Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2015	2015_306510_0004	H-002015-15	Resident Quality Inspection

Licensee/Titulaire de permis

UNITED MENNONITE HOME FOR THE AGED
4024 Twenty-Third Street Vineland ON L0R 2C0

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

UNITED MENNONITE HOME
4024 Twenty-Third Street Vineland ON L0R 2C0

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

IRENE SCHMIDT (510a), BERNADETTE SUSNIK (120), CAROL POLCZ (156), CATHY FEDIASH (214), ROBIN MACKIE (511)

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): February 18, 19, 20, 23, 24, 25, 26 and 27 2015

During this RQI, the following were also inspected: Follow up from log #H-000019-14, Critical Incidents #H-001888-15,#H-001541014 and #H-001038-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI)Coordinator/Wound Nurse, Environmental Services Manager, Dietary Manager, Dietician, Volunteer Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and dietary aides.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

16 WN(s)
6 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_214146_0001	156

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

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

Specifically failed to comply with the following:

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

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

The current plans of care for two identified residents indicated that staff were to

"encourage fluids during the day to promote prompted voiding responses". Interviews with the DOC, ADOC, two RPN's and two PSW's on an identified date reported different understanding of this direction. Some staff understood this to mean pushing fluids while others understood it to mean timed consumption of fluids followed by attempts at voiding. The plans of care did not set out clear directions to staff and others who provide direct care to the residents. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) The plan of care for an identified resident indicated that the resident refused to wear certain apparel and also indicated that staff were to ask the resident if they required this apparel every shift. On an identified date, the RPN confirmed that the directions were not clear. The RPN reported that the question agitated the resident and that staff should not be asking the resident about the apparel since it was consistently refused. The plan of care was not based on an assessment of the resident and the needs and preferences of that resident.

B) A review of an identified resident's Minimum Data Set (MDS), with an identified date, indicated the resident demonstrated certain behaviors and that these behaviours occurred up to five days during the observation period. A review of the Resident Assessment Protocol (RAP) that was completed for this resident on an identified date, indicated that the home would care plan with the goal that the resident would show fewer episodes of the identified behaviors, through the next review date. A review of the resident's plan of care indicated that no interventions were in place to decrease the number of episodes during which the behaviors were demonstrated. An interview with the Resident Assessment Instrument Coordinator (RAI Coordinator) confirmed that the resident's plan of care had not contained interventions to decrease the number of episodes and that the plan of care was not based on an assessment of the resident and the resident's needs. [s. 6. (2)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The MDS quarterly assessment completed on an identified date, for an identified resident, indicated the resident frequently demonstrated identified symptoms; however, the corresponding RAP indicated that the resident occasionally demonstrated the

identified symptoms. The RPN confirmed on an identified date that the assessments were not integrated, consistent with or complement each other. [s. 6. (4) (a)]

4. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A review of an identified resident's clinical record indicated that on an identified date, the resident had a fall that resulted in a fracture. A review of the Minimum Data Set (MDS) that was completed on an identified date as a result of a significant change in the resident's status, indicated that for walking in their room, the resident required extensive assistance of two or more persons for physical assist. A review of the resident's written plan of care indicated under locomotion and on an identified date, that the resident required one staff assistance when they walked in their room. An interview with the DOC confirmed that staff had not collaborated in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent and complemented each other. [s. 6. (4) (b)]

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

A review of an identified resident's clinical record indicated that the resident sustained a fall on on an identified date. A review of the Risk Management tool that the home uses to record resident falls was completed for this fall and indicated that a predisposing factor to this fall was that the call bell was not in the resident's reach at the time of their fall. A review of the resident's written plan of care on an identified date, indicated under the falls focus, that the resident's call bell was to be within reach. This intervention was initiated prior to the fall. An interview with the DOC confirmed that the care set out in the resident's plan of care was not provided to the resident as specified in their plan. [s. 6. (7)]

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

An identified resident was noted to have a decline in activities of daily living (ADL's) according to the MDS assessments in on two identified dates; however, the resident was

not reassessed and the care plan reviewed and revised when care needs changed. The ADOC confirmed on an identified date that the resident was not assessed and the plan of care was not updated to reflect the decline in ADL's. [s. 6. (10) (b)]

7. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A) A review of an identified resident's clinical record indicated that the resident sustained a fall on an identified date, when they self-transferred themselves from their chair. A review of the resident's written plan of care, indicated under the falls focus that staff were to reinforce the need for the resident to call for assistance and to not try to transfer themselves. An interview with the DOC confirmed that the resident had not called for assistance; did transfer themselves and that the resident was no longer capable of performing the intervention of calling for assistance and not trying to transfer themselves and that the home did not review and revise the residents plan of care when care was no longer effective.

B) A review of an identified resident's clinical record indicated that the resident sustained two falls on an identified date, when they attempted to self-transfer themselves. A review of the resident's current written plan of care indicated under the falls focus, that staff were to reinforce the need for the resident to call for assistance and to encourage the resident to call for assistance. An interview with the DOC confirmed that the resident had not called for assistance prior to these falls; was no longer capable of performing the intervention of calling for assistance and that the home did not review and revise the resident's plan of care when the care was no longer effective. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care:
1. sets out clear directions to staff and others who provide direct care to the resident
2. is based on an assessment of the resident and the resident's needs and preferences
3. demonstrates that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
4. demonstrates that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other,
5. demonstrates that the care set out in the plan of care is provided to the resident as specified in the plan,
6. demonstrates that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or the care set out in the plan is not effective, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) Policy 04.01.05 'Changes in Weight/Weighing Procedures' was not followed. The policy indicated that an unplanned weight change would be investigated by the Registered Dietitian. All residents would be weighed monthly as per nursing policy and a referral would be made to the registered dietician for residents with unplanned weight loss or inappropriate weight gain.
At the time of the inspection, the home was completing weekly weights for all residents and these weight changes were not being assessed by the Registered Dietitian. As confirmed with the Registered Dietitian and Director of Care, the policy was not being followed. (156)

B) A review of the home's policy, 'Falls' (03.10 and dated October 4, 2007), indicated the following:

i) Nursing staff would complete a fall-risk assessment on admission, every 3 months, following a fall with injury, or if there had been 2 falls within 30 days.

A review of an identified resident's clinical record for a particular period of time, indicated that the resident did not have a fall- risk assessment completed every three months. An interview with the DOC confirmed that the fall-risk assessment had not been completed for this resident every three months and that the home did not comply with their policy.

ii) The interdisciplinary team will: consider the use of hip protectors/helmet to reduce fractures.

A review of the clinical record's for four identified residents indicated that they had sustained falls and were at risk for falling. A further review of these resident's clinical record's indicated that no consideration to the use of hip protectors/helmet to reduce fractures was noted. An interview with the DOC confirmed that the home had not considered these interventions for the identified resident's and that their policy was not complied with. (214)

iii) Under the title, Environmental Considerations, the home's policy indicated that the interdisciplinary team would place an "at risk" indicator (for risk of fall) at the bedside. An

interview with the DOC confirmed that the home did not place an "at risk" indicator at bedside of four identified residents and that the home did not comply with their policy.

iv) Under the title, Environmental Considerations, the home's policy indicated that the interdisciplinary team would perform environmental rounds to promote safe environment and that the form titled, "APPENDIX E: Environmental Hazards Checklist", would be completed. An interview with the DOC confirmed that the Environmental Hazards Checklist was not completed and that the home did not comply with their policy. (214)

C) A review of the home's policy, "Head Injury" (03.09 and dated with a revision date of January 2015) indicated the following:

The Neurological Observation Record would be implemented for all suspected or confirmed head injuries and that the frequency of neurological vitals would be taken as follows:
-q. (every) 30 minutes x 3 hours, and if stable (6x)
-q. (every) 2 hours x 21 hours, and if stable (10x)
-q. (every) 1 hour x 4 hours, and if stable (4x)
-q. (every) 8 hours for 24 hours
-for total of 48 hours or as specifically ordered by the physician.

A review of the clinical records for two identified residents indicated that they sustained a fall on identified dates. Neurological Observation records were implemented for both residents. A review of the Neurological Observation Records indicated that the documents did not have the q. (every) 1 hour x 4 hour intervals listed on these records. An interview with the DOC confirmed that the neurological vitals had not been taken every hour for four hours and that the home did not comply with their policy. [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:
1) all residents shall be weighed monthly and a referral made to the registered dietician for residents with unplanned weight loss or inappropriate weight gain, as set out in policy #04.01.05.
2) risk assessments for falls and interventions to minimize risk for falls will be completed in a manner consistent with the home's policy #03.10
3) "At Risk" (for falls) indicators will be placed at residents bedsides as directed by the homes policy #03.10.
4) An interdisciplinary team will undertake environmental rounds and complete the Environmental Hazards Checklist as set out in policy #03.10.
5) Neurological assessments will be initiated and completed as set out in policy #03.09., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) An interview with the DOC confirmed that the home had not completed an annual program evaluation for their Fall Prevention and Management program in 2014. (214)

B) An interview with the DOC and ADOC confirmed that the home had not completed an annual program evaluation for their Continence Care and Bowel Management program in 2014. (156)

C) An interview with the DOC confirmed that the home had not completed an annual program evaluation for their Skin and Wound program in 2014. (510) [s. 30. (1) 4.]

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

A) A review of an identified resident's written plan of care dated February 13, 2015, indicated under the falls focus that the resident was to be checked every 1 hour to ensure safety. An interview with front line staff and the DOC confirmed that the resident was checked hourly. However, the home does not have a process to document the safety checks, and the hourly checks had not been documented.

B) A review of an identified resident's clinical record indicated that the resident sustained a fall on an identified date and that the resident stated they had hit their head. Following the resident's fall, the home implemented the Neurological Observation Record and was required to obtain and document neurological vital signs at set intervals onto this record. A review of this document indicated that at identified dates and times, no documentation of the resident's vital sign(s) were recorded. An interview with the DOC confirmed that the information above had not been documented as required.

C) A review of an identified resident's written plan of care indicated under the falls focus that the resident was to be checked every 1 hour to ensure safety. An interview with front line staff and the DOC confirmed that the resident was checked hourly; however, the home did not have a process to document the safety checks and that the hourly checks, had not been documented

D) A review of an identified resident's clinical record indicated that the resident had a fall on an identified date, sustained a head injury and subsequently, passed away. A review of the resident's written plan of care, indicated under the falls focus that the resident was to be checked every 1 hour to ensure safety. An interview with the DOC confirmed that the resident was checked hourly; however, the home did not have a process to document the safety checks and the hourly checks, had not been documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
1) in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, the licensee shall keep a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
2) resident assessments, reassessments, interventions and resident responses to interventions are documented., to be implemented voluntarily.

WN #4: 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 did not ensure that residents with the following weight changes were 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 their health status.

At the time of the inspection, the home was weighing and recording residents twice weekly making it difficult to ascertain which weights to use for assessment and often there were large weight discrepancies during the same week which were not assessed.
A) An identified resident had weights recorded over an identified period of time and demonstrated weight changes of 10.9 % and 14.7% in one month. The RD and Nutrition Manager confirmed these weight changes were not assessed using an interdisciplinary approach, actions were not taken and outcomes were not evaluated.

B) An identified resident had a weight change of 6.7% in one month. This weight change was not assessed using an interdisciplinary approach and actions were not taken and outcomes evaluated as confirmed with the RD and Nutrition Manager on February 27, 2015. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with the weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that 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 times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
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. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received, as a condition to continuing to have contact with residents, annual retraining in accordance to O. Reg. 79/10, s. 219(1) in the area of falls prevention and management and continence care and bowel management in accordance with O. Reg. 79/10, s. 221(1)1, in relation to the following: [76(7)6]

A) An interview with the DOC and the ADOC confirmed that the home only provided annual retraining in the area of lift and transfer training to direct care staff and had not provided annual retraining in the area of falls prevention and management in 2014. (214)

B) An interview with the DOC and the ADOC confirmed that the home only provided product assessment and management to direct care staff and had not provided annual retraining in the area of continence care and bowel management in 2014. (156) [s. 76. (7) 6.]

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 all staff who provide direct care to the residents receive, as a condition to continuing to have contact with residents, annual retraining in the area of all required programs, including falls prevention and management and continence care and bowel management, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed for cleaning and disinfection of resident care devices such as bed pans and wash basins in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices.

During a tour of 4 soiled utility rooms in the home, domestic style dishwashers were observed in all but one of the utility rooms. Disinfectant product was available in 2 of the

3 utility rooms. No instructions were posted in these rooms to determine when the disinfectant product and the machines were to be used, for what purposes, how and by whom. In the 4th utility room, a personal care device washer-disinfector machine was observed and tested. Only photos were located in the room as to how to load the machine.

According to the Infection Control Designate (ICD), no written procedures had been developed to guide staff as to where, when and how to clean and disinfect personal care devices between use. Written information that was available included instructions from the manufacturer for the washer-disinfector machine. The ICD was not aware if staff used the dishwashers but stated that the expectation was that staff clean wash basins in place (in resident's washroom) followed by the application of a "hand sanitizer" containing ethanol as the active ingredient. The ICD reported that the Triad product was not used as it left a residue on the surface of wash basins that caused irritation to residents' skin and eyes. No written instructions were made available to staff for the expected practice.

Evidence-based practices or best practices developed by the Provincial Infectious Diseases Advisory Committee titled "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, May 2013" stipulates on page 26 that non-critical personal care devices that are re-useable and do not come into direct contact with mucous membranes be cleaned followed by low level disinfection. A low level disinfectant does not include any product identified as a "hand sanitizer" and where the manufacturer does not specify that the product can be used on hard surfaces. Pages 33, 36 and 72 of the document identify acceptable low level disinfectants as those with a Drug Identification Number (DIN) and that those contain either 3% hydrogen, 0.5% enhanced action formulation hydrogen peroxide, diluted sodium hypochlorite, quaternary ammonium compounds, phenolics and 65-90% alcohol. Although the hand sanitizer used by the licensee included 70% ethanol (alcohol) as the active ingredient, it is not an appropriate disinfectant to be used on hard surfaces in accordance with evidence-based practices. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed for cleaning and disinfection of resident care devices such as bed pans and wash basins in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 11. Every resident has the right to, iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

On an identified date, at the morning medication pass, registered staff was observed to discard medication wrappers in the general garbage. Registered staff confirmed that medication packages, which contained residents' names and medication regimes, were discarded with the general garbage and not disposed of in a manner which would ensure that the residents' personal health information was protected. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to stairways and to unsecured outdoor areas of the home were equipped with an audible alarm.

Doors tested included stairwell 1C, 1E, 2A and 2B and the front main entrance doors. Doors 1C, 2A and 2B were held open for 30 seconds until they sounded at the nurse's stations and during this time period, did not alarm at the door (or keypad). The main front doors were held open longer than 60 seconds and did not alarm. Other stairwell doors were not tested. [s. 9. (1)]

WN #9: 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 did not ensure that all furnishings and equipment were maintained in a good state of repair.

A) Tub lift seat surfaces in identified areas were worn down to a porous layer, no longer in a state or condition to allow for adequate cleaning and removal of bacteria. Although the lifts were part of a preventive maintenance program completed by an external contractor on a yearly basis, more frequent internal monitoring was not in place. The Environmental Services Supervisor, Director of Care or Infection Control Designate were not aware of the condition of the seats.

B) A white laminated cabinet with multiple shelves on wheels was observed next to the tub in the Harbour Lane tub room. It was not in a good state of repair as the laminated layer along the edges had worn away, exposing rough particle board on the top surface and each of the shelves below. [s. 15. (2) (c)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) During stage 1 RQI, the bed of an identified resident was observed to have two 1/4 rails in the up position. Review of the document the home refers to as the care plan directed that the resident required 1/4 bed rails up, while in bed.
Registered staff confirmed there was no bed rail assessment completed and that they are unfamiliar with the requirement to complete a bed rail assessment. The DOC confirmed bed rail assessment was not completed.

B) During stage 1 RQI, the bed of an identified resident was observed to have two 1/2 rails in the up position. Review of the document the home referred to as the care plan directed that the resident required two half bed rails up during days, evenings and nights for independence with bed mobility. Registered staff confirmed there was no bed rail assessment completed and that they are unfamiliar with the requirement to complete a bed rail assessment. The DOC confirmed bed rail assessments were not completed.

C) During stage 1 RQI, the bed of an identified resident was observed to have to two 1/2 rails in the up position. Review of the document the home referred to as the care plan directed that the resident required two half bed rails up during days, evenings and nights for independence with bed mobility. Registered staff confirmed there was no bed rail assessment completed because the bed rails were not restraints. This was also confirmed by the RAI coordinator. The DOC confirmed bed rail assessments were not completed. [s. 15. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that applied was titled "In all other areas of the home". A hand held light meter was used (Sekonic Handi Lumi) to measure the lux levels in the shower areas of each of the home area shower rooms as they appeared dark. Directly under the round light covered with an opaque lens was 100 lux. The surrounding area where residents were normally showered dropped below 100 lux. The minimum required level is 215.28 lux. [s. 18.]

WN #12: 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,
(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 the resident who is 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, and

An identified resident had altered skin integrity to an identified area. The document the home referred to as the care plan directed staff to turn and reposition the resident every hour when up in the wheel chair. At an identified time and date, the resident was observed sitting in a Broda chair. Registered staff reported they had been in the Broda chair for an identified time frame. PSW staff reported the resident had not been repositioned while up in the chair. [s. 50. (2) (d)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The admission assessment minimum data set (MDS) completed for an identified resident on an identified date, indicated that the resident was usually continent of bladder. The quarterly review assessment MDS completed for this resident on an identified date, indicated that the resident was occasionally incontinent of bladder. The ADOC confirmed that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for continence, when the resident's continence status had changed. [s. 51. (2) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

A) During the observed lunch meal on an identified date:
i) the menu indicated that peach slices and strawberry ice cream were to be provided for dessert. Residents on thickened fluids would be offered pudding cups in place of the strawberry ice cream as an alternate dessert. On the day of observation, there was only one choice of dessert (peaches) for those on thickened fluids as the pudding cups were not available. This was confirmed with the dietary aide.
ii) the menu indicated that pineapple juice was to be provided. During the observed lunch meal, it was noted that a beverage on the tables had separated liquids. The inspector asked what the beverage was and the dietary aide reported that it was cranberry juice mixed with pineapple juice. The dietary aide reported that there was leftover cranberry juice that was used up and mixed with the pineapple juice. The two liquids were separated and not observed to be stirred prior to consumption by the residents. The menu was not followed as pineapple juice was not provided to the residents during the observed meal.

B) On an identified date, the serving of breakfast was observed on Harbour Lane home area. The posted daily menu identified that pineapple juice would be served. The dietary aide confirmed that orange juice was being served as the menu she was working from indicated orange juice. The dietary manager confirmed that the menu the dietary aide was working from identified orange juice and that this was an error. The planned menu item was not offered or available. (510) [s. 71. (4)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

During the observed lunch observation on an identified date, meals were not served course by course.
A) Five identified residents had dessert on the table while being fed the entrée. The plans of care for these residents did not indicate that the residents had been assessed as requiring meal courses to be served at the same time.
B) Two identified residents had the dessert on the table while the residents were eating the entrée. The plans of care for these residents did not indicate that the residents had been assessed as requiring meal courses to be served at the same time.
C) An identified resident was slowly eating their entrée. A PSW was feeding the resident dessert at the same time. The plan of care for this resident did not indicate that the resident had been assessed as requiring meal courses to be served at the same time. [s. 73. (1) 8.]

2. The licensee failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

During the observed lunch observation on an identified date and home area, a staff

member was observed assisting four residents who required total assistance with eating and drinking at the same time.
One identified resident was given the entrée after the table mate was almost finished. The resident required total assistance with eating and was fed by a staff member. The plan of care for this resident indicated that the resident required extensive assistance and total assistance when the resident was lethargic. On the day of observation, the resident required total assistance. The table mate, fed them self the entrée; however, required assistance with drinking. The staff member assisted the resident with drinking. The plan of care for this resident indicated that the resident required supervision in eating; however, on the day of observation, the resident required assistance with drinking.
Two identified residents at the neighbouring table received total assistance in eating by the same staff member at the same time. The staff member wheeled the stool from one table to the other to assist the four residents. The plan of care for one identified resident indicated that the resident required extensive assistance and staff may need to feed the resident the entire meal. The plan of care for another identified resident indicated that the resident required extensive assistance and would often require a total feed. On the day of observation, both of these residents required total assistance in eating.
The staff member did not assist only one or two residents at the same time who need total assistance with eating or drinking. [s. 73. (2) (a)]

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

An identified resident was observed being served the lunch meal on an identified date; however, the resident was not provided with assistance in eating. The meal sat on the table for over ten minutes until a staff member was available to provide assistance to the resident. [s. 73. (2) (b)]

WN #16: 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 an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act was reported to the Director immediately r. 107. (1)

On an identified date, Public Health declared a respiratory outbreak at the Home.
On another identified date, the Critical Incident Report was submitted to the Director .
This was confirmed by the Assistant Director of Care (ADOC).
An outbreak of a reportable disease was not reported immediately. [s. 107. (1)]

Issued on this 24th day of June, 2015

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

Original report signed by the inspector.