Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 1, 2014	2014_283544_0019	S-000257-14	Resident Quality Inspection

Licensee/Titulaire de permis

The West Nipissing General Hospital
725 Coursol, STURGEON FALLS, ON, P2B-2Y6

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

THE WEST NIPISSING GENERAL HOSPITAL
725 COURSOL, STURGEON FALLS, ON, P2B-2Y6

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

FRANCA MCMILLAN (544), KELLY-JEAN SCHIENBEIN (158)

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): July 2, 3, 4, 7, 8, 9, 10, 11, 2014 related to

Log # S- 000257-14

During the course of the inspection, the inspector(s) spoke with Chief Nursing Officer (CNO), Clinical Co-ordinator, Unit Co-ordinator, Registered Staff, Personal Support Workers (PSWs), Environmental Manager, Environmental Aides, Food Service Manager, Dietary Aides, Residents and Families.

During the course of the inspection, the inspector(s) observed daily the delivery of care and services to the residents, staff to resident interactions, residents with responsive behaviours, reviewed resident health care records, progress notes, physician orders, treatment records (TARS), medication records, policies and procedures regarding Medication Administration, Responsive Behaviours Program, Skin and Wound Program, Continence Care and Bowel Management Program, and Environmental Cleaning Schedules.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. Inspector # 158 identified Staff # 111 documented Resident # 7971 was sitting on their bed, all dressed. Resident stated to Staff # 111 that they did not sleep well. It was documented in the progress notes that Resident # 7971 appeared to be depressed.

Staff # 112 documented that Resident # 5945 seemed very lonely and remained alone many times. When Resident # 5945 was in hospital, the Resident was always chatting with their roommates and went for walks in hallway. Now their curtains were always closed, does not interact with anyone and always was laying in their bed.

Resident # 7971's and Resident # 5945's care plans did not identify their change in behaviours nor do the care plans identify clear direction to manage their behaviours.

The licensee did not ensure that clear direction to staff and others who provide directed care to Resident # 7971 and Resident # 5945, was set out in their plan of care. [s. 6. (1) (c)]

2. Staff # 104 documented in the progress notes that Resident # 5945 was placed on contact isolation.
Inspector # 158 observed that contact precautions for isolation were in place.
Inspector # 158 reviewed Resident # 5945's plan of care, which included their progress notes and care plan.
The Resident's current illness and their need to be isolated were not documented in their care plan.

The licensee did not ensure that clear direction to staff and others who provide direct care to resident # 5945 regarding isolation was set out in his plan of care. [s. 6. (1) (c)]

3. Inspector # 544 reviewed Resident # 5900's's care plan and identified that there was no focus, goals or interventions in the care plan regarding Resident # 5900's bladder care, bowel management or toileting schedule to ensure bowel movements were regular and the Resident is clean and dry.

Resident # 5900's care plan was revised and identified that under the focus for toileting the only interventions identified were that Resident # 5900 was to be transferred by a 2 person assist with constant supervision. Resident # 5900 suffers from a cognitive impairment.
This is confirmed by Staff # 104 who recently updated Resident # 5900's care plan.

There is no other clear direction or specific toileting program for Resident # 5900's incontinence and toileting practices.

The licensee did not ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Resident # 5904’s current weight documented in Point Click Care was 54.7 kg, a loss of 6.8 kg in seven months.
Inspector # 158 reviewed Resident # 5904's health care record, including the physician's orders, progress notes and care plan.
The physician ordered a supplement to address Resident # 5904's weight loss. This supplement was discontinued when the Resident continually refused to drink it.
A review of Resident # 5904's care plan identified that the supplement was still documented as an intervention.

The licensee did not ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

5. Inspector # 158 observed that Resident # 7971 was wearing their pajamas one day. The Resident stated to the Inspector that, "there are some days when I prefer to stay

in my pajamas". A RAI/MDS assessment was completed and identified that the Resident was independent with Activities of Daily Living (ADL). Inspector # 158 reviewed Resident # 7971's care plan. The care plan failed to identify any Activities of Daily Living (eating, toileting, transferring, dressing), the lack of assistance, any assistance from staff, or Resident's # 7971 preferences, specifically related to dressing.

The licensee failed to ensure that resident # 7971's care plan was based on an assessment of the Resident's needs and preferences. [s. 6. (2)]

6. Inspector # 544 reviewed Resident # 5898's health care records, care plan, progress notes and medication profile and identified that Resident # 5898 had been receiving several medications regularly, on a daily basis, to assist with controlling their pain.

The Plan of Care for Resident # 5898 does not identify any focus, goals or interventions for the pain that Resident # 5898 was experiencing and as documented in the progress notes.
Resident # 5898 is on several pain medications on a daily basis and as required (prn) and there is no evaluation of the effectiveness of the analgesics given.

Resident # 5898 had a pain assessment completed and Resident # 5898 has not had any further re-assessments for their pain. There are no comprehensive interventions for Resident # 5898's pain to guide the provisions of care, services and treatments in the care plan.

Inspector # 544 then reviewed the Skin and Wound Management Policy No. 605H-15 Date Revised May 2011 and it states, "Residents with altered skin integrity will have a skin assessment weekly. The Plan of Care for Resident with Altered Skin Integrity shall outline the skin care measures to be provided to the Resident. Those measures shall include but not limited to:
- Minimizing pain and discomfort".

The licensee did not ensure that the care set out in the plan of care for Resident # 5898 was based on an assessment of the Resident's needs and preferences. [s. 6. (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 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, 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. Inspector # 544 reviewed Resident # 5907's health care record and identified that Resident # 5907 had a fall and was sent to hospital for an X-ray. The X-ray did not show a fracture but a fracture could not be ruled out.
It was confirmed by Staff # 100, Staff # 101, and Staff #104 that Resident # 5907 was then sent to hospital for a further X-rays, where it was confirmed, that Resident # 5907 had a fracture.

Inspector # 544 reviewed the home's Fall Prevention and Management Program- Policies Procedures and Training Program.
It identified that the Registered Staff is to complete a Morse Fall Scale in Point Click Care, complete a Falls Risk assessment within 24 hours of admission and when any significant change of health status or any fall occurs.
It also identified Post Fall Management Investigation- The interdisciplinary team will,
- initiate Head Injury Routine and assess the Resident's level of consciousness and any potential injury associated with the fall

- initiate a plan of care to address patient identified as high risk with the implementation of high risk strategies such as yellow armband, signage and a special bed.
- make referrals to the interdisciplinary team members and/or as per physician orders
- ensure procedures for all high-risk residents are in use
- evaluates the plan of care as need arises and on a quarterly basis.
- monitor the resident for 48 hours after a fall if they are on anticoagulants such as Heparin, Coumadin or Aspirin.

Inspector # 544 reviewed Resident # 5907's health care records, progress notes, assessments and doctor's orders.

Resident # 5907, was receiving one of the medications listed in the policy.

Inspector # 544 reviewed the vital signs record in Point Click Care, post falls assessment and progress notes and could not find any documentation or clinical assessments conducted immediately post fall and for 48 hours post fall or that head injury routine was initiated post fall.

Inspector also noted that Resident # 5907 had several falls and there was no documentation on the health care record, progress notes or other assessments, of head Injury routine or vital signs taken or that Resident # 5907 was on an observation program for 48 hours post falls.

Where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, in regards to the home's Fall Prevention and Management Program, any plan, policy, protocol, procedure, strategy or system, required by the licensee to be instituted or otherwise put in place, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. Resident # 5945, who was in isolation, spoke to the Inspector. The Inspector noted that Resident # 5945 had a foul mouth odour and thick saliva hung from their lips. The Resident's partial plate was not in place.
Resident # 5945's plan of care, which included assessments, progress notes and care plan was reviewed by Inspector # 158.
Staff # 104 completed the RAI/MDS assessment which identified that Resident # 5945 required help from staff for their oral hygiene due to cognitive decline and having only some of their own teeth.
Staff # 112 documented in the progress notes that when they tried to pull out the partial in Resident # 5945 's mouth, the Resident resisted and did not want the partial

plate removed because it was too painful. The partial plate was left in their mouth.
The Inspector spoke with Staff # 102 who stated that the Resident's partial was not used now and that the Dentist identified that the Resident's bottom teeth were broken and advised staff not to insert the partial plate.
The progress notes were reviewed but there was no documentation in regards to the Resident's dental appointment.
Resident # 5945 care plan did have a section under Personal Hygiene to identify the level of assistance for mouth care, however, the provision of 1 staff physical assistance was not specific to mouth care nor was there direction related to the care of Resident # 5945's broken teeth or partial plate.

Resident # 5945's care plan was not based on an interdisciplinary assessment.

The licensee did not ensure that Resident # 5945's plan of care was based on an interdisciplinary assessment of the Resident's dental and oral status, including oral hygiene. [s. 26. (3) 12.]

2. Resident # 5927 was admitted to the home and Staff # 114 completed a nutritional assessment identifying that Resident # 5927 was a moderate nutritional risk.
Resident # 5927’s health care record, including her progress notes, physician’s order and the plan of care was reviewed by Inspector # 158.
The Resident was admitted to the hospital as a result of a fracture. An assessment related to nutrition was not completed by Staff # 114 when the resident returned from the hospital.
A written physician’s order for the resident’s diet was not found.
The care plan did not identify the Resident’s diet or texture.
Staff # 115, who replaced Staff # 114, did not assess Resident # 5927, when the Resident returned to the long-term care home after hospitalization and a significant change in their condition was noted related to their fracture.

The licensee did not ensure that the Registered Dietitian, who is a member of the staff of the home, completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition. [s. 26. (4)]

3. Staff # 114 assessed Resident # 5907 and identified the Resident as a high nutritional risk. There were no further nutritional assessments completed by the dietitian.
Resident # 5907’s health care record, including the progress notes, physician’s order

and the plan of care were reviewed by Inspector # 158.

Resident # 5907 had a fall and sustained a fracture. The Resident was transferred to hospital for treatment and returned to the home. A significant change assessment was completed by Staff # 102.
An nutritional assessment was not completed when the Resident returned to the home after hospitalization or when the Resident # 5902's had a significant change in condition related to the fracture.
A written physician's order for the Resident's diet was not found.
The care plan did not identify the Resident's diet or texture.

Staff # 115, who left their position in the home, did not assess Resident # 5907, when the Resident returned to the home after their hospitalization and a significant change in their condition related to their fracture.

The licensee did not ensure that the Registered Dietitian, who is a member of the staff of the home, completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition. [s. 26. (4) (a),s. 26. (4) (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 a plan of care is based on, at a minimum, interdisciplinary assessment of dental and oral status, including oral hygiene and that a dietitian who is a member of the staff of the home and completes nutritional assessments for Residents on admission an whenever there is a significant change in a Resident's health condition, to be implemented voluntarily.

WN #4: 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. It was identified in Resident # 5927's wound assessment, that Resident # 5927 had a Stage 3 wound.
An assessment related to nutrition was not completed by a dietitian.
Staff # 116 assessed Resident # 5927 and suggested a high protein diet be ordered for the Resident to promote wound healing. As well, they identified that the Resident's risk, increased to moderate and this would be monitored q 6 weeks. There was no documentation identifying that the Resident was re-assessed. There was no referral made to the dietitian.
Staff # 115 (dietitian) did not assess Resident # 5927, when it was identified that the Resident had a Stage 3 wound.

The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home. [s. 50. (2) (b) (iii)]

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 resident's exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds. is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #5: 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. Inspector # 544 entered the medication room of the home and identified that there were empty original medication pouches in the regular garbage in the medication room.
The medications that were in these pouches, had been pre-poured by registered staff. The medication pouches were not defaced in anyway as to ensure that the Residents' personal information remained private.
The original medication pouches were labelled with the Resident`s name, the date and time the drugs were to be administered, the names of the drugs (generic and brand names), dosages of the drugs, the drugs identification number (DIN), the colour of the medication and the doctor`s name ordering the medication.

Inspector # 544 was able to obtain the discarded medication pouches, for several different residents, from the regular garbage bin in the medication room.

Also in the regular garbage in the medication room, Inspector # 544 identified and observed that there was an empty medication card for Resident # 5927. The identifiers on the medication card gave the resident's name, the name and dosage of the controlled drug, the name of the doctor ordering the drug and the name of the home where the Resident was residing.

The licensee failed to ensure that the rights of residents are fully respected and promoted: 11. Every resident has the right to, iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. [s. 3. (1) 11. iv.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector # 544, during a dining observation, identified that 26/30 dining room chrome chairs were dirty with bread crumbs and debris in the corners of the arms and had rust build up on the chrome legs and chair arm corners. The chrome parts of the dining room chairs were also spotted with liquids.
Inspector # 544 also noted this debris when the dining room was cleaned after the breakfast and lunch meals.
Staff # 106 conducted a tour of the dining room with Inspector # 544 and saw the unclean chairs and confirmed that the chrome on the chair arms and legs were quite rusty and that 26/30 chairs were dirty with debris and bread crumbs after the breakfast meal. The dining room had already been cleaned and Staff # 106 was exiting the dining room after washing the floor. The door was then locked until the lunch meal was to be served at noon.

Inspector # 544 interviewed Staff # 105 and identified that the chrome chairs in the dining room are to be cleaned fully every 2 weeks. The chairs are to be "washed down" at the end of every meal. Staff # 105 will ensure to remind staff to do this in their duty routines, this task was on the duty checklist. Staff # 105 will also ensure to provide a cleaner and scrub pads to assist with the present build up of rust and debris and the prevention of rust on the chrome chairs as outlined on the task duty checklist.

The licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. Inspector # 158 observed, on several consecutive days, that a lap tray was used when Resident # 5898 was sitting in the wheelchair (w/c) and 4 bed rails were in the

"up" position when the Resident # 5898 was in their bed.
Staff # 102 told the Inspector that Resident # 5898 would not be able to push the lap tray restraint off.

The home's policy titled "Restraints" was reviewed by Inspector # 158. The policy identified that a doctor's order will be obtained and would identify the type of restraint, the reason for the application, instructions on how to use the restraint and the duration of its use. The policy also identified that a Registered staff would reassess the effectiveness of the restraint and the need for the restraint every eight hours.

Resident # 5898's progress notes and the "Restraint Administration Records" were reviewed for a one week period. It was identified on the Restraint Administration Record that the "lap tray" was applied daily and signed by the PSWs on the day shift and afternoon shift. The progress notes showed that the Registered staff did not document the use of the lap tray restraint 6 out of 9 day shifts and did not document the use of the lap tray restraint 6 out of 9 evening shifts, when the lap tray restraint was applied.

Inspector # 158 reviewed Resident # 5898's health care records including doctors orders, progress notes, restraint administration record and care plan.
A doctor's order for "4 side rails up " was found. An order for the lap tray restraint, when the Resident was sitting in the wheelchair, and an order for the use of a quick release (lap tray restraint) were not found. An order for the 4 bed rails was not found.

The Restraint Administration Records identified that the PSWs documented the restraints hourly. Staff # 113 stated to the Inspector that the Registered staff documents on the restraint use each shift in the resident's progress notes.

2. On several consecutive days, Inspector # 158 observed that Resident # 5904 was sitting in a wheelchair and 4 bed rails were in the "up" position when the Resident was in bed.
Staff # 118 documented that the Resident still needed their lap belt tied on while in the chair and 4 side rails in the "up" position.

The home's policy titled "Restraints" was reviewed by Inspector # 158 on July 8, 2014. The policy identified that a doctor's order will be obtained and would identify the type of restraint, the reason for the application, instructions on how to use the restraint and the duration of its use. The policy also identified that Registered staff would reassess

the effectiveness of the restraint and the need for the restraint, every eight hours.
The physician ordered a quick release restraint in bed or in the chair. A current order for the use of a quick release (lap belt restraint) was not found. A physician's order for the 4 bed rails was not found.
Staff # 118 documented that Resident # 5904 still required the lap belt tied on the chair and 4 bed rails in the "up" position.

The Restraint Administration Record completed by the PSWs identified that a lap belt was applied for several hours on a certain day, and on the same day, 4 bed rails were used for several hours, when the Resident was in bed. There was no documentation identifying that the Registered staff re-assessed the Resident's need for the restraint.

The Restraint Administration Record completed by the PSWs identified that a lap belt was applied for several hours for Resident # 5904 on a specific day. There was no documentation identifying that the Registered staff re-assessed the resident's need for the restraint.

The Restraint Administration Record completed by the PSWs , for the next day for Resident # 5904, identified that a lap belt was applied for several hours. There was no documentation identifying that the Registered staff re-assessed the resident's need for the restraint.

The licensee did not ensure that its' Restraint Policy is complied with.

3. Inspector # 158 observed that a lap belt was used when Resident # 5945 was sitting in their wheelchair (w/c) and that 4 bed rails were in the "up" position when the Resident was in bed.
Staff # 102 confirmed that the Resident would not be able to undo the restraints.

The home's policy titled "Restraints" was reviewed by Inspector # 158. The policy identified that a doctor's order will be obtained and would identify the type of restraint, the reason for the application, instructions on how to use the restraint and the duration of its use. The policy also identified that Registered staff would reassess the effectiveness of the restraint and the need for the restraint, every eight hours.

Resident # 5945's progress notes and Restraint Administration Record were reviewed.

Resident # 5945's Restraint Administration Record, which is completed by the PSWs,

identified that a lap belt was applied for several hours when Resident # 5945 was sitting in the wheelchair. There was no documentation identifying that the Registered staff re-assessed the Resident's need for the restraint every eight hours.

On another day, the Restraint Administration Record completed by the PSWs identified that a lap belt was applied from several hours on Resident # 5945. There was no documentation identifying that the Registered staff re-assessed the resident's need for the restraint.

The Inspector reviewed Resident # 5945's health care record. Staff # 117 completed a "physical restraint assessment" for Resident # 5945 and identified that they required the use of a quick release restraint when in a chair and the use of bed rails. The assessment indicated that the restraint use would be re-assessed in a month. No further re-assessments were found. Current doctor's order for the use of a quick release (lap belt restraint), when the resident is sitting in their wheelchair or the 4 bed rail use, when the Resident is in bed, was not found.

The licensee did not ensure that its restraint policy was complied with. [s. 29. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. For several consecutive days, Inspector # 158 observed that Resident # 5945 was unshaven. It was identified in the RAI/MDS assessment that the Resident, who has cognitive impairment, required assistance of one staff for the provision of personal hygiene.
It was documented in Resident # 5945's care plan that one staff was to assist with the Resident's personal hygiene, such as combing hair and shaving the Resident. Resident # 5945 did not receive individualized personal care with grooming, specifically shaving on a daily basis.

The licensee did not ensure that Resident # 5945 received individualized personal care, including hygiene care and grooming, on a daily basis. [s. 32.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Resident # 5907 had a fall and was sent to the hospital for X-rays. The X-rays did not show a fracture but it could not be ruled out and further X-rays were ordered by the Doctor for a more conclusive diagnosis.

Resident # 5907 had complained of pain for several days post fall.
The most recent X-ray that was taken, confirmed that Resident # 5907 sustained a fracture.

Inspector # 544 reviewed Resident # 5907's health care record, progress notes and assessments conducted after the fall and could not find a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls.

Staff # 100 and Staff # 101 confirmed that a post falls assessment was not completed using a clinically appropriate assessment instrument that is specifically designed for falls.

Staff # 103 and Staff # 104 confirmed that they were not aware of a post-falls assessment instrument being used in the home. They further confirmed that Registered Staff take the Resident's vital signs, quickly look for any injuries, notify the doctor and the then follow the doctor's orders if any are given.

The licensee failed to ensure that when a Resident has fallen, the Resident is assessed and that when the condition or circumstances of the Resident require, a post-falls assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

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

Specifically failed to comply with the following:

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

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Inspector # 544 reviewed Resident # 5927's health care record, progress notes and other assessments which were completed for the Resident.
Inspector # 544 could not find any documentation that a Continence Care and Bowel Management assessment was completed for Resident # 5927 within 14 days of admission to the long-term care home. The Resident was incontinent and to date, there was still no documentation of an assessment having being completed with Resident # 5927 in regards to Continence Care and Bowel Management, in the health care record.

Inspector # 544 reviewed the Resident's care plan and identified that there was no focus, goals or interventions in the care plan regarding Resident # 5927's bowel care, bowel management or toileting schedule to ensure bowel movements are regular.

There is was no focus, goals or interventions in the care plan for daily peri-care hygiene for Resident # 5927. This was confirmed by Staff # 103 and Staff #104.

Inspector # 544 reviewed the Continence Care Policy # 605H-16 Revised May 2011 and it states:

"Each resident's bowel and bladder functioning, including routines and the resident's level of continence, shall be:
- assessed within 14 days of admission, as part of the interdisciplinary assessment
- re-assessed at least quarterly
- re-assessed when there is any changes in the Resident's Health status that affects continence. and re-assessment shall be documented in the resident's plan of care
The findings of each assessment and re-assessment shall be documented in the resident's plan of care."

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

2. Inspector # 544 reviewed Resident # 5900's health care record, progress notes and assessments completed for the Resident and identified that Resident # 5900 was incontinent.
The only bowel care and bladder functioning assessment was completed on their admission as part of the admission assessments that are to be completed.
No re-assessments have been completed and no documentation could be found to support any further re-assessments.

The care plan identified that Resident # 5900 had a device at one point. There was no documentation to support the need for this device, no focus, goals or interventions in the plan of care while the device was in situ.

Resident # 5900 did not receive an assessment that identified causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Re-assessments were not conducted as Resident # 5900's care needs changed using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require. This is confirmed by Staff # 103 and Staff # 104.

The licensee failed to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence

and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. Inspector # 544 identified that the home does not have a Responsive Behaviour Program established in the home. The home, reported to Inspector # 544 that, they have hired a Registered Staff member to initiate, organize and write policies and procedures for this program and that his staff member is still in a training and

orientation program. This was confirmed by Staff # 100 and Staff # 101.

There were no written approaches to care developed to meet the needs of the residents with responsive behaviours, no screening protocol, no assessments, no reassessment, and no identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Strategies have not been developed and implemented to respond to the resident demonstrating responsive behaviours.

The home uses the "Community Care Acces Centre's Behavioural Assessment for Placement Services" form to assess their Residents who exhibit responsive behaviours.
Staff # 100 provided Inspector # 544 with forms that staff use to assess residents who exhibit responsive behaviours.
They are:
PIECES of my Personhood.
Intake and Triage Form North East Behavioural Supports Ontario
NE BSO Clinical P.I.E.C.E.S Report
CCAC Behavioural Assessmnet for Placement Services.

Staff # 102 and Staff # 104 confirmed that they have never completed any of the above forms for residents who exhibit responsive behaviours.

Inspector # 544 identified and observed that Resident # 5900 exhibited responsive behaviours. The responsive behaviours were well documented in the progress notes and the health care record.
The responsive behaviours had been occurring since their admission to the home.
Resident # 5900 has a diagnosis of dementia.

Staff # 102, # 100 and Staff # 108 confirmed that Resident # 5900 has not been assessed by Behavioural Support Ontario (BSO), the Senior's Mental Health Outreach Program, North Bay Regional Health Centre or has had any other assessment in regards to their responsive behaviours.

The licensee failed to ensure that the following are developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including

screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required. [s. 53. (1) 1.]

2. Inspector # 544 reviewed Resident # 5900's health care record and care plan and identified that strategies, include techniques and interventions to prevent, minimize or respond to the responsive behaviours are not on the care plan and based on the assessed needs of Resident # 5900.
There are no procedures or strategies identified on the care plan to assist Resident # 5900 and staff who are at risk of harm that minimize the risk of altercations.

Resident # 5900's responsive behaviours have escalated according to the home's documentation. Also Resident # 5900's condition has been deteriorating more rapidly as identified in the progress notes.
This was confirmed by Staff # 102 and Staff # 108.

Staff # 102 and Staff # 104 also confirmed that there is no documentation regarding any assessments conducted with Resident # 5900 due to the fact that Resident # 5900 has never been assessed by BSO, the Senior's Mental Health Outreach program and the local hospital. Resident # 5900 has never had a mini mental assessment, Montreal Cognitive Assessment (MoCA) or PIECES of my Personhood assessment completed.

Inspector # 544 interviewed Staff # 100 who confirmed that the home does not yet have a Responsive Behaviours Program. Staff # 100 stated that a Registered Staff has been hired for the home to lead the Responsive Behaviour Program. This Registered Staff employee is currently in an orientation and training program and as yet has not started to work in the long-term care home.

The licensee failed to ensure that, Resident # 5900, demonstrating responsive behaviours, the behavioural triggers are not identified, strategies are not developed and implemented to respond to these behaviours and actions are not taken to respond to the needs of Resident # 5900, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. [s. 53. (4) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Resident # 5907's current weight documented in Point Click Care was 39.1 kg, a loss of 6.6 kg during a six month period.

The home's policy "Weight Loss/Gain Protocol" identified that if there is a significant change in weight (+/-3 lbs or 1.4 kg), the resident is re-weighed.

There is no documentation of Resident # 5907's re-weights in Resident # 5907's health care record.
Staff # 102 told the Inspector that direction to re-weigh residents came from Staff # 116 as an interim measure because the dietitian left the home.

Resident # 5907's progress notes were reviewed and although, Staff # 116 assessed Resident # 5907 direction to re-weigh Resident # 5907 was not given.

2. Resident # 5904's most current weight documented in Point Click Care was 54.7 kg, a loss 6.8 kg in seven months.

The home's policy "Weight Loss/Gain Protocol" identified that if there is a significant change in weight (+/- 3 lbs or 1.4 kg), the resident is re-weighed.
Documentation of Resident # 5904's re-weights were not found on Resident # 5904's health care record.

Staff # 102 told the Inspector that direction to re-weigh comes from Staff # 116 as an interim measure due to the dietitian leaving the home.

Resident # 5904's progress notes were reviewed and although, Staff # 116 assessed Resident # 5904 several times, direction to re-weigh the resident was not given.

The licensee did not ensure that policies and procedures relating to nutrition care outlined in the nutrition care and hydration program were implemented. [s. 68. (2) (a)]

WN #13: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector # 158 observed that Staff # 119 was providing morning nourishments to the Residents. The Inspector observed that tea, coffee, orange drink, labelled cans of Ensure and labelled glasses of "fortified drinks" were on the nourishment cart. No dietary list was available for the dietary staff to reference which would identify residents' diets, special needs and preferences.

The licensee did not ensure that a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences was implemented. [s. 73. (1) 5.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (1) Every licensee of a long-term care home shall ensure that there is at least one registered dietitian for the home. O. Reg. 79/10, s. 74 (1).

Findings/Faits saillants :

1. Staff # 100 confirmed that in 2012, Staff # 114, was dedicated to the long-term care home. A new dietitian, who was hired, left in June 2014. Although the licensee contracted the services of a Food Service Manager to assess Residents who are identified at a low and medium nutritional risk, there presently is no dietitian for the home.

The licensee did not ensure that there is at least one Registered Dietitian for the home. [s. 74. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Inspector # 544 reviewed a Critical Incident Report.

Resident # 5907 had a fall. The Resident was sent to the hospital and had X-rays taken. The X-rays did not show a fracture but a fracture could not be ruled out therefore, further X-rays were ordered by the Physician for a more definite diagnosis. Resident # 5907 had complained of pain for several days after the fall.
The X-rays completed at the later date, confirmed that Resident # 5907 sustained a fracture.
It was confirmed by Staff # 100, Staff # 101, and #104 that Resident # 5907 was sent to hospital following a fall and had sustained a fracture.

It was confirmed by Staff # 100 and Staff # 101, that the Critical Incident was not reported to the Director immediately.

The licensee did not ensure that the Director was informed no later than one business day after the occurrence that Resident # 5907's fall caused an injury for which the Resident was taken to the hospital and that resulted in a significant change in the Resident's health condition. [s. 107. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. Inspector # 544 observed Staff # 109 and Staff # 110, in the medication room, pre-pouring their medications for a medication pass. The medications were in their original pouches and they were being poured into white medication cups. The medication cups were then labelled with the Resident's name in pen on the outside of the cup. Staff # 109 and Staff # 110 discarded the original medication pouches, that contained the medications and the residents' personal information on the pouches, in the regular garbage.

In pre-pouring the medications ahead of the medication administration time, the medications were not in their original labelled containers.
This was witnessed by Staff # 101.

Inspector # 544 reviewed Pharmasave's Medication Administration Policy revised October 2013. The home follows these policies and confirmed to the Inspector by Staff # 100.

The policy states, "Medication is only administered by the registered staff member who has: 1) poured the medication for immediate administration to a specific resident and 2) documented the administration immediately after it has been given."

The licensee did not ensure that the resident's drugs remained in their original labelled container or package provided by the pharmacy service provider or the Government of Ontario, until administered to the residents or are destroyed. [s. 126.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. Inspector # 544 observed that Resident # 5945 had a medicated cream at their bedside. Resident # 5945 is severely cognitively impaired. A doctor's order could not be found in the health care record to have this medication at Resident # 5945's bedside or to keep it in the room for self administration.

Inspector # 544 identified that Resident # 7971 had a medication on their dresser from a different service provider than the home contracted. The Resident stated that the "nurses where supposed to come and take them away, but still have not". Resident # 7971 was admitted to the home weeks ago and the medication, was reported to be a personal supply while in their home, was still at their bedside.

There was no doctor's order for this medication to be left at the bedside for Resident # 7971 to use for their own use to self administer.

Inspector # 544 identified that Resident # 5904 had a jar of medicated cream at their bedside. There had been an order from the doctor to allow the Resident to have this cream at the bedside several months earlier. However, since that date, Resident # 5904's condition had deteriorated according to the progress notes notes and the recent full RAI/MDS assessment.
There was no current order from the doctor to leave this cream at Resident # 5904's bedside for the Resident to self administer this cream. This is confirmed by Staff # 102 and Staff # 108.

The licensee did not ensure that residents do not administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. [s. 131. (5)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. It was documented in the progress notes that Resident # 5945 was placed on contact isolation.
Inspector # 158 observed that contact precautions for isolation were in place. During the provision of direct care, these precautions included, wearing a N95 mask, an isolation gown and gloves, prior to entering the resident’s room and washing hands after leaving the resident’s room.
Inspector # 158 observed that Resident # 5945’s nasal prongs were not in place and that Resident #5945 had dyspnea.
The Inspector approached Staff # 118 who promptly entered the Resident’s room and re-inserted the nasal prongs into Resident # 5945’s nares. Staff # 118 did not use the required infection control preventative equipment (mask, gloves, gown during Resident care) nor wash their hands when they left the Resident's room.

The licensee did not ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. The health care records of 3 residents were reviewed by Inspector # 158.

Resident # 5923's immunization record showed that the Resident was immunized for Influenza and Pneumoccocus after their admission. There was no documentation to identify that Tetanus and Diphtheria immunization was offered. Resident # 5923 identified to the Inspector that the Tetanus and Diphtheria immunization was not offered.

Resident # 5835 received immunization against Pneumoccocus however, their immunization records did not identify whether Tetanus and Diphtheria was offered. The Resident was not able to recall whether the Tetanus and Diphtheria immunization was offered.

The Chief Nursing Officer (CNO), identified to Inspector # 158 that there was no policy for this type of immunization.

The licensee did not ensure that 2 out of 3 residents were offered immunization against Tetanus and Diphtheria, in accordance with the publicly funded immunization schedules. [s. 229. (10) 3.]

Issued on this 1st day of August, 2014

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