Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 7, 2014	2014_323130_0002	H-000198-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

UPPER CANADA LODGE
272 WELLINGTON STREET, P. O. BOX 1390, NIAGARA-ON-THE-LAKE, ON, L0S-1J0

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

GILLIAN TRACEY (130), CAROL POLCZ (156), IRENE PASEL (510), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 19, 20, 21, 24, 25, 26, 27 and 28, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Resident Assessment Protocol (RAI) Coordinator, Registered Staff, personal support workers (PSW), Food Services Manager (FSM), Manager of Housekeeping and Laundry Services, housekeeping staff, dietary staff, physiotherapy staff, Recreation Manager, hairdresser, residents and families.

During the course of the inspection, the inspector(s) Interviewed staff, residents, families, contracted service providers, reviewed clinical records and relevant policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (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).

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 did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

a) The plan of care for resident #732, identified conflicting statements regarding the mobility and sleep and rest patterns for the resident. Staff interviewed confirmed the

plan of care did not provide clear directions to staff.

b) The plan of care for resident #687, identified skin breakdown to a specific area with specific treatment on identified dates. The physician's orders provided different directions regarding treatment. Registered staff confirmed the plan of care did not provide clear directions. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of the resident.

a) The Minimum Data Set (MDS) assessment completed on a specific date in 2014, indicated resident #739 had dentures which required daily cleaning by staff; required extensive assistance of two staff for bed mobility; required supervision for locomotion in room, corridor and on unit. The plan of care indicated the resident required set-up assistance by one staff for self oral hygiene; staff hand resident the toothbrush and encourage them to brush own teeth; required extensive assistance of two staff for bed mobility; required supervision for locomotion in room, corridor and on unit. The resident was interviewed and stated they required staff to clean their dentures, required limited assistance of one staff for bed mobility and transfers and ambulated independently with walker. The resident was observed ambulating independently with a walker, on and off the unit, on multiple occasions during this inspection. Staff confirmed the statements made by the resident and verified the plan of care was not based on the assessed needs of the resident.

b) The Transfer and Repositioning Assessment completed on a specific date 2014, for resident #732, following a surgical intervention, indicated they required a sit to stand lift for transfers. The plan of care indicated total assistance of two staff with mechanical sling lift. Staff interviewed confirmed the plan of care was not based on the assessment of the resident.

c) On an identified date in 2014, resident #675 and resident #300, had physician's orders for specific textured fluids. At that time, the home was using a powdered thickener for thickening the fluids. Fluids were prepared by the front line staff in the dining room at point of service. As confirmed by the FSM, the staff were having difficulty with the thickener and were preparing it to a thickness "like cement". A few days later, the home changed products from the powdered thickener to a gel product because of this issue and changed these two residents to receive fluids to a specific consistency. When the Inspector questioned why the residents' fluid consistencies

were changed, the FSM indicated that the residents were choking on the thickened fluids. Upon further review, it was noted that there was not individual assessments completed based on the needs and preferences of these residents to change the consistency of the fluids. This was confirmed by the registered staff and DRC.

d) The care plan for resident #675 indicated the resident ate specified meals in the unit dining room, and one meal in their room, at their request. The registered staff confirmed the resident was incapable of making this request due to cognitive impairment.

e) The RAI and MDS assessments completed for resident #672 on an identified date in 2013, indicated the resident was in bed for a specific period of time, however, the plan of care initiated on an identified date in 2013, was inconsistent with assessment. Staff confirmed the plan of care was not based on the assessed needs of the resident. [s. 6. (2)]

3. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

a) The MDS assessment completed for resident #739, on an identified date in 2014, indicated the resident required limited assistance of one staff for transfers and extensive assistance of one staff for dressing, however, the RAP completed during the same assessment period indicated the resident required extensive assistance of two staff for bed mobility and limited assistance of two staff for dressing. The RAI Coordinator confirmed, the RAP summary was not consistent with the MDS coding and did not accurately reflect the care needs of the resident.

b) Wound assessments completed for resident #687 on an identified date in 2013, and on a second date in 2013, indicated the resident had impaired skin integrity to an identified area. The MDS assessment completed around the same time period, identified no impaired skin integrity and no history of impaired skin integrity for the previous 90 days. A skin assessment completed around the same time period, identified no impaired skin integrity to the identified area. A physician's order dated the same day directed treatement interventions for the affected area. Registered staff confirmed the resident continued to have impaired skin integrity during this time frame and the staff assessments were not integrated and did not complement each other. [s. 6. (4) (a)]

4. The licensee did not ensure that care set out in the plan of care was provided to the resident as specified in the plan.

a) On an identified date in 2013, at the noon meal, Inspector #584 observed resident #675 receiving full assistance with foods and fluids from a psw in the dining room. The staff reported that the resident was receiving pudding-thick fluid consistency. The psw was observed mixing thickener into thin fluids by adding one scoop of powder at the dining table. The Inspector noted the fluid consistency was lumpy and was approximately nectar-thick. The Inspector asked the psw if the consistency was appropriate and the psw responded that it was. When the resident was fed, the Inspector noted two bouts of wet coughing by the resident shortly after consuming the fluids. On another date in 2013, during the observed lunch meal, Inspector #584 interviewed the registered staff and was told that resident #675 had been receiving nectar-thick fluids for a long period of time. The physician's orders for this resident created in 2011, indicated nectar thickened fluids. On the same observation date, during the observed lunch meal, Inspector #156 observed resident #675 with a psw who started to give fluids that did not appear to be thickened. The Inspector intervened and the staff indicated that the fluids were thickened. It was noted that the home had recently changed thickening products and staff had pumped one pump of the thickening gel into the cup as per the directions, however, the fluid was still thin consistency. The Inspector observed the staff pump approximately 20 pumps into the juice to thicken it, however, it did not thicken well, even with vigorous agitation. After a few minutes, the juice was still not nectar consistency. On a specific date in 2014, the resident was observed receiving nectar thickened fluids during the lunch meal. Later that day, the FSM was interviewed regarding the new thickener. The FSM indicated that the resident had been changed to pudding consistency, however, as noted, the resident did not receive pudding consistency as the resident was observed receiving nectar thickened fluids. [s. 6. (7)]

5. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or when care set out in the plan was no longer necessary.

a) The plan of care for resident #732, revised on an identified date in 2014, indicated the resident's spouse resided in the home on another unit and that they "spent a lot of time together", however, it was confirmed by the resident's family that the resident's

spouse deceased in 2012. The plan of care identified the resident had responsive behaviours and there were interventions in place to manage physical aggression towards staff and other residents, however, registered staff confirmed the resident no longer had responsive behaviours and had not displayed physical aggression for some time. The plan of care directed staff to give the resident the "opportunity to perform portions/as much of ADLs (activities of daily living) on own as tolerated" and facilitate participation in at least two montessori activities per week. Registered staff confirmed the resident's requirements for care and participation in programs had changed. Registered staff also verified the plan was not revised when interventions were no longer necessary nor when the resident's condition had changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complemented each other, that care set out in the plan of care is provided to the resident as specified in the plan and 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 when care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee did not ensure that the resident was properly sheltered, fed, groomed and cared for in a manner consistent with his or her needs.

a) According to the clinical record, resident #732, sustained a fall on a specific date and time in 2014. Although the initial fall assessment indicated no apparent injury, progress notes recorded from the time of the fall until a number of hours later, indicated the resident had received assistance with specific care on at least two occasions, had stated they had pain to a specific area, required analgesics and displayed facial grimacing, moaning, rubbing of the affected area and had difficulty with morning care. The resident was transferred to hospital and confirmed to have an injury requiring surgery. Registered staff confirmed that front line staff should not have provided specific care when there had been signs and symptoms of pain, observed and reported by the resident and that registered staff should have reassessed the resident when their symptoms worsened. The resident was not cared for in a manner consistent with their needs.

b) On an identified date in 2013, resident #674 sustained two falls within an hour and a half. Immediately after the second fall staff observed resident #674 laying on the floor. Staff documented a visible "dent" was noted to a specific area. Staff reported to the physician that the resident was experiencing pain and was having difficulty performing specific tasks. Tests conducted of the affected area were negative of injury. The resident sustained an additional fall sometime later in 2013, with subsequent increase in pain, decrease in mobility and deteriorating skin integrity. A second test confirmed injury to an identified area. The resident was sent to hospital for surgical intervention. Progress notes indicated that although staff initially reported injury to the physician; a physician's assessment was not conducted between the time of the first fall and the time of the resident's admission to hospital. Resident #674 was not cared for in a manner consistent with their needs for prompt diagnosis and treatment.

c) The plan of care for resident #684, indicated they required extensive assistance from two staff to transfer into bed. On an identified date in 2014, resident #684 and their spouse stated that the resident had been consistently transferred to bed earlier than their desired bedtime, which required them to eat their meal in their room. The resident had informed staff that this was not their preference. Staff had informed the resident that they could not attend a specific scheduled activity, as staff were not available to transfer the resident into bed afterward. The resident's plan of care indicated the resident would occasionally their meal in bed.
On a specific date during this inspection, the resident was observed in bed with pajamas on, prior to the dinner meal; they stated it was not their preference to be in bed. Resident #684 was not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are properly sheltered, fed, groomed and cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #3: 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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted was complied with.

The home's Falls Prevention Program, Index No: MP00-002 indicated: A. Initial Post Fall Assessment, Appendix B, C and D, Notify Substitute Decision Maker (SDM) regarding incident and notify the attending physician if resident injured. Appendix B: Long Term Care (LTC) Post Fall Decision Guidelines directed the nurse to assess mental status and blood sugar if diabetic. The home's policy Lift and Transfer – Back to Care, Index No: RKM00-011 indicated: 7. Residents who have fallen will be lifted using a passive (mechanical) lift, unless the resident can get up independently. 9. During a transfer, the resident must initiate the movement (e.g., sit to stand). The staff must not lift the resident up from a sitting to a standing position.

a) Resident #732 sustained a fall on an identified date in 2014, at a specific time. According to the clinical record the resident was found on the floor and assisted to a standing position by three nursing staff and then ambulated with staff to the bathroom. The resident was a known diabetic and did not have their blood sugar level assessed post fall. The resident's Power of Attorney (POA) was not informed of the fall until the resident was being transferred to hospital. Registered staff confirmed staff should not have transferred the resident without a mechanical lift, staff did not assess the residents blood sugar post fall and staff did not inform the POA immediately after the fall, as per the home's policy.

b) On an identified date in 2013, resident #674 sustained two falls within a specified time period. Immediately following both falls, progress notes indicated that two staff assisted the resident to a standing position and assisted with ambulation to the chair. Staff confirmed that a mechanical lift was not used for the initial transfer, in accordance with the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

a) The plan of care for resident #702, indicated the resident required one person to provide assistance with eating. During the lunch meal on an identified date, the resident was observed sitting with the meal in front of them for approximately 30 minutes without assistance being provided. On another date, the lunch meal was observed in front of resident #702. The resident proceeded to wipe the food onto the bib. No assistance was provided to the resident and the resident wiped the entire plate of food onto the bib and then started to bang the tray. The plate was then removed by a staff member and the resident was provided with a new plate of food. The resident proceeded to feed themself the meal without any assistance. Staff interviewed indicated that the resident required total feeding on some days and other days required encouragement.

b) The plan of care for resident #701, indicated the resident had a specific care need and required limited assistance of one staff for eating. On specific date during this inspection, staff interviewed verified the resident's care needs, however, it was noted that no assistance was provided to the resident. The same resident then asked to go to the bathroom but did not return to dining room and food/beverages remained unconsumed at end of lunch service. On an identified date during this inspection, the resident was observed sitting at the table not eating. The resident made a request to staff for assistance; no assistance or encouragement was provided for approximately fifteen minutes until the resident removed the bib and was going to leave the table. The resident indicated they were not feeling well; staff then intervened and encouraged the resident to have a drink.
Staff interviewed confirmed the resident required encouragement and assistance recently but not every day. [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the infection prevention and control program.

a) During the lunch meal on an identified date in 2014, Inspector #510 observed staff handling dirty dishes and not washing hands before serving dessert/napkins to residents. During the lunch meal on another date in 2013, Inspector #584 observed a front line staff serving dessert and not washing hands between clearing dirty dishes and going back to dessert service. Another front line staff was observed scratching under their nose and continuing to serve dessert.

b) The home's Infection Prevention and Control Policy (Control Measures, Isolation Routines) revised on October 5, 2013, indicated that "Garbage container must be kept within room for easy disposal of gloves etc." and for contact precautions "gown to be worn when entering resident area". On an identified date in 2014, upon exiting two identified rooms under contact precautions, the Inspector could not locate a garbage for easy disposal of used personal protective equipment (PPE). Staff were notified and confirmed that garbage should be easily accessible for disposal of used PPE.

c) On February 21, 2014, the Recreation Manager confirmed that the requirement for vaccinations for pets was not posted as per the home's policy for Resident and Community Programs: Visiting Pets (RC020108) revised December 2008.

d) On February 26, 2014, a scraper was noted laying on a resident bedside table in an identified room. The resident confirmed that they saw housekeeping staff scraping the floor with it earlier that day.

e) The plan of care for resident #676, indicated the resident was positive for a specific infection to a specific area. The resident had contact precaution signage on their room door and staff interviewed stated they were required to don gowns and gloves whenever providing direct care to the resident. On an identified date in 2014, the resident was observed in the hair salon, getting their hair done. The hairdresser did not use PPE while doing this resident's hair. The Administrator verified that although the hairdresser was not an employee of the home, it was the expectation that all staff, visitors, volunteers and contracted service providers comply with the infection control program of the home. [s. 229. (4)]

2. The licensee did not ensure that the home's policy Prevention Measures, index number IC04-002, stated that there were "4 moments for Hand Hygiene", including before initial patient/ patient environment contact such as "helping a resident to move around", after body fluid exposure risk such as "handling waste" and after patient/patient environment contact such as "helping a patient to move around".

a) On an identified date in 2014, at the noon meal, staff in an identified home area dining room,
were observed to clear tables of used dishes and then proceed to serve soup to other clients without washing their hands. A psw interrupted feeding one resident to redirect and assist another resident. Staff did not wash their hands between contacts with different residents. A dietary staff clearing tables retrieved clean serviettes from the servery and distributed to residents without first washing her hands. Staff confirmed they would normally wash their hands between removing soiled dishes and retrieving, distributing and returning serviettes to servery. [s. 229. (9)]

3. The licensee did not ensure that residents were offered immunizations against pneumococcus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

a) Resident records did not indicate if residents were offered vaccinations or when residents were scheduled to receive vaccinations according to the publicly funded immunization schedules. Resident #714's record did not indicate that they were offered diptheria vaccination within the past 10 years; Resident #711 and #673's records did not indicate that they were offered diptheria or tetanus within the past 10 years according to the publicly funded immunization schedules. Staff could not confirm that residents were offered tetanus and diptheria vaccinations according to the publicly funded immunization schedules. [s. 229. (10) 3.]

4. The licensee did not ensure that there was a staff immunization program in accordance with prevailing practices.

The "Best Practices for Infection Prevention and Control Programs in Ontario In All Health Care Settings, 3rd edition" by the Provincial Infectious Diseases Advisory Committee (PIDAC) (rev. 2012) indicated a) that the communicable disease status at the time of employment of all health care providers should be evaluated and should include vaccination status and serologic screening for select vaccine-preventable diseases; b) health care providers must be offered appropriate vaccinations for communicable diseases; c) staff vaccination rates should be used as a patient safety indicator; d) health care provider vaccinations should include tetanus, diphtheria, influenza, hepatitis B, vericella (if not immune), measles/mumps/rubella, acellular pertussis and other vaccinations as indicated.

a) A staff medical record audit of three employees, revealed staff were screened for tuberculosis and offered an annual influenza vaccination. Administration staff confirmed that no other immunization program was offered to staff. [s. 229. (10) 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 all staff participate in the implementation of the infection prevention and control program, that there is in place a hand hygiene program, in accordance with evidence-based practices and, if there are non, in accordance with prevailing practices, and with access to point-of-care hygiene agents, that all residents are offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website and that there is a staff immunization program in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with 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 did not ensure that the home, furnishings and equipment were kept clean and sanitary.

a) It was noted on February 26, 2013, that the kitchen area walls and garbage cans were found to be dirty and in need of cleaning. A cleaning schedule was posted in the kitchen area, however, the FSM confirmed that staff did not sign off for accountability when completed. On February 28, 2014, in the Virgil home area, it was noted that the servery was dirty. The wood panel wall was dirty with food debris and dust and was in need of cleaning. The ceiling fan and lights in the dining room had a thick layer of dust and required cleaning. [s. 15. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had a response made to the person who made the complaint indicating what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for that belief.

a) On an identified date in 2013, resident #685 spoke with the DRC to complain about a staff member's behaviour. Documentation of the home's investigation did not include a response made to resident #685. The Administrator confirmed that documentation of a response to the resident was not available. The resident stated that they did not feel that this issue had been resolved and that management of the home had not responded to their complaint. [s. 101. (1) 3.]

WN #8: 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 did not ensure that all areas where drugs were stored were kept locked at all times, when not in use.

a) At 0955 hours, the medication cart was observed in the common area outside the Queenston dining room, unlocked and unattended, with residents present. The inspector was able to open the drawers of the medication cart. At 1000 hours, registered staff returned and confirmed it was the home's policy that the medication cart be locked when not in use. [s. 130. 1.]

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

Issued on this 29th day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Gillian Tracey.

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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) :	GILLIAN TRACEY (130), CAROL POLCZ (156), IRENE PASEL (510), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2014_323130_0002
Log No. / Registre no:	H-000198-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 7, 2014
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF NIAGARA 2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	UPPER CANADA LODGE 272 WELLINGTON STREET, P. O. BOX 1390, NIAGARA-ON-THE-LAKE, ON, L0S-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARGARET LAMBERT

To THE REGIONAL MUNICIPALITY OF NIAGARA, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the plans of care for residents, including #672, #675, #732 and #739 are based on an assessment of the resident and the needs and preferences of the resident. The plan shall be submitted electronically to Inspector Gillian.Tracey @ontario.ca by April 15, 2014.

Grounds / Motifs :

1. The licensee did not ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of the resident.

a) The Minimum Data Set (MDS) assessment completed on a specific date in 2014, indicated resident #739 had dentures which required daily cleaning by staff; required extensive assistance of two staff for bed mobility; required supervision for locomotion in room, corridor and on unit. The plan of care indicated the resident required set-up assistance by one staff for self oral hygiene; staff hand resident the toothbrush and encourage them to brush own teeth; required extensive assistance of two staff for bed mobility; required supervision for locomotion in room, corridor and on unit. The resident was interviewed and stated they required staff to clean their dentures, required limited assistance of one staff for bed mobility and transfers and ambulated independently with walker. The resident was observed ambulating independently with a walker, on and off the unit, on multiple occasions during this inspection. Staff confirmed the statements made by the resident and verified the plan of care was not based on the assessed needs of the resident.

b) The Transfer and Repositioning Assessment completed on a specific date

2014, for resident #732, following a surgical intervention, indicated they required a sit to stand lift for transfers. The plan of care indicated total assistance of two staff with mechanical sling lift. Staff interviewed confirmed the plan of care was not based on the assessment of the resident.

c) On an identified date in 2014, resident #675 and resident #300, had physician's orders for specific textured fluids. At that time, the home was using a powdered thickener for thickening the fluids. Fluids were prepared by the front line staff in the dining room at point of service. As confirmed by the FSM, the staff were having difficulty with the thickener and were preparing it to a thickness "like cement". A few days later, the home changed products from the powdered thickener to a gel product because of this issue and changed these two residents to receive fluids to a specific consistency. When the Inspector questioned why the residents' fluid consistencies were changed, the FSM indicated that the residents were choking on the thickened fluids. Upon further review, it was noted that there was not individual assessments completed based on the needs and preferences of these residents to change the consistency of the fluids. This was confirmed by the registered staff and DRC.

d) The care plan for resident #675 indicated the resident ate specified meals in the unit dining room, and one meal in their room, at their request. The registered staff confirmed the resident was incapable of making this request due to cognitive impairment.

e) The RAI and MDS assessments completed for resident #672 on an identified date in 2013, indicated the resident was in bed for a specific period of time, however, the plan of care initiated on an identified date in 2013, was inconsistent with assessment. Staff confirmed the plan of care was not based on the assessed needs of the resident. [s. 6. (2)]
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

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
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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.

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

Ministère 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

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 7th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : Gillian Tracey

Name of Inspector / Nom de l'inspecteur : GILLIAN TRACEY

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