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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 27, 2018	2018_624196_0018	011611-18	Resident Quality Inspection

Licensee/Titulaire de permis

Sioux Lookout Meno-Ya-Win Health Centre
Fifth Avenue South PO Box 909 SIOUX LOOKOUT ON P8T 1B4

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

William A. 'Bill' George Extended Care Facility
75 Fifth Avenue SIOUX LOOKOUT ON P8T 1K9

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

LAUREN TENHUNEN (196), JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 25 - 29, 2018.

The inspectors also conducted daily tours of the resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (AD/DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), Assistant to the Residents' Council, Housekeeping Aide, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **5 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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #003 was identified to require further inspection with regards to an increase in pain as indicated through the Resident Assessment Instrument – Minimum Data Set (RAI-MDS), from an approximate three month time period in 2018.

A record review was conducted by Inspector #196, and the PSW flow sheets, during a time period of approximately two weeks in 2018, indicated that resident #003 expressed discomfort in an area of their body on several shifts.

During an interview with PSW #103, they reported to the Inspector that resident #003 would express discomfort during activities of daily living.

During an interview with the Resident Assessment Instrument Coordinator (RAI) they reported to the Inspector that the resident had a change in pain level according to the most recent RAI-MDS assessment. In addition, during monthly rounds in a specific month in 2018, the resident was identified as having an increase in pain in an area of their body and the RAI Coordinator reported that staff were to complete a pain assessment and this had not been done.

During an interview with the Administrator/Director of Care (AD/DOC), they reported to the Inspector that upon review of the home's "Pain Management Program in Long Term Care - LTC.2.40" that a pain assessment should have been conducted by the staff administering analgesia during medication rounds, or by the staff who completed the RAI assessment in which the change in pain had been identified. [s. 52. (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 that ensures when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consulted regularly with the Residents' Council, and in any case, at least every three months.

Inspector #621 reviewed minutes of the Residents' Council from the previous 12 months. On review of the minutes, it was identified that the home's management had not been in attendance to any of the three meetings, two in late 2017, and one in spring 2018.

During an interview with the Assistant to the Residents' Council, they reported to Inspector #621 that neither the AD/DOC of the home, nor any other management representative of the organization met to consult with the Residents' Council over the previous year.

During an interview with the AD/DOC, they reported to Inspector #621 that they understood that they could not attend a meeting of the Residents' Council unless they were invited. The AD/DOC confirmed that they had not attempted invitation to a meeting of Residents' Council, and as a consequence, over the previous year had not consulted with the Residents' Council, in any case, at least every three months. [s. 67.]

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 that ensures the licensee consulted regularly with the Residents' Council, and in any case, at least every three months, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 or the Act was documented and, without limiting the generality of this requirement, the licensee ensured that the following was documented: 5. The person who applied the device and the time of application.

Resident #001 was identified to require further inspection with regards to the use of a safety device that was observed to be used, functioning as a potential restraint device.

On three dates, Inspector #621 observed that resident #001 was using a safety device while seated.

During an interview with the RAI Coordinator, they reported to Inspector #621 that resident #001 utilized a specific type of safety device as a form of restraint. When the Inspector inquired where restraint documentation was kept, the RAI Coordinator indicated that documentation of the safety device restraint for this resident was kept in a white binder in the staff charting room titled "Restraint Binder". Further, the RAI Coordinator dentified to the Inspector that the RPN on duty was responsible for all restraint documentation, and it was expected that the RPN would obtain details from PSW staff on each respective shift as to when the restraint device was applied, and who applied the device.

Together with Inspector #621, the RAI Coordinator reviewed resident #001's safety device restraint documentation for a specific month in 2018. From the review, the RAI Coordinator verified to the Inspector that the resident was up in their assistive device daily during this month, and that documentation on the specific month's restraint record did not identify that the safety device had been applied at any time on five particular dates in 2018. Additionally, the RAI Coordinator confirmed that there was no documentation on the restraint record over an approximate three and a half week time period in 2018, identifying, after the safety device restraint had been applied, which PSW or RPN staff had applied the restraint. Finally, the RAI Coordinator reported to the Inspector that they were aware that there was a lack of documentation with regards to restraint use in the home.

During an interview with the AD/DOC, they reported to Inspector #621 that it was their expectation that the RPN on duty completed all restraint documentation, including documentation of when a restraint was applied, and who applied the restraint. [s. 110. (7) 5.]

2. Resident #002 was identified to require further inspection with regards to the use of a safety device that were observed to be used, functioning as a potential restraint device.

On three dates, Inspector #621 observed resident #002 with the safety device in use.

During an interview with the RAI Coordinator they reported to Inspector #621 that resident #002 utilized the safety device as a form of restraint. When the Inspector inquired where restraint documentation was kept, the RAI Coordinator indicated that documentation for this resident's safety device restraints was kept in a white binder in the staff charting room titled "Restraint Binder". Further, the RAI Coordinator identified to the Inspector that the RPN on duty was responsible for all restraint documentation, and it

was expected that the RPN would obtain details from PSW staff on each respective shift as to when the restraint device was applied, and who applied the device.

During an interview with the AD/DOC, they reported to Inspector #621 that it was their expectation that the RPN on duty completed all restraint documentation, including documentation of when a restraint was applied, and who applied the restraint.

Together with Inspector #621, the AD/DOC reviewed resident #002's safety device restraint documentation for a specific month in 2018. From the review, the AD/DOC verified to the Inspector that documentation in that month's restraint record did not identify that the safety device had been applied at any time on five particular dates in 2018, despite knowing that resident #002 participated in an activity daily. Additionally, the AD/DOC confirmed that there was no documentation on the restraint record for an approximate three and a half week period of time in 2018, identifying, after the safety device had been applied, which PSW or RPN staff had applied the restraint. Finally, the AD/DOC verified with the Inspector that the home's restraint form had no place for staff to initial indicating they had applied a restraint. [s. 110. (7) 5.]

3. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 or the Act was documented and, without limiting the generality of this requirement, the licensee ensured that the following was documented: 6. All assessment, reassessment and monitoring, including the resident's response.

Resident #001 was identified to require further inspection with regards to the use of a safety device that was observed to be functioning as a potential restraint device.

On three dates, Inspector #621 observed that resident #001 was using a safety device.

During an interview with PSW #104 they reported all residents were to be monitored hourly and that documentation of hourly monitoring for those residents who had a restraint device applied, was completed by the RPN on duty.

During an interview with the RAI Coordinator, they reported to Inspector #621 that resident #001 utilized a safety device as a form of restraint. When the Inspector inquired where restraint documentation was kept, the RAI Coorinator indicated that documentation of the safety device restraint for this resident was kept in a white binder in the staff charting room titled "Restraint Binder". Further, the RAI Coordinator identified to the Inspector that the RPN on duty was responsible for all restraint documentation, and it

was expected that the RPN obtained details from PSW staff on each respective shift as to hourly monitoring of the restraint device when it was applied, and the resident's response. The RAI Coordinator also confirmed that the RPN on duty was to perform an assessment/reassessment of the resident's condition and the effectiveness of the restraint at least every eight hours.

Together with Inspector #621, the RAI Coordinator reviewed resident #001's safety device restraint documentation for a specific month in 2018. From the review, the RAI Coordinator verified to the Inspector that the resident participated in a daily activity during the month and that the restraint document did not have a code for hourly monitoring and the resident response for staff to utilize on the record. Consequently, resident #001's safety device restraint record for an approximate three and a half week time period of 2018, had no record of hourly monitoring and the resident's response at any time after the device was applied. Additionally, the RAI Coordinator confirmed that there was no record of the RPN on duty completing an assessment/reassessment every eight hours for this same month in 2018, for the following dates and times:
- At 0700 hrs on 18 dates in 2018;
- At 1500 hrs on 15 dates in 2018; and
- At 2300 hrs on 12 dates in 2018.

Finally, the RAI Coordinator reported to the Inspector that they were aware that there was incomplete restraint documentation in the home.

During an interview with the AD/DOC, they reported to Inspector #621 that it was their expectation that the RPN on duty completed all restraint documentation, including documentation of hourly monitoring of the resident while restrained, and assessment/reassessment of the resident's condition at least every eight hours. The AD/DOC confirmed that the home's restraint record did not provide RPN staff the ability to document the resident's response while restrained. [s. 110. (7) 6.]

4. Resident #002 was identified to require further inspection with regards to the use of a safety device, observed to be functioning as a potential restraint device.

On three dates, Inspector #621 observed resident #002 with a safety device in use.

During an interview with PSW #104, they reported all residents were to be monitored hourly and that documentation of hourly monitoring for those residents who had a restraint device applied, was completed by the RPN on duty.

During an interview with the RAI Coordinator they reported to Inspector #621 that resident #002 utilized the safety device during an activity which acted as a form of restraint. When the Inspector inquired where restraint documentation was kept, the RAI Coordinator indicated that documentation was kept in a white binder in the staff charting room titled "Restraint Binder". Further, the RAI Coordinator identified to the Inspector that the RPN on duty was responsible for all restraint documentation, and it was expected that the RPN obtained details from PSW staff on each respective shift as to hourly monitoring of the restraint device when it was applied, and the resident's response. The RAI Coordinator also confirmed that the RPN on duty was to perform an assessment/reassessment of the resident's condition and the effectiveness of the restraint at least every eight hours.

Together with Inspector #621, the RAI Coordinator reviewed resident #002's safety device restraint documentation for a specific month in 2018. From the review, the RAI Coordinator verified to the Inspector that the resident participated in an activity at various times each day for rest periods, and that the home's restraint document did not have a code that staff could use for documenting hourly monitoring or the resident response. Consequently, resident #002's safety device restraint record from an approximate three an and a half week time period, had no record of hourly monitoring and the resident's response at any time after the safety device were applied. Additionally, the RAI Coordinator confirmed that there was no record of the RPN on duty completing an assessment/reassessment every eight hours for this same month in 2018, for the following dates and times:
- At 0700 hrs on 15 dates in 2018;
- At 1500 hrs on 24 dates in 2018; and
- At 2300 hrs on 12 dates in 2018.

During an interview with the AD/DOC they reported to Inspector #621 that it was their expectation that the RPN on duty completed all restraint documentation, including documentation of hourly monitoring of the resident while restrained, and assessment/reassessment of the resident's condition at least every eight hours. The AD/DOC confirmed that the home's restraint record did not provide RPN staff with the ability to code for hourly monitoring, or document the resident's response while restrained. [s. 110. (7) 6.]

5. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 or the Act was documented and, without limiting the generality

of this requirement, the licensee ensured that the following was documented: 7. Every release of the device and all repositioning.

Resident #001 was identified to require further inspection with regards to the use of a safety device that was observed to be functioning as a potential restraint device.

On three dates, Inspector #621 observed that resident #001 was using a safety device.

During an interview with PSW #104, they reported that residents with restraints, including resident #001 and their safety device were supposed to be released from the device and repositioned every two hours. However, PSW #104 indicated that timing of when the restraint was actually released and the resident repositioned often varied.

During an interview with the RAI Coordinator, they reported to Inspector #621 that resident #001 utilized a safety device as a form of restraint. When the Inspector inquired where restraint documentation was kept, the RAI Coordinator indicated that documentation of the safety device restraint for this resident was kept in a white binder in the staff charting room titled "Restraint Binder". Further, the RAI Coordinator identified to the Inspector that the RPN on duty was responsible for all restraint documentation, and it was expected that the RPN would obtain details from PSW staff on each respective shift as to when the restraint device was released and the resident was repositioned. The RAI Coordinator also confirmed that repositioning of a resident with a restraint applied was to occur at least once every two hours.

Together with Inspector #621, the RAI Coordinator reviewed resident #001's safety device restraint documentation for a specific month in 2018. From the review, the RAI Coordinator verified to the Inspector that the resident participated in an activity daily during the month and that on six dates, the restraint record for resident #001 had no documentation for all shifts, including restraint removal and resident repositioning. Additionally, the RAI Coordinator confirmed that on twelve dates between 0900 and 1900 hours, there was no record that the safety device was both released, and the resident repositioned every two hours. The RAI Coordinator further identified that the restraint document did not have a code for releasing the restraint device, only for its removal. Finally, the RAI Coordinator reported to the Inspector that they were aware that there was a lack of documentation with regards to restraint release and resident repositioning in the home.

During an interview with the AD/DOC, they reported to Inspector #621 that it was their

expectation that the RPN on duty completed all restraint documentation, including documentation of release and repositioning of a resident after a restraint was applied, at least every two hours. [s. 110. (7) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures every use of a physical device to restrain a resident under section 31 or the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following was documented: the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #196 reviewed medication incident reports that had occurred since a specific date in 2018, involving residents, including:

- A report dated in 2018, that identified resident #005 was administered a specific dose of medication instead of the ordered dose. The incident report did not indicate that the pharmacy service provider or the Medical Director had been notified of the medication incident; and

- A report dated in 2018, that identified resident #005 was administered a specific dose of medication instead of the ordered dose. The incident report did not indicate that the pharmacy service provider or the Medical Director had been notified of the medication incident.

During an interview with Inspector #196, the AD/DOC reported that the medication incidents had not been reported to the pharmacy service provider and the Medical Director had not been informed of every medication incident occurrence. [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record was kept of everything provided for in clauses (a) and (b).

During a record review of the licensee's medication incident reports, Inspector #196 determined that the pharmacy service provider was not informed of all medication incidents and adverse drug reactions.

During an interview with the AD/DOC, they reported to the Inspector that the pharmacist from the pharmacy service provider had only been onsite to the home once in the previous year; there had been a pharmacist turnover at the pharmacy; and there had been no quarterly reviews of the medication incidents with the pharmacy service provider. [s. 135. (3)]

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 that ensures every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents received training provided for in subsection 76(7) of the Act based on the following: 1. Subject to paragraph 2, staff must receive annual training in all areas required under subsection 76(7) of the Act.

The Long-Term Care Homes Act (LTCHA), 2007, s.76(7)4 requires the licensee to ensure all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at time or intervals provided for in the regulations: 4. How to minimize the restraining of residents, and where restraining is necessary, how to do so in accordance with this Act and the regulations.

Resident #001 was identified to require further inspection with regards to the use of a

safety device that was observed to be used, functioning as a potential restraint device.

On three dates, Inspector #621 observed that resident #001 was using a safety device.

During an interview with PSW #104, they reported to Inspector #621 that resident #001 utilized a safety device as a form of restraint. PSW #104 identified that PSW staff were responsible for monitoring the resident every hour when the safety device was engaged, and that sometimes the casual PSW staff failed to engage resident #001's safety device as they either didn't know it was required, or forgot about it.

When the Inspector inquired when direct care staff including PSW staff last received restraint training from the home, PSW #104 reported that they didn't recall any specific training provided to them.

During an interview with PSW #110, they reported to Inspector #196 that they had started employment with the home approximately one month earlier as a casual PSW, and identified that while they obtained orientation training, they didn't recall restraints training being part of the orientation.

During an interview with the AD/DOC, they reported to Inspector #621 that the home implemented two restraints training modules in the previous three weeks as part of a computer based training program. The AD/DOC identified through training records, that a specific percentage of PSW and RPN staff working in the home had completed the online restraints training up to the time of inspection. Additionally, the AD/DOC confirmed that prior to implementing the computer based training program restraint modules, the home had not completed annual training/retraining of direct care staff on restraints. Further, when the AD/DOC provided a hard copy of the two restraint modules being utilized as part of the current annual restraints training, the Inspector noted that training was specific to use of a particular type of restraints. The AD/DOC reviewed the modules and confirmed to Inspector #621 and #196 that they had only taken a cursory review of the restraint modules prior to their implementation, and that this type of restraint was not utilized in the home. Further, the AD/DOC stated that the restraint education provided in the two modules was not appropriate as it did not speak to the type of restraints actually used in the home, nor was the education consistent with legislative requirements for annual restraints training. [s. 221. (2) 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 that ensures all staff who provide direct care to residents receive training provided in subsection 76(7) of the Act, how to minimize the restraining of residents, and where restraining was necessary, how to do so in accordance with this Act and the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10, s.48(1)3 requires the licensee to ensure that the following interdisciplinary program is developed and implemented in the home: 3. A continence care and bowel management program.

Resident #001 was identified to require further inspection with regards to continence.

During the inspection, Inspector #621 reviewed resident #001's health care records, including the quarterly continence assessment record. On further review of the resident's quarterly continence assessments, the Inspector identified gaps of greater than three months between assessments that were documented on the "Quarterly Continence Assessment" form from an approximate two year time frame.

Inspector #621 reviewed the home's policy titled "Continence Care and Bowel Management Program in Long Term Care – LTC.4.20", approved October 24, 2016, which identified that registered nursing staff were to conduct a bowel and bladder continence assessment utilizing forms from Appendix A and B, on admission, quarterly and after any change in condition that may have affected bladder and bowel continence.

During an interview with the RAI Coordinator, they reported to Inspector #621 that resident #001 had a specific continence type and required the completion of a quarterly continence assessment by RPN staff, consistent with the home's policy. On review of a "Quarterly Continence Assessment" form found in resident #001's paper chart, they confirmed to the Inspector that a quarterly continence assessment utilizing the required forms from Appendix A and B of the home's policy was not completed on a quarterly basis from an approximate two year time period and should have been. [s. 8. (1) (b)]

WN #7: 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 has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On three dates, Inspector #621 observed resident #001's personal aid to be unclean.

During an interview with PSW #104, they reported to Inspector #621 that every week on a specific night, PSW staff removed any unclean wheelchairs or walkers from resident rooms and gave them to the night Housekeeper to clean. PSW #104 identified that the Housekeeper performed a deep clean of the wheelchair or walker and if a resident's wheelchair or walker became soiled between weekly cleanings, that PSW staff would spot clean the soiled areas using sanitary wipes.

During an interview with Housekeeping Aide #105, they reported to Inspector #621 that the Housekeeper on the specific evening shift was responsible for cleaning approximately five wheelchairs and/or walkers each week that were identified by PSW staff to need cleaning. Housekeeping Aide #105 identified to the Inspector that the wheelchairs and walkers were taken to a room in the home where there was access to a large sink for soaking of soiled cushions, as well as a washing machine and dryer to launder soiled cushion covers. Additionally, Housekeeping Aide #105 indicated that industrial detergent, clean cloths, hot water, and a scrub brush were used to perform a deep clean of the wheelchairs and walkers. Finally, Housekeeping Aide #105 reported that if a resident's wheelchair or walker became quite soiled at any point between the regular weekly cleanings, that the daytime Housekeeper would make it a priority to get the item cleaned at that time.

During an interview with the AD/DOC, they reported to Inspector #621 that the Housekeeping Aide on specific nights performed cleaning of resident wheelchairs and walkers. The AD/DOC observed the condition of resident #001's wheelchair with the Inspector, and confirmed that the resident's wheelchair was soiled and in need of cleaning. Additionally, the AD/DOC confirmed that they had no documentation to reference when the last time resident #001's wheelchair had been cleaned. [s. 15. (2) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents' Council advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee within 10 days of receiving the advice, responded to the Residents' Council in writing.

Inspector #621 reviewed the minutes of Residents' Council March 29, 2018, meeting. During the review, it was identified that as part of a menu review completed during this meeting, there was nine complaints and/or suggestions made.

On further review of the home's documentation for Residents' Council, the Inspector was unable to find a written response from the home's management to the complaints and/or suggestions that were identified from the March 29, 2018, meeting.

During an interview with the AD/DOC they reported to Inspector #621 that they had not been in attendance to the March 29, 2018, meeting of Residents' Council; however, they were aware of the concerns and/or suggestions brought up at the meeting and recorded in the minutes. Additionally, the AD/DOC verified that the hospital Food Service Manager that was present at the meeting was a contract service provider and was not management representation of the licensee. Finally, the AD/DOC confirmed that they had not provided a written response to the concerns and/or suggestions brought forward at the March 29, 2018, Residents' Council meeting, and should have. [s. 57. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 65. No interference by licensee
A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Findings/Faits saillants :

1. The licensee has failed to ensure that meetings or operation of the Residents' Council was not interfered with.

Inspector #621 reviewed the Residents' Council meeting of March 29, 2018. During the review it was identified that during the meeting there were eight staff members named as present, in addition to 10 residents. As part of menu review during this meeting, there were nine concerns and suggestions for the menu identified; however, there was no indication of whether the suggestions recorded within the minutes were made by residents or staff present.

During an interview with the AD/DOC they reported that while they had not been in attendance at the March 29, 2018 meeting, they were aware the contract Food Services Manager from the hospital attended the meeting of Residents' Council to follow up on the home's menu. The DOC/Administrator indicated that home's staff including PSW #104, PSW #106, PSW #103, PSW #107 and the RAI Coordinator and a Co-Op student attended the meeting, in order to provide feedback into the menu review. On review of the March 29, 2018, minutes of Residents' Council, the AD/DOC confirmed that (with exception of the Assistant to Residents' Council), there was no record in the minutes that members of Residents' Council approved of having other members of home's staff in attendance to their meeting; that the minutes did not identify whether the concerns or suggestions made on the menu were the voice of the residents, and brought forward by them, or a contribution made by staff; and although actions to include staff were well intended, that the AD/DOC could not assure that the March 29, 2018, Residents' Council meeting was not interfered with. [s. 65. (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

During observations of the home's medication room, Inspector #196 noted several large containers of government stock drugs.

The AD/DOC reported to the Inspector that the home had received a large amount of government stock drugs when they were last ordered. Specifically, the home had 49 unopened containers of 1000 tablets of one drug and approximately 7200 of another drug. [s. 124.]

Issued on this 27th day of July, 2018

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

Original report signed by the inspector.