Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 21, 2014	2014_293554_0034	O-000876-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet LINDSAY ON K9V 5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH LINDSAY ON K9V 4R2

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

KELLY BURNS (554), CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553), SAMI JAROUR (570)

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): September 15-19 and September 22-26, 2014

The following intakes were completed concurrently during this inspection: #O-000712-13, O-001019-13, O-001078-13, O-000710-13, O-000328-13, O-000883-14, O-000759-14, O-000835-14. O-000684-14, O-000683-14, O-000668-14, O-000782-14, O-000572-14, O-000552-14, O-000463-14, O-000392-14, O-000337-14, O-000168-14, O-000154-14, O-000901-14, O-000915-14, O-000993-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Assistant Director of Care(ADOC), Infection Control Lead, Director of Building Services (DBS), Nutritional Care Manager, Registered Dietitian (RD), Office Manager, Behaviour Support Team, Receptionist, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Dietary Aide(s), Activity Manager, Activity Staff, Maintenance Worker(s), Pharmacy Representative, Residents and Families

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Admission and Discharge
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with 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. (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. Related to Log #O-001019-13, for Resident #55:

The licensee failed to comply with LTCHA, 2007, s. 6 (1), ensuring that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident.

Resident #55 was admitted to the home on an identified date. Based on information supplied by the Community Care Access Centre package and family communications, the home was aware prior to admission that Resident #55 had known responsive behaviours which placed the resident at risk; resident was admitted to the secured home unit within the home.

At the family's request Resident #55 was discharged from the secured unit approximately a month later and was relocated to another resident care area, within the home (this was not a secured unit).

Progress notes for Resident #55 were reviewed for a specific time period indicated Resident #55 attempted to or exited the home on numerous occasions.

The written care plan for Resident #55, during the period reviewed, failed to identify resident as exhibiting responsive behaviours which place resident at risk for wandering and or elopement.

The Behaviour Support Ontario Team Lead (Staff #115) and the Director of Care indicated responsive behaviours which placed resident at risk should have been identified in the written care plan for Resident #55 and that interventions should have been identified.

Director of Care indicated that at all times the plan of care should reflect the care needs of each individual resident.[s. 6. (1)]

2. Related to Resident(s) #40, 43 and #60:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care was provided to Resident's #40, 43 and #60 as specified in the plan.

Related to Resident #43:

Review of Resident #43's plan of care (current as per inspection date) related to Nutritional Risk indicated resident was considered as being a high nutrition risk. An identified goal for this resident is to prevent episodes of choking and or aspiration.

Interventions listed in the plan of care for Resident #43 were specific to resident's positioning during meal times, assistance required and methods in which resident was to receive meals or nourishment.

Observations, of Resident #43, made during four specific dates failed to support that the planned care for this resident, relating to correct positioning at mealtime and or assistive aides used during mealtime or nourishment were being followed.

Staff #101 indicated that Resident #43 is able to eat independently while using an assistive device; staff commented that resident is never positioned according to the planned care as resident continuously slides down while resident is seated in the chair.

During an interview, the Registered Dietitian indicated being asked by registered nursing staff to see resident due to concerns with positioning; this assessment was completed as requested; it was identified that staff were unable to maintain a 90 degree angle positioning at meals; the most recent strategy was to have resident positioned at 45 degree angle and up as possible during mealtimes. Resident is not to be served meals with straws; a sippy cup is to be. [s. 6. (7)]

3. Related to Log #O-000883-14, for Resident #40:

Critical Incident Report(CI), was submitted for a falls incident that occurred.

Details of the Critical Incident Report are as follows:
- Resident #40 was being toileted by staff; staff left the resident and went to get a co-worker to assist in getting Resident #40 off the toilet. During staff's absence, Resident #40 stood up, tripped over the pants which were around the resident's legs and fell to the floor.

Resident was transferred to hospital as a result of the fall, was admitted to hospital due to injuries sustained.

Resident #40's care plan (for the above time period) detailed the following:
- Toileting - resident requires assistance of staff; 2 staff are to assist resident, staff are to remain with resident throughout the process.

The Critical Incident Report for this incident detailed that the staff member who left Resident #40 unattended on the toilet did recognize that the fall could have been prevented if the plan of care had been followed. [s. 6. (7)]

4. Related to Log # O-000933-14, for Resident #60:

Critical Incident Report(CI) for incident resulting in a fall.

Details of the incident were as follows:
- Resident #60 was having care completed by a staff member; while staff was assisting with care, resident fell to the floor. As a result of the fall, resident sustained injuries.

A review of plan of care for Resident #60, indicated that two staff were to be utilized during care (e.g. bed mobility).

A review of clinical health records, details that Staff #137 had been completing care for Resident #60's without the assistance of a second staff, when the incident occurred.

Since sustaining the fall, Resident #60 has had a decline in functional abilities and an increase in discomfort. [s. 6. (7)]

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 there is a process in place to monitor that all residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when a resident's care needs change; and to ensure that different approaches are considered when care set out in the resident's plan of care has not been effective, to be implemented voluntarily.

WN #2: 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 failed to comply with O. Reg. 79/10, s. 8 (1), by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is: (b) complied with:

O. Reg. 79/10 s. 136 (1)(a) requires every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of, all expired drugs.

The home's policy, Expiry and Dating of Medications (#5-1) directs that registered

nursing staff are to do the following:
- examine the expiry date of all medications on a regular basis, being especially careful to check all storage areas for extra medication, PRN medications, government stock, monitored medication (narcotic and controlled), topicals and eye drops
- remove any expired medications from stock and order replacement as necessary

The home's policy, Recommended Expiry Dates Once Product is Opened (#5-2) states the following:
- Products, such as creams, ointments (repacked in jars), have an expiry once opened of 1 year
- Topical mixtures (e.g. Hydrocortisone powder in cream), have an expiry date once opened of 6 months

During an observation during this inspection, there were numerous resident treatment creams or ointments identified as being expired.

Staff #115 indicated that the expectation in the home is that the night staff are to pull expired treatment creams and review whether or not the creams are still required. [s. 8. (1)]

2. O. Reg. 79/10 s. 131 (6) Where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand, (a) the use of the drug and (b) the need for the drug.

The home's policy, Self-Administration of Medications (#5-5) directs the following:
- prescriber and nursing team assesses a resident's capacity to self-administer their own medication(s) and are to complete the Self-Administration Assessment Form
- the resident is to sign the Self-Administration of Medication Agreement; the agreement is to be filed in the resident's chart once completed

A review of Resident #27 and Resident #41's health record failed to provide supporting documentation that the Self Administration Agreement for self administration was completed in accordance with the home's policy.

The Assistant Director of Care, during an interview, stated that the expectation of the home is that if a resident is self-administering medications the Self-Administration Form and Resident Self-Administration of Medication Agreement is to be filled out completely

by the registered nursing staff. [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 to ensure there is a process in place to monitor that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is: (b) complied with, specific to medication management, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Related to Log #O-000783-14, for Resident #49:

The licensee failed to comply with LTCHA, 2007, s. 20 (1) by ensuring that written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home's policy, Abuse and Neglect of a Resident – Actual or Suspected (VII-G-10.00) directs reportable matters set out in Section 24 shall be immediately reported.

The policy further directs that the Registered Nurse, in charge will, immediately notify the family representative or substitute decision maker and the Administrator/ Director of Care of an instances of alleged abuse.

The policy indicates the Administrator or designate will, notify the MOHLTC Director immediately according to protocols established for reporting of abuse and other critical incidents.

Staff #124, who was designated as in charge during the evening shift on a specific date, failed to:
- notify the Resident #49's family as to the allegation of staff to resident (emotional/verbal) abuse
- immediately notify the MOHLTC as to the allegation of suspected abuse of a resident by staff
- immediately notify the Director of Care and or Administrator as to the alleged abuse

The Director of Care indicated that Staff #124 was a relatively new registered nursing staff within the home, which may have been a contributing factor in this situation. DOC commented that Staff #124 was provided further education, specific to reportable matters set out in Section 24, following the incident. [s. 20. (1)]

2. The licensee failed to comply with LTCHA, 2007, s. 20 (2)(d), by ensuring at minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall contain an explanation of the duty under Section 24 to make mandatory reports.

The home's policy, Abuse and Neglect of a Resident – Actual or Suspected (VII-G-10.00) directs reportable matters set out in Section 24 shall be immediately reported.

The home's policy Abuse and Neglect of a Resident – Actual or Suspected does not provide:
- an explanation of the duty to make mandatory reports under Section 24 in its policy to promote zero tolerance of abuse and neglect
- a clear explanation to Personal Support Workers, Registered Nursing Staff, Support Staff or others, of their individual obligation for reporting to the Director, under Section 24 of the LTCHA, irrespective of the licensee's duty to report [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written policy that promotes zero tolerance of abuse and neglect of residents is complied with; and at minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall contain an explanation of the duty under Section 24 to make mandatory reports, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to Log #O-000933-14, for Resident #60:

The licensee failed to comply with LTCHA, 2007 s. 24 (1), by ensuring that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director,
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of

harm to a resident
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A Critical Incident Report(CI) was submitted for an incident that occurred where a resident was injured as a result of improper care.

The CI, details Staff #137 assisting Resident #60 with care; during the care procedure, resident fell and sustained injuries. The report indicated the planned care for this resident, was, two staff were to be present for all care; as per the CI Staff #137 did not have a second staff present during the care procedure.

Staff #103, who was in charge at the time of this incident, stated awareness of notification and submission requirements under Section 24 and confirmed that both were late. Staff #103 indicated being busy investigating the situation and in turn forgot about the need to report the incident to MOHLTC.

The Director of Care indicated awareness that the incident was late being reported and confirmed that the Staff #103 should have notified the Director immediately upon discovery of the incidence of improper care. [s. 24. (1)]

2. Related to Log #O-000783-14, for Resident #49:

The Director of Care reported an incident of Staff to Resident emotional/verbal Abuse which occurred. The details of the incident were as follows:

Registered Practical Nurse (RPN) indicated overhearing Staff #123 speaking to Resident #49 in a raised voice. The report indicates resident, commented to the RPN, being upset as to the interaction.

Resident #49 communicated that Staff #123 not only spoke in a raised voice, but was leaning inward towards the resident's face and was waving hands around; resident commented feeling intimidated by the interaction. Resident #49 stated that Staff #123 indicated resident's request for nourishment was an imposition and became upset.

The report indicates that the RPN did speak with Staff #123 as to the inappropriate interaction.

The Registered Practical Nurse who overheard the interaction reported the situation to Registered Nurse #124; staff #124, was in charge of the home during the evening shift on the date indicated.

The Director of Care (DOC) indicated that the incident involving Staff to Resident Abuse was not reported to the Ministry of Health and Long Term Care (MOHLTC) until late afternoon the next day when the incident was reported by Staff #124 to the DOC.

According to the Director of Care, Staff #124 should have contacted MOHLTC at the time of the incident, as the Registered Nurse is considered in charge of the home during the absence of the management team.

Director of Care communicated that both the Registered Practical Nurse, as well as the Registered Nurse have been provided re-education specific to Section 24 - duty to report. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place to monitor that when a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specific to, improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to a resident; abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, or other requirements under section 24, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 37 (1) (a), by ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new item.

The following was observed during the inspection:
- Room #204 – toothbrush and a k-basin sitting on the bathroom vanity, all items were unlabelled; this is a shared washroom
- Room #211 – a toothbrush, denture cup and roll on deodorant were on the bathroom vanity, all items were unlabelled; this is a shared washroom
- Room #214 – a denture cup, roll on deodorant, two toothbrushes were on the bathroom vanity, all items were unlabelled; this is a shared washroom
- Room #217- bar soap in a baggie, and an electric toothbrush were sitting on the bathroom vanity, all items were unlabelled; this is a shared washroom
- Room #220 - two toothbrushes, a k-basin, a bar of soap in a dish and a nailbrush were sitting on the bathroom vanity, all items were unlabelled; this is a shared washroom
- Room #222 – two denture cups containing upper and lower dentures and a purple hairbrush were sitting on the bathroom vanity, all items were unlabelled; this is a shared washroom
- Room #223 – 4 toothbrushes, and a comb were sitting on the bathroom vanity, all items were unlabelled; this is a shared washroom
- Room #216 – four toothbrushes in a cup, all items were unlabelled; this is a shared washroom

Staff #104 indicated that all personal care items are to be labelled for individual use.

The Director of Care confirmed that all resident care items are to be labelled on admission and when the resident obtains new supplies; DOC indicated that Personal Support Workers are to label or re-label resident care supplies as needed if staff notice the supplies are not labelled. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place to monitor that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, are labelled within 48 hours of admission and of acquiring, in the case of new item, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 86 (2) (b) , by ensuring there are measures in place to prevent the transmission of infections.

The following was observed during the inspection:
- Room #210B – unlabelled urinal in the washroom; this is a shared washroom
- Room #203A – unlabelled bedpan lying on the washroom floor; this is a shared washroom
- Room #114B – unlabelled basin in the washroom; this is a shared washroom
- Room #104A – unlabelled basin in the washroom; this is a shared washroom
- Room #107A – unlabelled basin in the washroom; this is a shared washroom
- Room #204A – unlabelled bedpan sitting on the back of the toilet; this is a shared washroom
- Room #215A – white care caddy sitting on the floor beside the toilet, container contained hairbrushes and k-basin; this is a shared washroom. In addition, there was a urine collection (hat) device on the handrails outside of the room
- Room #214A – two unused incontinence products sitting on the vanity beside a toilet, the lid of the toilet was open and the toilet contained urine
- Room #217A – 3 unused incontinent products sitting on the back of the toilet, the lid of the toilet was open; this is a shared washroom
- Room #220B – unlabelled bedpan on the toileting bar; this is a shared washroom
- Room #111A – two unlabelled bedpans in the washroom; this is a shared washroom
- Room #116B – unlabelled bedpan and urine collection hat in the washroom; this is a shared washroom

Staff #104 indicated that all resident care items, including bedpans and urinals are to be labelled for individual use, especially if in a washroom shared by more than one resident. [s. 86. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place to monitor that measures are in place and followed to prevent the transmission of infections, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 99 (b), by ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

The Director of Care indicated that the home has not conducted an evaluation of the effectiveness of the home's policy to promote zero tolerance of abuse and neglect of residents in the previous year; the DOC was unsure when an evaluation was last completed.

As communicated by the Director of Care, the home is currently in the process of evaluating the policy specific to zero tolerance of abuse, with the expected completion by the end of the year. [s. 99. (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 there is a process in place to annually evaluate the effectiveness the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10, s. 129 (1)(a), by ensuring that drugs are stored in an area or a medication cart,
i) that is used exclusively for drugs and drug-related supplies, and
ii) that is secured and locked

Observations made by an inspector:

- The Nursing Supply Room, on one of the care units, was observed to house medicated treatment creams for residents, in addition to treatment creams, personal care items

such as body lotion, tooth brushes, deodorants, razors and bedding are kept in this room. The above findings of personal care products being stored with treatment creams were consistent in the seven other nursing supply room found within the home.

Staff #102 indicated that medicated treatment creams are kept on the unit in rooms designated as "nursing supply room". Staff #104 confirmed this is the practice of the home and that registered and non-registered staff have access to this room.

- Staff #102 was observed to leave the medication cart unlocked and unattended as staff went into a room behind the care centre; during this same observation, the medication room on this unit was also left unlocked and was propped open by a garbage can. This observation was also witnessed by the Pharmacy Consultant.

- Staff #125 left a medication cart unlocked and unattended; two members of the dietary staff were outside of dining room nearby the cart during this observation.

- The medication cart was unlocked and inside of an unlocked medication room; there were no registered nursing staff present at the time of this observation. Resident's were observed in the common area lounge, which is within 5 feet of the unlocked medication room. [s. 129. (1) (a)]

2. Observations made by an inspector:

- A medication cart was observed unlocked and unattended; an inhaler, a bottle of laxative and three bottles of eye drops were sitting on top of the medication cart during this same time.

Staff #102, who is a registered practical nurse, was inside of the dining room (approximately 15-20 feet away from the medication cart, with back to the cart. One resident was observed sitting beside the medication cart.

Staff #102, 112 and #125, all of whom are registered nursing staff indicated awareness that the medication cart and medication room(s) are to be locked whenever registered nursing staff are not in attendance.

The Director of Care and Assistant Director of Care indicated that all registered nursing staff are aware that medication cart(s) and or medication room(s) are to be locked whenever registered nursing staff are not in attendance. [s. 129. (1) (a) (ii)]

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 there is a process in place to monitor that drugs are stored in an area or a medication cart, that is used exclusively for drugs and or drug-related supplies, and that is secured and locked, to be implemented voluntarily.

WN #9: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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 failed to comply with O. Reg. 79/10, s. 229 (2)(d), by ensuring that the Infection Prevention and Control Program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's Infection Control Lead indicated that the home has not completed an Infection Control Program annual review for the previous year.

The Director of Care confirmed that no Program Evaluation for the Infection Control Program had been completed for the previous year. DOC indicated this is an area of required improvement and the team is currently looking at completing prior to the end of the year.

This was previously issued as an area of non-compliance. [s. 229. (2) (d)]

2. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by ensuring that all staff participate in the implementation of the infection prevention and control program.

The following observations were made:

- Staff #102, was observed administering medications on a resident unit, staff was in the dining room administering an injection to one resident, then turned to another resident, placed the protective cover of the injection needle tip into staff's mouth, removed the lid of the injection device with mouth and administered medication to the second resident; staff then returned to the medication cart and prepared medication for a third resident; there was no hand hygiene before or after administering medication to the three residents.

- Staff #108 came back to the medication cart after administering medications in the dining room. Staff #108 did not perform hand hygiene upon exiting the dining room, or once at the medication cart. At this point, Resident #42 approached Staff #108 and asked Staff #108 to remove a band aid present on their hand. Staff #108 obliged, however Staff #108 did not perform hand hygiene before or after this interaction with Resident #42 and proceeded to prepare the next resident's medications.

- Staff #112 was seen coughing into a Kleenex while standing at the medication cart on a resident unit, staff then placed the kleenex into waste container on the side of the cart, staff then administered medications to two residents; staff did not perform hand hygiene following disposal of the kleenex nor before or after administering medications to the two residents.

- Staff #112 was seen administering medication to a resident on a resident unit, returning to the medication cart, disposing of the needle tip from the medical device, staff was then observed taking a bottle of eye drops from the medication cart and administering the eye drops to a resident; staff did not perform hand hygiene before or after to the two residents.

The Infection Control Lead for the home indicated that all staff are provided education including, a) the need for infection control, b) the six links in the chain of infection and c) hand hygiene during orientation and annually.

The Infection Control Lead confirmed that Staff #102, #108, #112 all had received training on the infection control program during the current year. [s. 229. (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 there is a process in place to monitor that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: 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:
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 failed to comply with LTCHA, 2007, s. 3 (1)11., by ensuring that each resident has his or her personal health information kept confidential.

During a medication administration observation, Staff #108 was seen throwing out the empty medication strip packs for the residents into a garbage bag bin which was located on the side of the medication cart.

The Medication strip packs identified the following resident information:
- the residents name
- resident location (unit and room number)
- date and time of when the medication(s) were to be taken
- a list of medications to be taken by the resident
- pharmacy transaction numbers of each listed medication

When asked how staff disposed of these medication strip packs, Staff #108 and #100 stated that the empty medication strip packaging is thrown into the home's regular garbage. [s. 3. (1) 11. iv.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 9 (1) iii, by ensuring all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The following observation was made:

- Residents and visitors were seen entering and exiting the home via the main entrance. During the same observation, one resident in a wheelchair took longer than usual to exit the home (approximately 1-2 minutes), the audio alarm connected to the door sounded and was noted to be barely audible; once the resident cleared the door's threshold the door alarm shut off automatically. To note, no staff arrived to check on why the alarm had been ringing during this observation.

Staff #115, during an interview, commented that the main entry door has been troublesome since early spring or summer. Staff #115 stated that staff use to have to physically attend to the door each time the door alarm sounded and use their swipe card or the door access code to turn off the door alarm, but lately no staff are required to attend as the door alarm automatically shuts off on its own.

Staff #115 further conveyed that staff do not know who is exiting and or entering the home as the door alarm can only be heard if one is sitting at MacMillian House (a resident care area) nursing station and even then the alarm is barely audible. Staff indicated that the concern with the door had been addressed with managers in the past, but to date had not been fixed.

The Director of Building Services(DBS) confirmed that the front doors to the home had been problematic and that new doors had been ordered. DBS indicated no awareness of the current problem with the door alarms not functioning properly and indicated that a service call would be made immediately to resolve the issue.

The Director of Building Services along with the Office Manager did implement measures to mitigate risk to residents, who may have had the potential for exit seeking and or elopement, when the concern was brought to their attention by the inspector.

The door alarm was repaired and the home was in compliance with legislation. by end of day on the date in which it was reported. [s. 9. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 21, by ensuring that the temperature in the home maintained at a minimum of 22 degrees Celsius.

During an interview, Resident #10 indicated being cold when in own room, in the home area lounge and in the dining room. Resident indicated the temperature of the home is not warm enough at any time or during any season, for resident's liking.

Resident #10 commented that it is a struggle to get out of their wheelchair and bend down to turn on baseboard heater in the room and when able to turn the baseboard heater on, staff come in and turn it off.

Resident #27 indicated to another inspector that the building is often cold during the winter months.

A review of the home's Interior Temperature records, taken over a five month time period, failed to demonstrate that the temperature within the home is being maintained at 22 degrees Celsius; the records indicated numerous occasions when temperatures ranged from 15 to 21.5 degrees.

Maintenance Worker #120 commented that thermostats within the home are set at 22 degrees, and that the temperature is monitored and recorded daily on the Daily Preventative Maintenance Check List. Staff #120 stated that if the temperature in any home or common area falls below 22 degrees that maintenance goes to the electrical room and turns the thermostat up by one degree, then re-checks the temperature the next day. Staff #120 indicated that there is frequently temperature fluctuations within the home, but most recently there has been an increase in the temperature fluctuation due to a roof top unit being broken.

The Director of Building Services (DBS) did confirm awareness of the temperature fluctuations within the home and that at times the temperature was not being maintained

at 22 degrees.

Director of Building Services indicated that each resident's room has a baseboard heater and that the heat could be controlled by the resident residing in individual rooms. DBS commented that baseboard heaters were turned on a month ago, one month earlier than usual, due to the circuit board being broken. DBS did convey awareness that the baseboard heaters are often turned off by nursing staff, and such is dealt with individual staff when noted.

The Director of Building Services did confirm that the roof top unit / circuit board were broken and that the home was waiting for approval for the required repairs. [s. 21.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Related to Log O-000933-14, for Resident #60:

The licensee has failed to comply with O. Reg. 79/10. s. 36, by ensuring that staff use safe transferring and positioning devices or techniques when assisting residents.

Staff #137 was assisting Resident #60 with personal care, during the completion of the care task, resident fell. Resident #60 sustained injuries as a result of the fall.

Staff #137, with the assistance of Staff #139 used the mechanical lift to assist Resident #60 off of the floor. Staff #139 is employed as support staff.

The Director of Care(DOC), during an interview, indicated that Staff #139 is not trained on how to properly use a mechanical lift. DOC further indicated that the expectation of the home is that when using a mechanical lift, there are to be two staff members present who are trained in the use of the mechanical lift.

The Director of Care indicated that since the incident the identified staff have been retrained on expectations around using mechanical transferring devices and who is permitted to use the same. [s. 36.]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 57 (2) in that the licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Residents' Council.

Review of Residents' Council minutes for a specific period indicated that the council raised concerns about staff shortages; unclean tea cups, and food shortages.

Review of Residents' Council minutes for a specific period indicated a concern about bathing and a recommendation that the dining room on a resident home area needed to be painted.

Review of Residents' Council minutes for a specific period indicated that the Council raised concerns about staffing; minutes of meeting indicated a recommendation of having clothing protectors with tighter and or smaller necks.

During an interview, the President of the Residents' Council indicated the Residents' Council does not receive written responses from the Administrator when concerns or recommendations are brought forward. The President of the Residents' Council commented that staffing shortages remains an outstanding concern to the Council.

During an interview, the Manger of Residents and Family Services and Residents' Council assistance indicated that the Residents' Council did not receive any written responses as the concerns were not formally forwarded to management. The concerns are dealt with by the responsible manager face to face at each Council meetings.

The Administrator confirmed that a written response was not given within 10 days to the Residents' Council when concerns or recommendations are brought forward by the Residents' Council. [s. 57. (2)]

WN #15: 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. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The license failed to comply with O. Reg. 79/10, s. 101 (3), by ensuring that the documented record of complaints received is reviewed and analyzed for trends, at least quarterly.

The Administrator did indicate that all concerns and complaints are documented and reviewed at the Leadership and Quality Committee meeting which is held on a quarterly basis.

A review of the Leadership and Quality Committee Meetings, held during a specific date, did indicate concerns were being reviewed, but failed to provide evidence that concerns or complaints were being reviewed and analyzed for trends, at least quarterly, nor was there evidence that the review of complaints /concerns were being taken into account to determine improvements within the home.

The Administrator indicated the home currently has not analyzed complaints and or concerns for trends in the current year nor in the previous year.
[s. 101. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. Related to Log(s) #O-000712-13 and #O-000710-13, for Resident #46:

Before discharging a resident under subsection 145 (1) the resident's requirements for care have changed and as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident of the safety of persons who come into contact with the resident).

The licensee failed to comply with O. Reg. 79/10, s. 148 (2), by ensuring that:
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if

any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Resident #46 was admitted to the home with a pre-existing medical condition.

According to the Director of Care (DOC) exhibited challenging responsive behaviours. DOC indicated Resident #46 didn't want to live at the long term care home; DOC commented that the resident voiced desire to leave the home.

Progress Notes were reviewed for a specific time period, notes detail numerous incidents where Resident #46 was exhibiting responsive behaviours; interventions implemented ranged from being effective, to fair or ineffective.

During the above time period, progress notes indicated, Resident #46 frequently voiced desire to be transferred to the hospital and stated displeasure at living in the long term care home.

There is no indication in the progress notes that attempts were made by the home to find alternative accommodations for Resident #46 despite voiced unhappiness with living arrangements.

Progress notes, written by registered nursing staff, indicate that on an identified date, Resident #46 was found on the floor; notes document that while a nurse was assessing the resident, resident grabbed the nurse. The nurse was eventually able to free self and call for help.

Registered Practical Nurse contacted the Registered Nurse, who was in charge of the home to report the incident. According to the progress notes, the charge nurse arrived on the unit and assessed the Resident #46 to be confused and combative. Registered nursing staff contacted Emergency Medical Services and Police to intervene; the resident was in turn transferred to hospital for assessment.

Progress notes indicate that the next day, both the Community Care Access Centre and the family were advised that Resident #46 was being discharged from the home. [s. 148. (2)]

2. Related to Log #O-000901-14, for Resident #47:

Resident #47 was admitted to the home with a pre-existing medical condition.

Progress Notes were reviewed for a specific time period, notes detail numerous incidents where Resident #47 was exhibiting responsive behaviours directed towards staff and other residents; interventions in place were effective until an identified date when responsive behaviours began to change. Progress note entries indicated resident was becoming difficult to redirect and interventions were documented as poor to ineffective.

Progress notes, on a specific date, detail resident's responsive behaviours escalating and becoming volatile in nature; registered nursing staff were unable to administer medications in an effort to de-escalate the situation. According to the progress notes, emergency medical services and the local police were contacted to intervene, resulting in Resident #47 being transferred to the hospital for assessment.

Progress notes, a day after the incident, indicated the physician in the emergency department at the hospital, Community Care Access Centre and Power of Attorney for Resident #47 were notified that the resident was being discharged from the home, indicating that the home was unable to provide care as 'resident exhibiting care needs which exceed the resources of the home, specific to resident's responsive behaviours' and further indicated that other residents in the home were at risk of harm.

The Director of Care indicated that resident's residing in the home were fearful of Resident #47.

The Director of Care indicated, during an interview, that the home did not ensure alternatives to discharge were considered, did not collaborate with placement coordinator for accommodation and or care, nor were Resident #46 and #47 or resident's substitute decision maker(s) given an opportunity to participate in the discharge planning process. [s. 148. (2)]

Issued on this 8th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554), CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2014_293554_0034
Log No. / Registre no:	O-000876-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 21, 2014
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF KAWARTHA LAKES 26 Francis Streeet, LINDSAY, ON, K9V-5R8
LTC Home / Foyer de SLD :	VICTORIA MANOR HOME FOR THE AGED 220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gerry Bencze

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To THE CORPORATION OF THE CITY OF KAWARTHA LAKES, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, s. 6 (7), by ensuring that:
- a process is in place to monitor that care set out in the plan of care is provided to each resident as specified in the plan, specific to falls prevention strategies, toileting, positioning during meal time in an effort to reduce risk of choking or aspiration, positioning and or repositioning when a resident is in bed.

The plan shall be submitted in writing and emailed to LTC Homes Inspector, Kelly Burns at kelly.burns@ontario.ca on or before December 05, 2014. The plan shall identify
who will be responsible for each of the corrective action listed.

Grounds / Motifs :

1. Related to Resident(s) #40, 43 and #60:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care was provided to Resident's #40, 43 and 60 as specified in the plan.

Related to Log # O-000933-14, for Resident #60:

Critical Incident Report(CI) for incident resulting in a fall.

Details of the incident were as follows:
- Resident #60 was having care completed by a staff member; while staff was assisting with care, resident fell to the floor. As a result of the fall, resident sustained injuries.

A review of plan of care for Resident #60, indicated that two staff were to be utilized during care (e.g. bed mobility).

A review of clinical health records, details that Staff #137 had been completing care for Resident #60's without the assistance of a second staff, when the incident occurred.

Since sustaining the fall, Resident #60 has had a decline in functional abilities and an increase in discomfort. [s. 6. (7)] (553)

2. Related to Log #O-000883-14, for Resident #40:

Critical Incident Report (CI), was submitted for a falls incident that occurred.

Details of the Critical Incident Report are as follows:
- Resident #40 was being toileted by staff; staff left the resident and went to get a co-worker to assist in getting Resident #40 off the toilet. During staff's absence, Resident #40 stood up, tripped over the pants which were around the resident's legs and fell to the floor.

Resident was transferred to hospital as a result of the fall, was admitted to hospital due to injuries sustained.

Resident #40's care plan (for the above time period) detailed the following:
- Toileting - resident requires assistance of staff; 2 staff are to assist resident, staff are to remain with resident throughout the process.

The Critical Incident Report for this incident detailed that the staff member who left Resident #40 unattended on the toilet did recognize that the fall could have been prevented if the plan of care had been followed. [s. 6. (7)] (553)

3. Related to Resident #43:

Review of Resident #43's plan of care (current as per inspection date) related to Nutritional Risk indicated resident was considered as being a high nutrition risk. An identified goal for this resident is to prevent episodes of choking and or aspiration.

Interventions listed in the plan of care for Resident #43 were specific to resident's positioning during meal times, assistance required and methods in which resident was to receive meals or nourishment.

Observations, of Resident #43, made during four specific dates failed to support that the planned care for this resident, relating to correct positioning at mealtime and or assistive aides used during mealtime or nourishment were being followed.

Staff #101 indicated that Resident #43 is able to eat independently while using an assistive device; staff commented that resident is never positioned according to the planned care as resident continuously slides down while resident is seated in the chair.

During an interview, the Registered Dietitian indicated being asked by registered nursing staff to see resident due to concerns with positioning; this assessment was completed as requested; it was identified that staff were unable to maintain a 90 degree angle positioning at meals; the most recent strategy was to have resident positioned at 45 degree angle and up as possible during mealtimes. Resident is not to be served meals with straws; a sippy cup is to be. [s. 6. (7)] (553)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2015

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 21st day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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