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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 5, 2014	2014_188168_0028	H-001629-14	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

LISA VINK (168), CAROL POLCZ (156), CYNTHIA DITOMASSO (528)

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): November 25, 26, 27, 28, and December 2, 3, 4, 2014.

This inspection report contains findings identified during Critical Incident Inspections H-000967-14 and H-0001147-14 and Complaint Inspection H-000755-14, which were conducted concurrently with the RQI Inspection.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director of Nursing Care (DONC), Neighbourhood Coordinator, Director of Recreation, Director of Environmental Services, Director of Nutritional Services, Physiotherapist, Kinesiologist, registered nursing staff, personal support workers (PSW's), housekeeping staff, dietary staff, families and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

14 WN(s)
11 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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).

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

On November 25 and 27, 2014, resident #19 was observed sitting in a wheelchair with a front fastening seat belt, which they could apply and remove independently. Review of the plan of care and profile did not include the use of the seat belt. Interview with PSW staff confirmed that the resident self applied the belt when in the wheelchair. Interview with registered staff confirmed that the plan of care did not set out the planned care related to self application of the belt. [s. 6. (1) (a)]

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

A. The plan of care for resident #17 indicated that they required the use of one full and

one half bed rail. On November 28, 2014, and December 3, 2014, two half rails were observed in the raised position. Registered staff confirmed that the plan of care for the resident was not accurate and did not set out clear directions to staff providing care related to the rails. (156)

B. The plan of care for resident #19, did not provide clear direction to staff and others who provided direct care to the resident, related to bed rail use.
i. On November 27, 2014, one three quarter rail and one assist rail were observed in the raised position.
ii. The plan of care related to falls prevention and management indicated that they were a high risk for falls and interventions directed staff to put both rails up when in bed (a three quarter rail and an assist rail) for safety. The plan for activities of daily living assistance related to bed mobility indicated that the resident required one bed rail when in bed for repositioning.
iii. The personal care profile for the resident did not include the use of any bed rails.
iv. Interview with registered staff confirmed that the resident required two bed rails in the raised position when in bed for safety and the plan of care, including the plan of care did not provide clear direction related to their use. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for resident #40 indicated that they were incontinent of both bladder and bowel and required extensive assistance with toileting of two staff at all times.
i. The Personal Care Observation and Monitoring Form directed staff to toilet ambulatory residents every two hours and as needed.
ii. On November 28, 2014, at approximately 1200 hours, the resident was toileted prior to lunch. Following lunch they were assisted to the common area. The resident was observed until 1445 hours, at which time, staff began the evening shift. The resident was not observed to be toileted after lunch.
iii. Interview with day shift PSW staff, at approximately 1430 hours, confirmed that the resident was not toileted anytime after lunch, as required every two hours, as outlined in the plan of care. [s. 6. (7)]

4. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A. In September 2014, resident #42 was assessed to be occasionally incontinent of both

bladder and bowel and required extensive assistance with toileting of one staff. Review of the plan of care directed staff to toilet the resident in the morning, after meals, and before bed. Interview with PSW staff revealed that the resident frequently requested to use the toilet, and as a result, an hourly toileting plan was being trialed. Interview with registered staff confirmed that the plan of care was not updated to include the new hourly toileting plan. (528)

B. The plan of care for resident #25 indicated that staff were to ensure that they were wearing glasses or hearing aids to eliminate sensory problems contributing to behaviours. The resident was not wearing glasses or hearing aids when observed. PSW staff and registered staff confirmed that the resident no longer wore glasses or hearing aids. The plan of care was not revised with a change in care needs. (156)

C. The plan of care for resident #25 indicated that staff were to encourage the resident to listen to music to redirect behaviours and for calming. The resident was not observed using a device to listen to music and registered staff confirmed that they no longer used it. The plan of care was not revised with changes in care needs. (156)

D. Resident #30 had a change in care needs following the identification of an injury in 2014. The plan of care in place following the injury and until the fall of 2014, was reviewed and was not revised to include the injury, a change in the resident's care needs, which was confirmed during an interview with the registered staff. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provided direct care to the resident, and that the care set out in the plan of care is provided to the resident as specified in the plan, and that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change, 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 ensure that any plan, policy, protocol, procedure, strategy or system put in place, was in compliance with and was implemented in accordance with applicable requirements under the Act.

Requirements under Ontario Regulation 79/10, section 50(2)(b)(iii) indicated that the licensee must ensure a resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

The home's policy Wound/Skin Care, 04-78, last revised October 2014, directed registered staff to "request a nutritional consultation for skin tears, stage two pressure ulcers and above" only. The policy did not direct staff to request a nutritional consultation for all areas of altered skin integrity, as required in the regulation. [s. 8. (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 that any plan, policy, protocol, procedure, strategy or system put in place, is in compliance with and implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #16's room was monitored for cleanliness on November 27, 28, 2014, and December 2, 2014. The bedroom floor was noted to be unclean with debris under and around the bed and there was dust on the shelving. Interview with housekeeping staff on December 2, 2014, confirmed that the bedroom floor and shelf were not clean. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment were maintained in a good state of repair.

A. On November 25, 2014, the wooden handrails throughout the nursing care areas on the South Tower were noted to be worn and chipped, exposing rough raw wood. Interview with the Director of Environmental Services confirmed that the home was aware of the condition of the rails, had previously addressed this issue, and a plan to fix the wearing and chipping. (528)

B. On November 25, 2014, a wooden bench located in the Brant spa room, was noted to be worn on the seat and arm rests, with extensive chipping leaving raw and rough wood exposed. Interview with PSW staff confirmed that the bench was used by the residents and that it was not in a good state of repair. (528)

C. On November 25 and 27, 2014, it was identified that the communication and response system at the toilets in the Appleby and Bronte tub rooms were not in a good state of repair. The switch plate on the communication and response system in Appleby did not include a pull cord and for this reason could not be activated. The switch plate on the communication and response system in Bronte had a pull cord which was approximately one and a half centimeters in length and when pulled did not activate a light or signal. Interview with PSW staff confirmed that neither bell was operational. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A. Resident #16 was observed to have one bed rail in the raised position, which was confirmed during resident and PSW interview. A review of the clinical record did not include an assessment of the resident for the use of the rail, which was confirmed during an interview with staff. (168)

B. Resident #17 was noted to have bed rails in the raised position. Registered staff confirmed on December 3, 2014, that there was no formalized assessment of the bed rails to minimize risk to the resident. (156)

C. Resident #19 required one three quarter bed rail in the raised position to help with bed mobility. Review of the clinical record did not include a formalized assessment for the use of bed rails. Interview with registered staff confirmed that the resident required assistance from bed rails for bed mobility, and that a formalized bed rail assessment was not completed. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A. During a bed rail audit dated September 2014, resident #17's bed failed entrapment for zones six and seven. The resident was observed with two half rails in the raised position on November 28, 2014, and December 3, 2014. Interview with the Director of Programs confirmed that the failed entrapment zones for the bed had not yet been corrected. (156)

B. During a bed rail audit dated September 2014, resident #19's bed failed entrapment for zones two and seven. Review of the plan of care indicated that the resident was a high risk for falls and required the use of bed rails raised to assist with safety and positioning. Interview with the Director of Programs confirmed that the failed entrapment zones for the bed had not yet been corrected. [s. 15. (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 where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, and to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident staff communication and response system was available in every area accessible by residents.

On November 25, 2014, the following resident areas did not include a resident staff communication and response system.
i. The second exercise room located on Main Street.
ii. The outdoor courtyard, accessible from Nelson.
Interview with the Director of Environmental Services confirmed that the identified areas did not have a resident staff communication and response system. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

Resident #23 was noted to have a history of responsive behaviours toward residents. On a specified date in 2014, the resident pinched resident #22, four days later the resident hit resident #22 on the head, and the following month the resident had contact with resident #22 resulting in injury. The DONC confirmed that resident #22 was abused by resident #23. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions were documented.

A. According to the clinical record resident #30 was observed to have unusual symptoms to a lower extremity on a specified date in 2014, which were assessed, the physician was notified and treatment was initiated. Thirteen days later the resident was noted to have additional symptoms to the same area, which were again assessed and the physician notified. Then two days later it was identified that the resident sustained an injury to the area, the cause of which was not determined. Staff interviewed confirmed that the resident's lower extremity was assessed, on an ongoing basis, during the identified period of time, although a review of the progress notes confirmed that not all assessments were documented. (168)

B. The plan of care, recent MDS assessments, and a progress note indicated that in spring of 2014, resident #15 had stage I skin breakdown. The Medication Administration Record (MAR) for April 2014, included staff signatures which indicated the application of zinc barrier cream to the area on April 9, and 11, 2014. The MAR for June 2014, included the application of zinc barrier cream on June 30, 2014, to the identified area. A review of the clinical record did not include any reassessment of the area of altered skin integrity by the registered nursing staff including, following the application of the barrier cream, as confirmed during staff interview. (168) [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the interdisciplinary falls prevention and management program was fully implemented.

A review of the Falls Prevention and Management Program, 04-33, dated February 2013, identified that, when a fall was discovered "if the Resident hits their head or there were no witnesses to the fall, the Head Injury Routine is followed", that "the Resident will be assessed each shift for 24 hours after the fall by the Registered Team Member who is on the Neighbourhood. A progress note will be completed x 3 shifts" and that "a Post-Falls Analysis will be completed by Registered Team Member 24 hours after the fall occurred".

A. According to the clinical record, resident #12 sustained unwitnessed falls on three identified evening shifts in 2014.
i. A review of the clinical record did not include Head Injury Routine (HIR) records following the identified falls. Registered staff interviewed identified that she was working on the identified shifts, when the resident sustained the falls, and that a HIR was not initiated following the incidents. Staff identified that the resident was cognitively well and denied striking their head during the incidents. It was based on the resident's account of the incidents and their cognitive status that the HIR was not implemented as per the policy.
ii. A review of the clinical record identified that post fall progress notes were not consistently recorded for a 24 hour period following the identified falls. The first fall included only one post fall progress note. The second fall did not include any post fall progress notes. The third fall included only one post fall progress note. Interview with registered staff confirmed the expectation to complete post fall progress notes for three shifts following each incident and verified during a review of the record that these notes were not completed.

B. Resident #15 sustained a fall in 2014, while out of the home. On return to the home the fall was reported and an assessment was completed.
i. A review of the clinical record did not include a progress note every shift for the first 24 hours following the fall. There was no progress note completed for the day shift following the incident, as confirmed during staff interview.
ii. A review of the clinical record did not include a Post Falls Follow Up Report, also known as an analysis, completed as required, in the home's program, as confirmed with registered staff. (168) [s. 48. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that an interdisciplinary falls prevention and management program is developed and fully implemented, with the aim to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. In 2014, resident #19 was noted to have new areas of altered skin integrity, which had since healed. Review of the clinical record included a progress note identifying two areas and treatment administered. This record did not specify the appearance or size of the areas. Interview with registered staff confirmed that a skin assessment was not completed by registered staff using a clinically appropriate assessment tool. (528)

B. In 2014, resident #15 was noted to have a stage I pressure ulcer in the progress notes. The presence of the ulcers was included in the MDS assessments. A review of the clinical record did not include an assessment of the areas by the registered staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, as confirmed during staff interview. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #10: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the daily and weekly menus were communicated to residents.

i. On November 25, 2014, the posted weekly menu on Brant was for week #1, however, the home was on week #2.
ii. On December 4, 2014, the posted weekly menu on Appleby was for week #2, however, the home was on week #3. [s. 73. (1) 1.]

2. The licensee failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

The following observations were made during the noon meal. The plans of care for residents #31 and #32 identified that they both required extensive assistance of staff with eating.
A. On December 2, 2014, the identified residents were observed to have soup served to them before 1217 hours. Neither resident made any attempts to eat or feed self.
i. At 1226 hours, a PSW began to feed resident #31 soup and fed the entire portion. At 1231 hours, the resident was served their main entree. Assistance was not provided to the resident by staff until 1237 hours.
ii. At 1227 hours, a PSW began to feed resident #32 soup and fed the resident the entire portion.

B. On December 3, 2014, resident #31 was provided with soup at 1213 hours, assistance was not provided until 1222 hours. Resident #32 was provided soup before 1205 hours and assistance was not provided until 1217 hours.

Staff interviewed confirmed that the residents required assistance of staff with eating. [s. 73. (2) (b)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's Infection Control Policy Sanitization/Risk Management: Personal Care Ware, 06-02, last revised March 2014, outlined that "all personal ware be labelled with Resident name or room number, including but not limited to, basin, cup, denture cup, personal care products".

On November 25, 2014, the following personal care products were noted to be unlabelled:
i. The Appleby tub room contained two used hair brushes as well as a used stick deodorant sitting out on the cabinet. (168)
ii. The spa room on Nelson contained two hair brushes, one electric razor, three roll on deodorants, and one tub of Eucerin Cream, all of which appeared to be used.
iii. The spa room on Oaklands contained four hair brushes, three combs, and two bars of soap, all of which appeared to be used.
Interview with PSW staff confirmed personal care items should have been labelled. [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 that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with the Residents' Council President identified that resident's concerns brought forward during meetings were not responded to in writing.
Review of the Meeting Minutes revealed that concerns discussed during the January 2014, meeting related to odours and cleaning of bathroom floors, were responded to at the following meeting in March 2014, and concerns at the July 2014, meeting related to privacy and toileting during dining service, were responded to at the following meeting in September 2014.
Interview with the Council Assistant confirmed that the home was aware of the requirement to respond, but that they did not respond in writing within ten days of becoming aware of the concerns and recommendations. [s. 57. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that they sought out the advice of the Residents' Council in the development and the carrying out the satisfaction survey, and in acting on its results.

Review of the Residents' Council meeting minutes from 2014 did not include information that the Council was involved in the development or carrying out of the satisfaction survey, which was confirmed during an interview with the Residents' Council President. The Council Assistant confirmed that the survey was developed on a corporate level and the residents were not included in process for 2013 or 2014. The Assistant General Manager confirmed that resident representatives participated in the development of 2015 the satisfaction survey. [s. 85. (3)]

WN #14: 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 failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On December 3, 2014, the medication storage room on Appleby contained a locked box for controlled substances ready for destruction. The locked box was located in a stationary cupboard that was unlocked. Interview with registered staff confirmed that the controlled substances in the destruction box were not double-locked within the locked medication room. [s. 129. (1) (b)]

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.