be used until repairs could be completed. Repairs were completed after 1400 hours on August 12, 2014. [s. 16.]

WN #13: 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 12, 2014 at 0905 the bedside call bells in a specified room, beds 1 and 2 were observed to be not functioning. The Environmental Manager confirmed that the call bells were not functioning.
Repairs to both call bells were initiated immediately.

On August 12, 2014 at 1032 hours resident #040 was observed to be laying in bed. The call bell was not accessible to the resident as it was laying on the floor. Staff interview confirmed that the call bell was not accessible to the resident.

The licensee failed to ensure the resident-staff communication and response system was easily accessible and usable by residents on August 12, 2014. [s. 17. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that any actions taken with respect to a resident under the Falls Program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #009 had a fall in 2014. They were assessed by the Registered Staff after the fall and given analgesic for pain for 8 days until an injury was observed.

The physician assessed Resident #009 and ordered an x-ray that afternoon at the Emergency Room.

There was no documentation of a transfer to the Emergency Room or a transfer back to the home. There was also no documentation of an assessment by Registered Staff on return from the hospital.

The Licensee failed to ensure that the assessments and interventions associated with Resident #009's transfer to the Emergency Room, for x-ray were documented. [s. 30. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received individualized personal care, including hygiene care and grooming on a daily basis.

Resident #008 was observed [redacted] to be unshaven with long hair on their neck.

Two days later the resident was observed to be unshaven with long facial hair on the upper lip and long hair on their neck. The residents hair was flattened against their head at the back and sides and the finger nails are observed to be long, chipped and dirty in appearance.

The plan of care for resident #004 indicated that the goal was for the resident to be neat, clean and odor free and that the resident required extensive assistance to comb hair, wash face and hands, help with teeth and shaving.

Staff interview identified that the resident is usually co-operative with care, although interview with the Personal Support Worker responsible for completing grooming indicated the resident had refused to be shaved and that the resident's finger nails were not cleaned.

Point of Care documentation reviewed indicated that the resident received extensive assistance with grooming (How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, washing/drying face, hands, and perineum). There was no documentation to support that the resident was resistive to the provision of care.

Resident #004 did not receive individualized personal care, including hygiene care and grooming on a daily basis. [s. 32.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #009 is frequently incontinent of urine and occasionally incontinent of bowels according to the Minimum Data Set (MDS).

According to a Personal Support Worker the resident wears a continence product and is occasionally incontinent.

Interview with the Director of Care (DOC) confirmed that a Continence Assessment for Resident #009 was not able to be located. The DOC also stated that there was not one done and it would be expected that one would be completed on any resident who was incontinent. [s. 51. (2) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified.

A review of resident #013's clinical health record indicated that the resident exhibited behaviours. The resident had reported to the Director of Care on repeated occasions that they felt they were not treated with respect/dignity and staff were talking about them when in their room providing care.

During an interview, the Director of Care reported that on several occasions, the resident had raised concerns in which the resident felt they were not treated in a manner that promoted respect/dignity.

A review of the home's investigation notes indicated that staff were talking in low voices amongst each other in front of the resident which triggered the residents paranoid and suspicious behaviour. The Director of Care confirmed this was a repeated trigger for the resident and that the current plan of care did not include the identified trigger for the behaviour including strategies for staff. [s. 53. (4)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the resident.

On August 11, 12 and 13, 2014 it was observed by Inspectors 165, 519, 568 and 192 that beds were not being made. Late into the afternoon on these dates there were several beds that had not been made. Interview with Personal Support Workers August 12, 2014 at 1112 hours confirmed that there was a shortage of bottom sheets and even after multiple requests to laundry no bottom sheets were available.

On August 13, 2014 at 1445 hours the beds in room 41 and 46 were observed to be unmade. Residents were observed sitting in their chairs next to the beds.

Interview with Environmental Services Manager on August 19, 2014 confirmed that the home had run out of bottom sheets and were short supplies on the floor. An emergency order was placed to acquire the necessary supply of bottom sheets.

The home failed to have a sufficient supply of clean bottom sheets on August 11, 12 and 13, 2014 resulting staff being unable to make resident beds. [s. 89. (1) (b)]

2. The licensee has failed to ensure that linens, face cloths and bath towels are kept maintained in a good state of repair and are free from stains and odours.

On August 12 and 14, 2014 the blanket on the first bed in a specified room was observed to be a white cotton blanket with several holes noted in the blanket. PSW staff interviewed indicated that linens that are thin or with holes are to be removed from service by the laundry staff.

Interview with Support Services Aide confirmed that laundry is to take linen with holes or stains out of service.

On August 14, 2014 the blanket on a specified bed was observed to have a white cotton blanket that was very thin with holes observed in the blanket.

During stage 1 of this inspection, Inspectors 568 and 165 observed soiled privacy curtains and bed linen with holes, runs in the fabric and stains.

The licensee failed to ensure that linens were kept in a good state of repair. [s. 89. (1) (c)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During observations made on August 13, 2014 at 0905 hours there were urine soiled sheets and a urine soiled incontinence product placed on top of a laundry cart.

During observations made on August 13, 2014 at 0907 hours a Personal Support Worker (PSW) was observed to be toileting a resident with their dietary apron on.

During the medication administration observation August 18, 2014 at 1150 hours it was observed that the Registered Practical Nurse did not wash her hands with hand sanitizer in between the 3 residents that she gave medications to. [s. 229. (4)]

Issued on this 18th day of September, 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) :	DEBORA SAVILLE (192), DOROTHY GINTHER (568), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_226192_0024
Log No. / Registre no:	L-000923-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 28, 2014
Licensee / Titulaire de permis :	SOUTHAMPTON CARE CENTRE INC 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	SOUTHAMPTON CARE CENTRE 140 Grey Street, P.O. Box 790, Southampton, ON, N0H-2L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BRENDA OHM

To SOUTHAMPTON CARE CENTRE INC, 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. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment;

Grounds / Motifs :

1. The licensee of the long term care home failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Interview with the Director of Care on August 14, 2014, confirmed that where bed rails were used residents of the home have not been assessed to minimize the risk to residents.

During observation in stage 1 of this inspection by inspectors #519, #192, #568 and #165, 30 of 40 residents were observed to have one or more bed rails in the

up position.

Where bed rails were in the up position, beds were observed to have no keepers in place at the foot or head of bed, allowing the mattress to move out of place with minimal lateral pressure and creating a potential zone of entrapment.

All beds in the home were assessed for entrapment risk September 27, 2012, by a contracted service, Joerns. At the time of the assessment 36 of 86 beds assessed were identified to have failed two or more zones of entrapment.

The Environmental Manager confirmed that the mattresses from the 36 beds that were identified to have failed were replaced however, had not been reassessed. The Environmental manager reported that mattresses have moved between bed systems. Since the independent assessment conducted in September 2012 the home did not track the changes to bed systems. The Environmental Manager confirmed that where changes in the bed system occurred, bed systems were not reassessed and steps taken to prevent resident entrapment.

During stage 1 observation on August 11 and 12, 2014, several assist rails were identified to be attached to resident bed systems by Long Term Care Home Inspectors #519, #192, #568 and #165. On August 19, 2014, it was observed with the Environmental Manager that specified residents had assist rails attached to the bed system in the up position. A review of the independent assessment conducted September 27, 2012, indicated that the assist rails were not attached to the bed system at the time the assessment was conducted. The Environmental Manager confirmed that several residents have assist rails that were added to the bed system after the independent assessment was conducted and bed systems were not reassessed and steps taken to prevent resident entrapment.

During stage one observation on August 11, 2014, a specified resident was identified to be on a therapeutic surface. The plan of care for the resident confirmed the use of two bed rails when the resident was in bed. A review of the independent assessment of all beds conducted September 27, 2012, confirmed that the bed the resident used, was not assessed.

During stage one observation on August 12, 2014, a specified resident was identified to be on a therapeutic surface and was observed by Long Term Care

Home Inspector #165 to have two 3/4 rails in the up position. The plan of care for the resident confirmed the use of two bed rails when the resident was in bed. A review of the independent assessment of all beds conducted September 27, 2012, confirmed that the bed the resident used, was not assessed.

The Director of Care reported that there were currently identified resident's to be on a therapeutic surface. The Environmental Manager confirmed that for residents with therapeutic surfaces, the bed systems had not been evaluated for the risk of entrapment. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 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. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for the development of a system for monitoring resident #016 and all residents of the home demonstrating gradual weight loss, ensuring that these residents are assessed, action taken and outcomes evaluated.

The plan is to be submitted electronically to Long Term Homes Inspector, Debora Saville of the London Service Area Office of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch at debora.saville@ontario.ca by September 5, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that residents with weight changes that compromises their health status were assessed using an interdisciplinary approach and that actions were taken and outcomes evaluate.

Resident #016 had experienced weight loss in 2014. A nutritional referral was sent to the home's Registered Dietitian, related to continued weight loss and to consider implementing the home's Food First #2 intervention to assist with the prevention of continued weight decline. The Registered Dietitian indicated that they would wait for a weight to be taken prior to taking action. The Registered Dietitian confirmed that there was no documentation since a specified date in 2014, related to an assessment of the resident's weight and there were no interventions implemented to assist with the prevention of continued weight decline. The resident was now below their goal weight range established by the home's Registered Dietitian. The Registered Dietitian confirmed that gradual weight loss was not monitored. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 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 28th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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