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

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Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2016	2016_200148_0009	008234-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

WOODLAND VILLA
30 Milles Roches Road R. R. #1 Long Sault ON K0C 1P0

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

AMANDA NIXON (148), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550), JOELLE TAILLEFER (211)

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): April 4-8 and 11-14, 2016.

The following inspections were also completed, including critical incident Log 007151-16 related to a staff to resident alleged abuse and Log 0230121-5 related to a resident fall; and complaint Logs 032155-15 and 027408-15 related to the involvement of substitute decision makers, Logs 031756-15 and 030590-15 related to nursing staffing levels, and Log 029415-15 related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Clinical Care Coordinator, RAI Coordinator, Nursing Administrative Service Manager, Environmental Service Manager (ESM), Life Enrichment Coordinator, Nutritional Manager (NM), Office Manager, Resident Services Coordinator, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physician Assistant, Wound Care Nurse, Physiotherapist, Maintenance Personnel, Food Service Workers, Activity Aides, family and residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

- **12 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM),

and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. (Complaint: Log #027408-15 and #032155-15)

Resident #048 was admitted to the home with several medical conditions requiring medical and parmaceutical interventions.

According to the resident's health record, the daughter was Power of Attorney for Personal Health and Property, as well as emergency and primary contact. A note indicated to call the daughter first, the spouse of the resident was also listed as a contact person.

According to the most recent plan of care, it was documented that the resident was being administered daily anti-psychotic medications for the management of behaviours such as anxiety, verbal & physical aggression and under the interventions, it indicated that the staff were responsible to discuss with the the family the ongoing need for use of medication.

On six identified dates, changes to anti-psychotic medications were made including decreases and discontinuation of specific anti-psychotic medications.

According to the progress notes, there was no evidence to demonstrate that the daughter/POA and/or resident's spouse were notified of the medication change, with the exception of one of the six identified instances.

The Medication Administration Record was reviewed by Inspector #545 and it indicated that resident #048 complained of pain and was administered a pain medication eleven times within an eight day period. In a progress note written within the period of time, it was documented that the resident's behaviours such as agitation, anxiety and restlessness had increased. The home initiated interventions to identify cause and manage the behaviours. There was no indication in the notes to demonstrate communication to the daughter/POA of the resident's change in condition.

During an interview with RPN #106 and RN #118, they indicated that it was the responsibility of the registered staff to communicate all changes regarding medication to the POA, adding that a checkbox on the Physician's Order titled: POA Notified should be checked each time an order is completed, as well as an entry in the progress notes. RN #118 confirmed that resident #048's POA was not notified of medication changes on five

out of six identified instances.

The Clinical Care Coordinator indicated to Inspector #545 that it was the home's expectation that staff communicate all changes in medications and changes in condition to the POA.

As such, Resident #048's daughter/POA was not given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. According to resident #049's health record, the daughter was power of attorney (POA) for personal health and property, as well as secondary emergency contact with one phone number. The resident's spouse was identified as primary emergency contact with two phone numbers.

During a period of six months, resident #049 experienced many health condition changes, such as falls, medication changes, and increase in behaviours requiring a room change, of which family indicated they were not notified.

After the six month period, an Annual Conference note indicated that the daughter/POA had not been informed of a fall that had occurred on a specific date and to "please call any time of day or night of occurrences and/or incidents".

During a review of resident #049's health record for the six month period identified, the resident had seven falls, seven medication changes and five incidents of behaviours.

As per a review of an "In-service Cover Sheet" dated August 6, 2015, it was indicated that a focus was made on the importance of notifying the family of medication changes; this meeting was attended by registered staff, and according to the note staff that did not attend were provided with the information.

During interviews with PSW #127, PSW #128 and PSW #129, they indicated that it was their responsibility to inform registered staff when they observed a change in the resident's condition or when a resident had fallen. They all indicated that the registered staff would then notify the family/POA.

RPN #124 indicated to Inspector #545 that it was the responsibility of the registered nursing staff to contact the family/POA with any medication change especially medications such as antibiotics and narcotics. Further, family are to be notified of any fall

even if no injuries were observed at time of fall, as bruising could later develop and that family should be notified of any other change in the resident's health condition.

RN #105 indicated that it was the home's expectation that all falls, medication changes and change in health status be communicated to the family/POA. She confirmed that resident #049's daughter/POA and/or spouse were not contacted for the instances described above, therefore were not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

During an interview with the DOC, she indicated that resident #049 did not usually make health care decisions and that the daughter/POA was expected to be contacted for changes in health condition, such as falls, medication changes and changes in behaviour. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the substitute decision maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 is complied with. (Complaint: Log #023012-15 and 029415-15)

In accordance with s.30 and s.48 of Regulation 79/10, the licensee shall ensure that there is a falls prevention and management program whereby there is a written description of the program that includes relevant polices, procedures and protocols.

The Inspector reviewed the home’s fall prevention program, specifically the policy titled "MORSE Falls Risk Assessment and Treatment Plan", policy # HLHS-TP-4.8, effective date May 2015. Under procedure, it was indicated:

2. All residents on admission will be assessed for falls risk using the MORSE Falls Risk Assessment tool as well as at significant change of status and post fall.

During an interview, the DOC indicated to the Inspector that although the policy was developed in May 2015, it was not implemented until September 2015.

Resident #041 was admitted to the home in early 2015, the resident fell four times in six months. The resident's last fall was in August 2015, which lead to injury and complications.

Inspector #550 reviewed the resident’s health record and was unable to find any documentation indicating that a fall risk assessment had been conducted to determine resident #041’s risk for falls.

During an interview, the DOC indicated that resident #041 was not assessed for risk of falls, demonstrating that the MORSE Falls Risk Assessment and Treatment Plan was not complied with.

Resident #015’s spouse reported that in the fall of 2015, during a transfer from bed to wheelchair with the assistance of one staff member, the resident fell and injured him/herself. Resident #015 has fallen three times in the last six months.

Inspector #550 reviewed the resident’s health records and was unable to find any documentation indicating that a fall risk assessment had been conducted to determine

the resident’s risk for falls.

During an interview, the DOC indicated to the Inspector that resident #015 was not assessed for risk of falls, demonstrating that the MORSE Falls Risk Assessment and Treatment Plan was not complied with.

A review of the home's policy # CS-12.1 titled “Resident Falls” dated January 2011, indicated the charge nurse is responsible to notify the physician and the family or Power of Attorney (POA). This policy is part of the home's fall prevention and management program.

Interview with the Physician Assistant revealed neither herself nor the physician were informed that resident #015 had four falls.

A review of the progress notes indicated that the family was not informed of three falls.

A review of the home's policy #CS-12.2 titled “Neurological Assessment Post Head Injury” dated September 2013, which indicated to implement a Head Injury Routine if the resident is known to or appears to have sustained a head injury. This policy is part of the home's fall prevention and management program.

On a specified date, the resident fell off the side of the bed. The resident had a slight red mark on his/her head and stated that his/her head made contact with the wardrobe.

An interview with RN #116 and RPN #106 revealed the neurological assessment post head injury was not completed.

In addition, in an interview with the Clinical Care Coordinator, it was confirmed that resident #015 had never been assessed using the MORSE Falls Risk Assessment tool.

The policies including MORSE Falls Risk Assessment and Treatment Plan, Resident Falls and Neurological Assessment Post Head Injury were not complied with as it relates to the falls described above for resident #013. [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 the relevant policies, procedures and protocols for the falls prevention and management program are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

The resident-staff communication and response system (call bell system), at the resident's bed location, consists of a wall panel to which a cord is connected. At the end of the cord is a red button. The call bell system is activated by pushing the button on the

end of the cord or pulling the cord out of the wall panel.

Resident #032 was observed in the resident's bedroom on April 5, 2016, seated in a comfortable chair near the foot of the bed on the left side. The call bell system's wall panel is located at the head of the bed. The cord was tied to the right side bed rail, which was in the down position. At the time of the observation the call bell cord and button were not easily seen or accessible to the resident. Inspector #148 untied the cord and made the cord available for the resident. When asked, resident #032 indicated that pushing the button would be used to call a staff member to the room. On a subsequent observation, on April 6, 2016, the Inspector entered the resident's room after a staff member had provided the nourishment pass and observed the resident to be seated in the same position in the room with the cord tied around the right side bed rail in the down position, the call bell cord and button were not easily seen or accessible by the resident. A review of the plan of care indicates that resident #032 is to have the call bell system available due to fall risk.

Resident #032 did not have the communications system within easily access on April 5 and 6, 2016. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

Inspector #148 observed a resident gathering space, identified as the Sunshine room, which is a seating area adjacent to the home's hair salon. Upon observation of the space it was determined that the Sunshine room does not have a communication system available. On April 6, 2016, the salon was closed, however, the Sunshine room was being used by a resident and visitors. When asked, the visitors indicated that they would shout or go to the nursing station if they needed assistance.

The Inspector spoke with the home's ESM, who indicated that she believes there to be a call bell system in the room, but that the wall panel is likely covered by wallpaper. Both the home's ESM and DOC agreed that there is no call bell system available in this resident accessible area. [s. 17. (1) (e)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect sexual abuse of a resident, shall immediately report the suspicion and the information upon which it was based to the Director.

Resident #052's health record was reviewed by Inspector #545. On a specified date, a progress note indicated that the resident had reported being sexually assaulted by a roommate, resident #049, during the night. The note indicated that management and family were notified of the incident. Four days after the progress notes, a second note indicated that on the previous day, resident #052 had complained about not eating well and feeling sick since the incident where resident #049 grabbed him/her and tried to kiss him/her.

RPN #124 indicated to Inspector #545 that on the date of the resident's report, she notified the DOC that resident #052 had reported that a roommate, resident #049, had grabbed him/her sexually, adding that the resident also indicated that resident #049 had tried to kiss him/her. The RPN stated that she believed that the management would have notified the Ministry (Director).

During an interview with the DOC, she indicated that she was made aware of the alleged sexual abuse involving resident #049 and resident #052. She indicated that an investigation was initiated and based on a discussion with resident #052's son, it was concluded that resident #052 was known to confabulate and not to be concerned.

The DOC and Administrator indicated that the information related to a suspected sexual abuse, between resident #049 and resident #052, was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a report is made to the Director immediately when a person has reasonable grounds to suspect abuse of a resident occurred or may occur, to be implemented voluntarily.

WN #5: 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 are kept clean and sanitary.

On April 4, 5, 7 and 8, 2016, Inspector #148 observed the wheelchairs of resident #036 and #037, including the lap belt in use for resident #037, and the four wheeled walkers of resident #032 and #033. The Inspector observed food and unidentified debris on the back and arm rests of the wheelchairs, including embedded debris in the material of the back rests and cushion covers. In addition, the lap belt of resident #037 had food stains and the wheelchair of resident #036 had white crusted matter on the right side wheel and arm rest. Both seats of the walkers were observed to have old food and unidentifiable matter. The condition of the walkers and wheelchairs were observed unchanged over the course of the observations.

The Inspector spoke with a day staff PSW and the ESM, who both indicated that the cleaning of wheelchairs and walkers is the responsibility of the night staff and is coordinated by the Life Enrichment Coordinator. PSW staff on the day shift, however, were expected to wipe away any obvious debris or food stuffs.

The Inspector spoke with the Life Enrichment Coordinator on April 11, 2016, who confirmed that night staff are responsible to wipe down resident ambulation equipment. She clarified that a wipe down is done with a disinfectant wipe or warm soapy water. The night staff are also to send the cushion covers to laundry for washing, as needed. The current schedule for cleaning is each Wednesday and Thursday, during the night shift.

Further to this, the home has a service provider enter the home every six month to deep clean the metal frames of ambulation equipment; the home is due for a six month cleaning in April 2016. She confirmed that night staff do not provide a deep clean to ambulation equipment due to time and workload. As indicated by both the Life Enrichment Coordinator and the ESM, the home has recently purchased a hand held steam cleaner and they are hoping to implement this as a deep clean process. Resident Council meeting minutes, of November 2015, indicate that the ESM reported the purchase of a steam cleaner for the purposes of cleaning furniture and ambulation equipment.

The wheelchairs and walkers of residents #032, #033, #036 and #037 were not observed in a clean and sanitary state. [s. 15. (2) (a)]

2. The licensee has failed to ensure that furnishings and equipment are maintained in a safe condition and in a good state of repair.

In the washroom of resident #007's bedroom, Inspector #550 observed that the commode chair that rolls over the existing toilet was damaged. Both armrests and the back rest are made of vinyl and the Inspector observed that the vinyl was cracked. This posed a risk of injury to resident's skin and cannot be cleaned properly.

PSW #115 indicated to the Inspector that in the morning, they transfer resident #007 from the bed onto the commode chair and use the commode to wheel the resident to the toilet. The PSW was aware that it was damaged but stated it was one of the last old ones and that she did not report it as the DOC was in the process of replacing the old commode chairs.

During an interview, the ESM indicated to the Inspector that she was not aware that the commode chair in this bathroom was damaged; had she known this, the vinyl or the chair would have been replaced as the DOC recently purchased new commode chairs. It is her expectation that all staff report, via the maintenance book, any repairs needing to be done or any equipment in disrepair. Inspector reviewed the maintenance book for the south wing from July 20, 2015, to the last entry dated April 4, 2016, and was unable to find a note regarding the damaged commode chair.

The maintenance person indicated to the Inspector during an interview that he was not made aware by staff that the commode chair in resident #007's bathroom was damaged and not in a good state of repair. [s. 15. (2) (c)]

3. On April 4 and 12, 2016, the Inspector observed that the portable plastic arm rests, attached to the toilet used by resident #013, to be cracked.

An interview with PSW #114 revealed the plastic on the portable arm rests had been in the above described condition for a long time and stated the maintenance staff was not informed since it was not written in the maintenance log book.

The portable arm rests attached to the toilet were not maintained in a safe condition and good state of repair and may pose a risk for residents' skin integrity.

Interview with the EMS confirmed that she was not notified of the cracks on the portable arm rests. [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

On April 4, 2016, Inspector #211 observed the tub room of the south wing area with the following items unlabelled: two hair brushes, a Vitarub ointment container, two barrier silicone skin cream containers, protective ointment pretolatum container, two used razors, toothpaste, roll-on antiperspirant deodorant, deodorant stick, zinc cream and body lotions stored in a nameless white basket.

Interview with PSW #102 and DOC confirmed that all above items should be labelled and not kept in the tub room.

On April 7, 2016, Inspector #211 observed a lower denture without a resident's name, place on a table in the management's office area.

Interview with the DOC confirmed that the lower denture was found on the unit this morning and since the denture is not labelled, they are not aware of who it belongs to. [s. 37. (1) (a)]

WN #7: 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. The licensee has failed to ensure when the resident has fallen, the resident is assessed and 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.

A review of the progress notes indicated that resident #013 had several falls within an eight month period.

On a specified date, the resident's roommate informed a staff member that resident #013 had a fall in the bedroom but was uncertain if the resident had hit his/her head. Interview with RN #116 and RPN #113 revealed the post fall assessment was not completed.

On a specified date, resident #013 informed the staff that he/she slipped and fell hitting his/her head, hard on the floor. An interview with RN #116 revealed the post-fall assessment was not completed.

On a specified date, the resident was found on the floor beside the roommate's bed. The nightstand was on top of the resident and the resident stated that it was quite a fall. A record review and interview with RPN #130 indicated that the post fall assessment was not completed on the above date.

On a specified date, the resident was found on the floor in his/her bedroom on hands and knees. The staff wrote that the resident had a scrape on the right elbow and a laceration on the left small finger. The resident was complaining of right hip pain. Interview with RN #116 and RPN #105 revealed the post-fall assessment was not completed.

Interview with the DOC confirmed a post-fall assessment instrument is available to staff, titled "Post Fall Investigation". Staff are to complete this assessment instrument for resident falls, in the electronic health care record. [s. 49. (2)]

WN #8: 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. The licensee has failed to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident body mass index and height upon admission and annually thereafter.

Census record reviews conducted during Stage 1 of this inspection identified that measures of height were not within the last calender year. Inspector #148 reviewed 10 resident health care records and found that each of the residents were admitted prior to January 2014. Each of the 10 residents were found to have their last height measured and documented in July 2014.

The Inspector discussed the process of height measurements with PSWs, RPNs, the home's NM and DOC. It was determined that the heights are measured on admission but that staff were unclear as to how annual height measures are taken. The home's DOC confirmed that in July 2014 the home measured all resident heights, but did not implement a process to ensure heights are measured annually. [s. 68. (2) (e) (ii)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with weight changes, as described within this provision, are assess using an interdisciplinary approach and that actions are taken and outcomes are evaluated.

Resident #037 is at nutritional risk related to unintended weight loss, decreased intake and chewing difficulties.

On a specified date, the resident was assessed by the home's RD, as part of the home's quarterly Minimum Data Set (MDS) assessment. At the time of the assessment the RD recognized that the resident's previous monthly weight, was below a normal weight range for age noting that the resident was provided nutritional supplements with a goal to maintain a stable weight.

The resident's monthly weight record was reviewed and demonstrated that in the month following the RD's assessment the resident had a 9 per cent weight loss, in addition to a 9 per cent weight loss over three months. In the proceeding month the resident's weight record demonstrates, a 9 per cent weight loss over three months and 11 per cent weight loss over six months.

Progress notes during this time, by registered nursing staff, note that the resident's intake was poor related to anxious behaviours. PSW #114, who is familiar with the resident, indicated that the resident's intake of food varies at meals but usually drinks quite well. Inspector #148 observed the resident at a lunch meal service, whereby the resident took only bites of food and when asked by staff indicated disinterest in eating.

Inspector #148 spoke with the home's RD and NM about the resident's weight loss and reviewed the resident's health care record. The home could not demonstrate that the weight change of resident #037 had been assessed or that action had been taken. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Family and Resident Councils was sought in developing and carrying out the satisfaction survey.

During interviews with the vice-president of the Resident Council and the president of the Family Council, they indicated that the licensee did not seek the advice of the councils in developing and carrying out the most recent satisfaction survey. The president of the Family Council indicated that the 2016 satisfaction survey was sent out to family members in the last month. He added that last week he had approached the appointed assistant to the Family Council to inquire if four to five questions could be added to next year's survey.

The Assistant to both the Resident and Family Councils and the Administrator indicated to Inspector #545, that the 2016 Satisfaction Survey was revamped. They both indicated that the licensee had not sought the advice of the Residents' and Family Councils in developing and carrying out the 2016 Satisfaction Survey. [s. 85. (3)]

WN #11: 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. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident whereby a resident was missing for less than three hours and who returns to the home with no injury or adverse change in condition.

As indicated by the resident's plan of care, resident #051 has been on the home's wanders list for safety since at least June 2015.

On a specified date, a Resident Incident report describes that resident #051 was found outside of the home near the road, by activity staff member #123. On a second specified date, a progress note described that resident #051 was found outside near the road by a passerby. On both occasions no injury or adverse change in condition was noted to have occurred.

On April 14, 2016, Inspector #148 reviewed the Critical Incident System, the reporting system used to inform the Director. No incidents of resident #051 missing for less than three hours were reported.

The Inspector spoke with the home's DOC regarding the incident of a missing resident, who indicated that since the resident was still on the property the incident was not reported. [s. 107. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On April 8, 2016, the Inspector observed insulin and food items in the medication refrigerator in the north wing. The food items included: a staff lunch, an apple sauce container, a ginger ale can, one prune nectar bottle, boosts and six resources drink containers, one chocolate pudding and one opened chocolate bar.

Interview with RN #105 and DOC confirmed that drugs should be stored in an area used exclusively for drugs and drug-related supplies. [s. 129. (1) (a) (i)]

Issued on this 9th day of May, 2016

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

Original report signed by the inspector.