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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 27, 2017	2017_615638_0014	013673-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST POSTAL BAG 1757 KIRKLAND LAKE ON P2N 3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST POSTAL BAG SERVICE 3800 KIRKLAND LAKE ON P2N 3P4

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

RYAN GOODMURPHY (638), AMY GEAUVREAU (642), LOVIRIZA CALUZA (687), SYLVIE BYRNES (627)

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): July 24-28, 31 and August 1-4, 2017.

The following intakes were inspected during this Resident Quality Inspection:
-One log was related to CO #001 from inspection report #2016_269627_0013, s. 6 (1) of the Long-Term Care Homes Act (LTCHA), 2007, specific to a lack of clear direction provided within the residents' plans of care;
-One log was related to CO #002 from inspection report #2016_269627_0013, s. 6 (7) of the LTCHA, 2007, specific to care not being provided as per the residents' plans of care;
-One log was related to CO #003 from Inspection report #2016_269627_0013, s. 15 (1) of the LTCHA, 2007, specific to the home's bed rail systems;
-One log was related to a critical incident the home submitted to the Director regarding a fall which resulted in a change in the resident's status;
-One log was related to a critical incident the home submitted to the Director regarding an incident of alleged staff to resident abuse; and
-One log was related to a critical incident the home submitted to the Director regarding an outbreak that was declared in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Dietary Manager (DM), Registered Dietitian (RD), Resident Assessment Instrument (RAI) Coordinator, Administrative Assistant (AA), Ward Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant staff personnel files, internal investigation notes, licensee policies, procedures, programs, relevant training and resident health care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **9 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #003	2016_269627_0013	638
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2016_269627_0013	627 642
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2016_269627_0013	627 642

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. 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 the policy titled "Risk Management - Falls Prevention and Management Program" last reviewed March 2017, was complied with.

Resident #003 was identified as having a fall from their Minimum Data Set (MDS) assessment. Inspector #638 reviewed resident #003's health care records and identified a progress note in Point Click Care (PCC) in May 2017, which indicated that the resident had sustained an unwitnessed fall in their room. The Inspector reviewed the resident's "Head Injury Routine" (HIR) document and determined that five out of ten or 50 per cent of the HIR checks had not been documented regarding their fall.

In an interview with Inspector #638, RPN #113 stated that whenever a resident sustained a fall that was not witnessed, they would implement a HIR to monitor the resident for any potential head injuries. The RPN stated that the HIR document was the only place they would document these assessments and that it should be completed in it's entirety. The RPN stated that they were working when resident #003 had fallen. Upon review of the completed HIR document with RPN #113, they stated that they could not recall specifically why they missed two of the checks, but they should have been completed.

During an interview with Inspector #638, RN #116 indicated that whenever a resident was on HIR, they were required to monitor the resident's status. The RN indicated that if the resident was considered stable they would not be required to continue checking the resident using the HIR document. Upon review of resident #003's health care records with the Inspector, RN #116 indicated that they were caring for resident #003 the day after the resident fell in May 2017, and must have forgotten to document the results of their assessments in the resident's HIR document.

The home's policy titled "Risk Management - Falls Prevention and Management Program" last reviewed March 2017, indicated that the HIR was implemented whenever a resident had an unwitnessed fall or a witnessed fall that may have resulted in a possible head injury. The routine included monitoring every hour for four hours, every two hours for four hours and then every four hours until a 24 hours period was reached to monitor for signs of neurological changes.

In an interview with Inspector #638, the ADOC stated that whenever a resident sustained an unwitnessed fall, a HIR would be implemented and staff should complete the document in it's entirety. Upon review of resident #003's HIR document for May 5, 2017,

the ADOC indicated that there should not have been incomplete checks on the HIR document. [s. 8. (1) (a),s. 8. (1) (b)]

2. Inspector #687 reviewed a Critical Incident Systems (CIS) report that was submitted to the Director in December 2016. The report indicated that resident #014 sustained a fall resulting in an injury.

Inspector #687 reviewed resident #014's health care record and identified that the resident was a high falls risk as identified in their Morse Fall Scale assessment.

In an interview with Inspector #687, PSW #120 stated that they found resident #014 on the floor. PSW #120 stated that they immediately informed RN #119 who responded to resident #014's fall. RN #119 sent the resident to hospital for further assessment.

The home's policy titled "Risk Management - Falls Prevention and Management Program" last reviewed March 2017, indicated that following an incident in which a resident sustains a fall, the registered staff member would complete a head to toe assessment.

During an interview with Inspector #687, RN #119 stated that they responded to resident #014's fall in December 2016. The RN stated that they responded to the resident and the resident reported that they were fine and did not report any pain. RN #119 informed the Inspector that when a resident falls the registered staff should complete a head to toe assessment on the resident in order to determine if there had been any injury or the extent of the injury and complete a post fall screening tool to document the incident. RN #119 indicated that they must have missed completing the required head to toe assessment as they were unable to identify a completed assessment in PCC. [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 home's policy titled "Risk Management - Falls Prevention and Management Program" was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director in June 2016. The report indicated that PSW #101 allegedly physically abused resident #013 while providing the resident with care.

a) In an interview with Inspector #687, PSW #100 stated that they witnessed the incident of alleged abuse towards resident #013 in June 2016. The PSW indicated they had not immediately reported the incident to the RN as the RN was a family member of PSW #101. The following day, PSW #100 informed a RPN regarding the incident and were notified that the suspected incident of abuse was required to be reported to the Administrator immediately.

During an interview with Inspector #687, PSW #104 indicated that they could recall an incident when PSW #101 was providing rough care and would forcefully manipulate resident #013's limbs when providing care. PSW #104 did not report this incident to anyone as they did not consider this a form of abuse at the time.

Inspector #687 interviewed PSW #105 who indicated that they worked with PSW #101 and witnessed the PSW would forcefully manipulate resident #013's limbs on a couple occasions when they were providing care. PSW #105 informed the Inspector that they spoke once to PSW #101 about their care and reported it to RPN #108 after the second incident. PSW #105 was unable to provide the exact dates of these incidents but was aware that they should immediately report any suspected incidents of abuse towards residents.

The home's policy titled "Risk Management - Zero Tolerance of Abuse and Neglect" last reviewed March 2017, indicated that any person reporting a witnessed or suspected incident of abuse would report the incident to the "Team Leader" who would immediately notify the charge RN.

b) During an interview with Inspector #687, PSW #100 indicated that they were working with PSW #101 on the date of the incident in June 2016. The two PSWs were providing care to resident #013, whereby PSW #100 witnessed PSW #101 being physically inappropriate with the resident and was shocked (regarding the incident).

In an interview with Inspector #687, PSW #104 indicated that they could recall an incident whereby PSW #101 was providing rough care to resident #013. PSW #104 informed inspector #687 that they had no difficulty with providing care to resident #013. The PSW stated that staff had to explain the steps to the resident #013 prior to initiating care to keep them more relaxed.

The home's policy titled "Risk Management - Zero Tolerance of Abuse and Neglect" last reviewed March 2017, indicated that physical abuse was defined as a physical force applied by anyone other than a resident that causes physical injury or pain.

In an interview with Inspector #687, the Administrator indicated that the alleged incident of abuse that occurred in June 2016, involving PSW #101 and resident #013 was not reported until one day after the incident had occurred. They indicated that following the investigation, PSW #101's employment was terminated due to the physical abuse of resident #013. [s. 20. (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 the home's policy to promote zero tolerance of abuse and neglect of residents is complied with, specifically on the definition of abuse and when staff are required to report suspected, witnessed or alleged incidents of abuse, to be implemented voluntarily.

WN #3: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident who exhibited altered skin

integrity, including skin breakdown, pressure ulcers, skin tears or wound, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #011 was identified as having an area of altered skin integrity from their Minimum Data Set (MDS) assessment. Inspector #627 reviewed the MDS Quarterly Review for resident #011, which identified that the resident had a specific area of altered skin integrity.

Inspector #627 reviewed resident #011's health care records in PCC and the electronic Medication Administration Record (eMAR) and was unable to identify any indication that resident #011 had an area of altered skin integrity.

The home's policy titled "Skin and Wound Care - Pressure Ulcer Screening" last reviewed March 2017, indicated that a validated skin assessment would be completed by registered staff on residents who demonstrated a significant change in status such as mobility status, major weight loss, recent fracture, major change in cognitive status or at any sign of skin breakdown.

In an interview with Inspector #627, the Resident Assessment Instrument (RAI) Coordinator stated that they had completed observations for resident #011 at the beginning of May 2017. They stated that they had been made aware of the resident's area of altered skin integrity during the morning shift report, where it was reported that resident #011 had an area of altered skin integrity.

Inspector #627 interviewed RN #116 who stated that when a PSW noted an area of altered skin integrity, they reported the finding to registered staff. The registered staff would assess the area and document their assessment in PCC. RN #116 stated that they had been made aware that resident #011 had an area of altered skin integrity in May 2017, during the morning shift report, however, due to the PSWs report, they felt this area of altered skin integrity had not required an assessment. RN #116 stated that they had not assessed resident #011's skin integrity concern when notified by the PSW.

In an interview with Inspector #627, RN #115, (Skin and Wound lead) and the Administrator stated that when a PSW reported to a registered staff member that a resident had an area of altered skin integrity, the registered staff member should have assessed the resident. If the area was determined not to be an area of altered skin integrity, they would document their findings in PCC. RN #115 stated that when it was

reported that resident #011 had an area of altered skin integrity in May 2017, the night shift RN may not have been able of assess the resident if the resident had been sleeping, however, the day shift RN should have followed up, assessed the resident and documented the findings in PCC. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that that a resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

Resident #009 was identified as being bedfast from a MDS assessment.

Inspector #627 observed resident #009 on July 27, 2017, from 0855 hours to 1330 hours and witnessed the following;

-0855 hours, the resident was in the dining room for their meal service. The resident's assistive device was positioned in a specific manner,
-1025 hours, the resident was assisted to the dining room for the morning snack pass, the resident had not been repositioned during this period (between 0855 hours - 1025 hours),
-1151 hours, the Inspector observed the resident in the lounge grinding their teeth and their arms fidgeting,
-1155 hours, the resident was assisted back to the dining room for the lunch meal service and moved back to the lounge,
-1330 hours, staff transferred the resident to bed.

The resident was not repositioned for over four and a half hours, during the Inspector's observations.

On August 1, 2017, at 0830 hours, Inspector #627 observed resident #009 in the dining room. The resident's assistive device was positioned in a specific manner. After the meal service the resident was moved to the lounge. At 1151 hours the resident was brought back to the dining room for the lunch meal service. Following the meal service, the resident was moved to their room at 1317 hours and transferred to bed. The resident was again not repositioned for over four and a half hours of the Inspector's observations.

The home's policy titled "Skin and Wound Care - Skin and Wound Care Program", last reviewed March 2017, indicated that dependent residents should be repositioned a minimum of every two hours depending on the resident's condition and the tolerance of

tissue load during waking, including chair positioning.

The Inspector reviewed resident #009's care plan in effect at the time of the inspection, which identified that the resident was at moderate risk for developing an area of altered skin integrity related to specific assessed care needs, the care plan directed staff to turn and reposition the resident at least every two hours.

In an interview with Inspector #627, PSW #105 stated that resident #009 required total care and was dependent on staff for repositioning. The PSW stated that the resident was usually up at a specific time in the morning and followed a specific rest routine. They indicated that staff repositioned the resident every two hours while in bed, however, repositioning was not necessary while the resident was in their assistive device.

During an interview with Inspector #627, RN #123 indicated that resident #009 required assistance with all their care. The RN indicated that the resident could not reposition themselves if they were not comfortable. They stated that resident #009 should be repositioned every two hours to offload pressure and for comfort.

Inspector #627 interviewed the ADOC who stated that resident #009 was unable to reposition themselves and that staff should reposition the resident every two hours to off load pressure and to maintain comfort measures. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, to be implemented voluntarily.

WN #4: 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Resident #009 was identified as being bedfast from a MDS assessment. Inspector #627 reviewed the care plan in effect at the time of the inspection and noted that the resident required assistance with continence care at specific times throughout the day.

Inspector #627 observed resident #009 on August 1, 2017, and identified that the resident was brought to the lounge after the breakfast meal service (without receiving care as per their continence care routine) and was only returned to their room after the lunch meal service to receive their continence care.

In an interview with Inspector #627, PSW #105 stated that resident #009 was provided continence care during specific times throughout each shift, which included providing continence care assistance after the breakfast meal service, as per the resident's assessed needs.

Inspector #627 interviewed RN #123 who stated that resident #009 was incontinent and was to receive continence care at specific times throughout each shift, including after the breakfast meal service.

During an interview with Inspector #627, the ADOC stated that resident #009 was to be provided continence care as per the care plan. The ADOC indicated that resident #009 was to be provided continence care at specific times throughout the day shift, and were to be provided with assistance with their continence care after the breakfast meal service. [s. 51. (2) (c)]

2. Resident #007 was identified as having worsening incontinence from a MDS

assessment.

Inspector #627 reviewed resident #007's care plan in effect at the time of the inspection and noted that the resident required extensive assistance with activities of daily living and to provide continence care at specific times throughout each shift.

Inspector #627 observed resident #007 on July 27, 2017, in the dining room from the breakfast meal service until the lunch meal service. At 0905 hours, the resident was observed walking to their room, with the use of an assistive device. At 1150 hours, the Inspector observed PSW #103 enter the resident's room and asked the resident if they would like to go to lunch. During this period the resident was not offered assistance with their assessed continence needs.

In an interview with Inspector #627 on July 27, 2017, PSW #103 stated that resident #007 had been provided with assistance for their continence needs earlier in the day, therefore, they would only be assisted later (contrary to the resident's assessed needs).

On August 1, 2017, Inspector #627 observed resident #007 between 0850 hours and 1330 hours. At 0850 hours, the Inspector observed resident #007 in the dining room for the breakfast meal service. At 0953 hours, the resident returned to their room. At 1126 hours, the resident ambulated to the front of the nursing station and requested assistance with their continence needs, which was provided by PSW #125. After the care was provided, the resident went to the lunch meal service. The resident returned to their room at 1254 hours. The Inspector left the unit at 1330 hours and noted that the resident had not been provided with assistance with their continence needs after the meal service as per their care planed continence interventions.

During an interview with Inspector #627, PSW #105 stated that resident #007 was provided assistance with their continence needs before breakfast, therefore, they would be assisted before lunch. They confirmed that the resident was to receive assistance with their continence needs, before meals, after meal and more often when required.

In an interview with Inspector #627, RN #124 stated that resident #007 was unable to identify their own continence needs most of the time due to their medical diagnoses. As a result staff should provide assistance to the resident at predetermined times throughout each shift as per their care plan. The RN confirmed that resident #007 should have been provided with assistance for their assessed continence needs before and after the breakfast and lunch meal services.

Inspector #627 interviewed the ADOC who stated that when a resident was incontinent, an assessment of the resident's needs would be completed and interventions would be put in place with a goal to increase continence and assist with skin integrity. The ADOC indicated that resident #007 had a change in their status and did not always recognize their own needs. The resident required prompting and assistance with their continence needs at specific times each shift. [s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #5: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was restrained by a physical device, the resident was released from the physical device and repositioned at least once every two hours.

During a resident observation on July 24, 2017, Inspector #627 observed resident #015 with a potential restraint applied while in their assistive device.

The Inspector observed resident #015 in the dining room for the breakfast meal service on July 27, 2017, at 0850 hours. The resident was sitting in their assistive device with a specific restraint applied. After the breakfast meal service, the resident was moved to an area between the lounge and dining room. The resident was not released from the device and repositioned. At 1143 hours, the resident was observed sleeping in their assistive device. The ADOC and a PSW brought the resident to their room whereby they were provided with continence care, and transferred to bed. The resident had not been repositioned and the restraint had not been removed and reapplied for nearly three hours.

On August 1, 2017, at 0945 hours, the Inspector observed resident #015 sitting in their assistive device with a specific restraint applied. At 1157 hours, the Inspector observed the resident being assisted to the dining room for lunch service. At 1302 hours, the resident was assisted to their room where they were transferred to bed, provided with continence care and transferred back to their assistive device and the specific restraint was reapplied. The resident had not been released from the physical device and had not been repositioned for the three hours observed by Inspector #627.

During an interview with Inspector #627, PSW #105 stated that they applied resident #015's specific restraint while the resident was in their assistive device. The PSW indicated that the resident was monitored every hour for safety. They stated that it was not necessary to release and reposition the resident as the resident could wiggle in their assistive device.

Inspector #627 interviewed RN #123 who stated that when a resident was restrained, the resident received hourly safety checks. The RN was not sure if the restrained resident should be repositioned while restrained in an assistive device and conferred with RN #116 who confirmed that a resident who was restrained by specific restraint in an assistive device, was required to be repositioned every two hours.

In an interview with Inspector #627, the ADOC stated that all restraints should be released and a check completed to ensure that restraint was applied appropriately. The ADOC indicated that resident #015 should be released and repositioned every two hours to ensure that the resident was safe and comfortable in their assistive device. [s. 110. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is restrained by a physical device, the resident is released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

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 had their personal items, including personal aids labelled within 48 hours of admission and of acquiring new items.

During the initial tour on July 24, 2017, at 1340 hours, Inspector #627 observed one hairbrush, one comb, one deodorant and one watch unlabelled in a tub room. Each of these items were used.

In an interview with Inspector #627, PSW #131 stated that all personal items should be labelled.

Inspector #638 observed one used brush and two used combs in one of the tub rooms at 1000 hours on August 3, 2017, each of the items were unlabeled.

In an interview with Inspector #638, PSW #106 indicated that resident specific items were to be labelled and kept in their room or bin. If they were not labelled they would be discarded to minimize risk to other residents. The PSW was unable to identify who the three items belonged to in the aforementioned tub room and indicated that they should have been labelled.

During an interview with Inspector #638, RN #130 stated that each resident's personal items including combs, nail clippers and personal clothing is labelled upon their admission to the home and then when required (as labels wear and upon acquiring new items). The RN indicated that one of the night shift duties of the direct care staff, was to review and label residents' personal items. [s. 37. (1) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that semi-annual meetings were convened to advise residents' families and persons of importance to residents of their right to establish a Family Council.

During an interview with Inspector #627, resident 018's family member stated that there was no Family Council in the home although they had attempted to establish one with the help of the home. They further indicated that there were no semi-annual meetings to advise resident's families and persons of importance to residents of their right to establish a Family Council held.

In an interview with Inspector #627, the ADOC indicated that they were attempting to establish a Family Council. They verbally informed the most active family members of their right to a council and reminded them in writing via the financial statements. The ADOC stated that the home had not held semi annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #8: 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 the resident with a change of five per cent of body weight, or more, over one month was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #003 was identified as having a decline related to nutrition from a 2017 MDS assessment.

Inspector #638 reviewed resident #003's health care records and identified that the resident had greater than five per cent weight change during a one month period in 2017. Upon further review of the resident's health care records, the Inspector was unable to identify any completed interdisciplinary assessments following the resident's identified weight change during the specific time frame in 2017.

In an interview with Inspector #638, RN #102 stated that each resident's weight was measured monthly and documented in PCC. The RN indicated that if there was a significant weight change identified within PCC, a "Dietary Requisition Form" would have been completed and submitted to the Dietary Manager (DM) for a review of the resident's needs.

The home's policy titled "Individualized Dietary Service – Changes in Weight" last reviewed March 2017, indicated that any unplanned or undesirable changes in weight greater than five per cent in one month would be communicated to the DM. The DM would visit the resident to investigate, initiate food intake record (if required), review the resident's findings with nursing staff and chart the resident's findings in the resident's progress notes.

In an interview with Inspector #638, the DM and RD indicated that they review resident weight changes weekly and if there was a significant weight change a nursing and dietary review of the resident would have been completed. The DM was unable to provide the Inspector with any completed assessments regarding resident #003's weight change in 2017, and indicated that they had not completed an interdisciplinary assessment of the resident. [s. 69. 1.]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A CIS report was submitted to the Director in July 2017, related to a disease outbreak in the home. The CIS report indicated that an outbreak had been declared within the home on July 9, 2017.

Inspector #638 reviewed the "Initial Outbreak Meeting" record which was held the day the outbreak was declared on July 9, 2017. The record identified that there were three residents listed for the outbreak on July 9, 2017.

The home's policy titled "Risk Management – Critical Incident Reporting" last reviewed March 2017, indicated that an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act would have been immediately reported to the Director on the Mandatory Critical Incident System (MCIS) form (during business hours) or phone the after hours pager (outside of business hours).

In an interview with Inspector #638, the ADOC indicated that there previously was confusion related to mandatory reporting and they believed that the outbreak was only required to be reported to the Director within a few days of the incident and immediately to public health. The ADOC indicated that they did not report the incident immediately. [s. 107. (1)]

Issued on this 6th day of October, 2017

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

Original report signed by the inspector.