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

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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 11, 2014	2014_199161_0019	O-000809-14	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF RENFREW
9 INTERNATIONAL DRIVE, PEMBROKE, ON, K8A-6W5

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

MIRAMICHI LODGE
725 Pembroke Street West, PEMBROKE, ON, K8A-8S6

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

KATHLEEN SMID (161), AMBER MOASE (541), JESSICA LAPENSEE (133), MEGAN MACPHAIL (551), WENDY PATTERSON (556)

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): August 25 - 29, 2014 and September 2 - 5, 2014.

During the course of the inspection, the inspector(s)conducted two critical incident inspections log #O-000659-14, #O-000691-14.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Volunteers, Chair of Residents' Council, Chair of Family Council, Personal Support Workers (PSW), Dietary Aides, Housekeeping Aides, Maintenance staff member, Registered Nurses (RN), Registered Practical Nurses (RPN), Environmental Service Supervisor (ESS), Dietitian, Food Service Supervisor, Resident Care Coordinator (RCC), RAI MDS Coordinator, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed three medication passes, observed 5 meal services, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a physician, or registered nurse in the extended class has ordered or approved the restraining of Resident #003.

Resident #003 was identified during stage 1 of the Resident Quality Inspection to have 2 full side rails in place while in bed. A review of Resident #003's health care record indicates there is a written care plan dated August 2014 indicating that the resident is to have two side rails while in bed as a restraint.

On August 28, 2014, the Director of Care was asked by Inspector #541 to provide a record of the physician's order for resident #003's restraint. The DOC stated that the physician's order for this restraint was supposed to be written yesterday however the message was not communicated and that the home would try to obtain this order today. The DOC stated that there is supposed to be a physician's order for every restraint. [s. 31. (2) 4.]

2. The licensee has failed to ensure that the restraint plan of care includes consent from Resident #003 for restraining by a physical device.

Resident #003's health care record indicates there is a written care plan dated August 2014 indicating that the resident is to have two side rails while in bed as a restraint. Resident #003 was observed by Inspector #541 on August 27, 2014 to have two side rails up while in bed.

A review of the homes policy entitled Resident Safety - Restraints: SOP # N-960 with

a revision date of July 8, 2014 states that prior to application of the restraint, informed consent must be obtained from the resident or substitute decision maker.

On August 28, 2014 Inspector #541 and the DOC could not locate a signed consent on Resident #003's health care record. On August 29, 2014 the DOC stated that as of today there is a signed consent for the use of 2 side rails as a restraint for Resident #003. The DOC stated that there is supposed to be a signed consent for every restraint. [s. 31. (2) 5.]

3. The licensee has Failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision maker of the resident with authority to give that consent.

The plan of care for Resident #002 indicates that a lap belt is to be used as necessary when the Resident is up in their wheelchair or gerichair for safety and to prevent the risk of falls.

A review of the homes policy entitled Resident Safety - Restraints: SOP # N-960 with a revision date of July 8, 2014 states that prior to application of the restraint, informed consent must be obtained from the resident or substitute decision maker.

On September 4, 5, 2014 Inspector #161 observed Resident #002 in their wheelchair with a lap belt applied. Inspector #161 spoke to the Resident on three occasions, as well as Resident Care Coordinator #S112 and confirmed that Resident #002 is not able to physically and cognitively able to remove the lap belt. The purpose of the lap belt was confirmed to be used for both safety and positioning. The lap belt is therefore, defined as a restraint under section 31 of the Act.

A review of Resident #002's health record demonstrated that their is no documented consent from the Resident or their Substitute Decision Maker. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a physician or registered nurse in the extended orders or approves the restraining, and the restraining of the resident has been consented to by the resident or a substitute decision maker for Resident #003 and Resident #002, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On August 28, 2014 in an interview resident #015 stated that she/he only receives one bath per week, but would certainly prefer two baths per week. #015 stated that the bath is scheduled for Wednesday and the resident likes to have it in the evening, however yesterday evening, Wednesday August 27th the staff were not able to provide a bath because they were too busy. #015 stated that she/he was not offered the opportunity to reschedule the missed bath. The documentation on Point of Care (POC) was reviewed and there was no documentation indicating why the resident did not receive the scheduled bath on August 27, 2014.

In an interview resident #016 stated that she/he had to stop having tub baths because the slings that are used to get her/him into the tub aren't big enough and they hurt her/him. #016 further stated that she/he has never been offered the option of having 2 baths a week, or the option of having a shower instead of a bath. #016 stated that

she/he is currently receiving bed baths but would prefer a tub bath or a shower twice a week if it could be accomplished without hurting her/him. A review of the documentation on POC for the task of bathing indicated that on Saturday August 9th, and 16th the activity of bathing did not occur. The Resident's health care record was reviewed and there was no documentation indicating that the resident had been offered a bath to make up for the baths that were missed, or indicating why the resident did not receive the scheduled baths on August 9th and 16th, 2014.

A review of the bath schedule on unit 3A was reviewed and it was noted that resident #009 was scheduled to have a bath every Sunday during the day shift, and Wednesday during the evening shift. A review of the resident's care plan indicated that #009 prefers a whirlpool tub bath 2X per week as per personal preference. A review of the documentation on POC for the task of bathing indicated that on Sunday August 24th the activity did not occur. There was no documentation indicating that the resident was offered a bath between Sunday and Wednesday to make up for the missed bath on Wednesday, or indicating why the resident did not receive the regularly scheduled bath on August 24th.

The bath schedule on unit 3A indicated that resident #010 was scheduled to have a bath every Sunday and Wednesday during the day shift. A review of the #010's care plan indicated that she/he prefers a whirlpool tub bath 2X per week as per personal preference. A review of the documentation on POC for the task of bathing indicated that on Sunday August 24th, and Wednesday August 27th the activity of bathing did not occur. #010's health care record was reviewed and there was no documentation indicating that the resident was offered a bath to make up for the missed baths, or indicating why the resident did not receive the regularly scheduled baths.

The bath schedule on unit 3A indicated that resident #011 was scheduled to have a bath every Sunday and Wednesday during the day shift. A review of the resident's care plan indicated that she/he prefers a whirlpool tub bath 2X per week as per personal preference. A review of the documentation on POC for the task of bathing indicated that on Sunday the 17th, and Sunday the 24th the task of bathing did not occur, and no documentation was completed on Wednesday August the 13th, 20th, or 27th indicating that the resident had received her/his bath as per the bath schedule. #011's health care record was reviewed and there was no documentation indicating that the resident was offered a bath to make up for the missed baths, or indicating why the resident did not receive the regularly scheduled baths.

A review of the bath schedule indicated that resident #012 was to receive a bath on Monday and Friday during the day shift. #012's care plan indicated that she/he prefers a whirlpool tub bath 2X per week as per personal preference. A review of the documentation on POC for the task of bathing indicated that the activity of bathing did not occur on Friday, August 1st or Monday, August 18th. The Resident's health care record was reviewed and there was no documentation indicating that the resident had been offered a bath to make up for the missed baths, or indicating why the resident did not receive the regularly scheduled baths.

A review of the bath schedule indicated that #013 was to receive a bath on Thursday during the day shift and Sunday during the evening shift. A review of the resident's care plan indicated that she/he prefers a whirlpool tub bath 2X per week as per personal preference. A review of the documentation on POC for the task of bathing indicated that the activity of bathing did not occur on Thursday July 31, and Sunday August 10, 2014. The Resident's health care record was reviewed and there was no documentation indicating that the resident had been offered a bath to make up for the missed baths, or indicating why the resident did not receive the regularly scheduled baths.

A review of the bath schedule indicated that #014 was to receive a bath on Monday and Thursday during the day shift. A review of the resident's care plan indicated that she/he prefers a whirlpool tub bath 2X per week as per personal preference. A review of the documentation on POC for the task of bathing indicated that the activity of bathing did not occur on Thursday July 31, and Monday Aug 18, 2014. The Resident's health care record was reviewed and there was no documentation indicating that the resident had been offered a bath to make up for the missed baths, or indicating why the resident did not receive the regularly scheduled baths.

In an interview the Resident Care Coordinator stated that residents' #009, #010, #011, #012, #013, #014, #015, #016 did not have a medical condition which contraindicated having a bath.

In an interview RPN #S108 stated that every time any unit in the home is short staffed the 7am-11am float shift from 3A is deployed to wherever they are short, leaving 3A short of staff, and that when that happens the residents on 3A don't get their regularly scheduled baths. #S108 further stated that when a resident's bath is missed the bath is not rescheduled and the resident has to wait until their next scheduled bath time to have a bath. As such, each resident of the home is not bathed, at a minimum, twice a

week. [s. 33. (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 Residents #009, #010, #011, #012, #013, #014, and #015 are bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that the planned menu options are offered and available to residents on unit 1A.

Resident home area 1A is a secure unit where twenty seven residents reside.

It was observed that none of the residents were offered a choice of entree and vegetable until Resident #018 and #021 were shown sample plates. By this time, all of the residents except for Resident #001 had been served their meals.

PSW, S #122 was interviewed and stated that her role was to serve the residents their meals. She was asked how she knew who to offer a choice to. This was discussed with other staff in the area, after which it was noted that staff proceeded to offer Resident #001 a choice of entree and vegetables, and residents were offered a choice of dessert. At lunch the following day, residents were offered a choice.

Food Service Worker, S #104 showed Inspector #551 the meal choices for puree which were chicken, mashed potatoes and mixed vegetables or a trepuree of beef, broccoli and mashed potatoes. There was only one serving of the trepuree. According to the Resident Diet List there are thirteen residents who consume puree texture at the dinner meal. [s. 71. (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 the planned menu items are offered and available at each meal to residents on unit 1A, to be implemented voluntarily.

WN #4: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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 :

The licensee failed to communicate the seven-day and daily menus to residents on a puree texture diet.

According to the Resident Diet List for an identified unit, there are ten residents who consume puree texture at all meals and four consume a combination of minced and pureed textures.

The regular texture seven-day and daily menus are posted outside of the dining room.

The Food Service Supervisor, S #125 was interviewed and stated that the puree menu does not follow the regular exactly. S #125 stated that the kitchen prepares one homemade puree entrée which follows the regular menu, and that the alternate puree option is a commercially prepared trepuree.

Three days of posted menu, production sheets and therapeutic spreadsheets were reviewed and the following differences between the regular and puree texture menus, that are not communicated to residents, were noted:

Monday, lunch, week 1:
- regular texture: bubbly baked fish, boiled potato and spinach salad with oranges
- puree texture: trepuree of white fish newburg, potato and broccoli

Monday, dinner, week 1:
- regular texture: corned beef salad plate with rye bread
- puree texture: Inspector #551 observed the option to be trepuree of beef, potato and broccoli

Tuesday, lunch, week 1:
- regular texture: hamburger on a bun with assorted salads
- puree texture: Inspector #161 observed the option to be trepuree of salmon

Tuesday, dinner, week 1:
- regular texture: pizza and caesar salad
- puree texture: trepuree macaroni and cheese

Wednesday, lunch, week 1:
- regular texture: beef and vegetable stir fry with rice
- puree texture: trepuree beef stroganoff

Wednesday, dinner, week 1:
- regular texture: egg salad sandwiches, cherry tomatoes
- puree texture: trepuree macaroni and cheese

The regular texture menu is communicated to the residents. As the puree menu does not follow the regular menu exactly, the seven day and daily menus are not communicated to residents who consume a puree texture diet. [s. 73. (1) 1.]

2. The licensee failed to ensure that residents are provided with the personal assistance and encouragement required to eat and drink as comfortably and independently as possible.

Meal service was observed on an identified unit at supper on August 25, 2014 and at lunch on August 26, 2014.

According to Resident #017's care plan, the resident is at high nutritional risk related to "variable appetite status due to cognitive decline". At dinner on August 25, 2014,

Resident #017 was served soup. Eight minutes later, the soup was removed from the table. It was noted that this resident had eaten some of the broth and had not been cued or encouraged to eat her/his soup. Resident #017 was served a half sandwich and two chicken nuggets. Approximately thirteen minutes later her/his plate was removed from the table. Resident #017 had consumed one quarter of a sandwich and one chicken nugget and had not been encouraged to eat her/his main course.

At lunch the following day, Resident #017 was observed and the following was noted:
- at 12:06, Resident #017 was served her/his meal.
- at 12:13: Resident #017 had eaten 1-2 bites of salad.
- at 12:14: Resident #017 had fallen asleep and was slouched over in chair. The resident awoke approximately four to five minutes later.
- at 12:20: Resident #017 was given a cup of tea but was not cued or encouraged to eat her/his meal.
- at 12:27: Resident #017 had eaten 1/4 of the hamburger and bites of salad.
- at 12:45: Resident #017 walked away from the table and had consumed 1/4of the hamburger, bites salad, 1/4 glass of juice and 1/4 cup of tea. The resident's plate was removed from the table.

Between being served her/his main course and leaving the dining room approximately forty minutes later, Resident #017 was not cued or encouraged to eat or drink.

According to Resident #018's care plan, the resident is at moderate nutritional risk and has diabetes. At dinner on August 25, 2014, Resident #018 was served her/his meal. Eleven minutes later, it was noted that the resident had eaten the potatoes and taken one bite of vegetables. The resident was not cued or encouraged to eat her main course.

According to Resident #023's care plan, he/she is at high nutritional risk. At lunch on August 26, 2014 at 12:17 Resident #023 was given a beverage and drank half with the assistance of a PSW. The staff member then pushed the beverage out of Resident #023's reach. Resident #023 was observed to reach for the beverage and put an empty spoon in his/her mouth. At 12:31, S #123 sat and assisted the resident to complete his meal. Resident #023 was then observed looking at chocolate milk and cranberry juice that are in front of him/her but not within reach and to be moaning audibly. The resident was not offered a drink of his beverage until 12:56.

At lunch on August 26, 2014, Resident #020 was served his/her meal at 12:26 and did

not attempt to feed himself/herself. Seven minutes later, S #123 sat and assisted the resident to eat. At 12:41 it was noted that the resident had completed half of the meal and that S#123 had left the table. Eight minutes later S#123 reheated the resident's meal and sat to assist the resident. [s. 73. (1) 9.]

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 on an identified unit are provided with the encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

On a date in August 2014 a contact precaution sign was observed outside an identified room stating hand hygiene before and after entering the room, gloves and long sleeve gown for providing direct care.

Resident #022 resides in the identified room and a review was conducted of the resident's care plan which indicated an infection and staff were to follow P/P for universal precautions while rendering care.

On a date in September 2014 Inspector #556 observed PSW #S128 enter #022's room at 8:28am carrying face cloth and towels, and putting on disposable gloves as she went into the identified room. #S128 did not perform hand hygiene before entering the room, nor did she take a gown into the room with her. At 8:31am PSW #S127 entered the identified room without performing hand hygiene, and putting on disposable gloves as she was going through the door. #S139 did not put on a gown or take a gown into the room with her. When the door opened neither PSW was observed to be wearing a gown.

In an interview PSW #S128 stated that peri care was provided to the resident, a clean continence product was applied, and mouth care was provided to #022.

When the PSW's left the room, #S128 did not perform hand hygiene.

An inspection of the PPE cart outside the resident's room was conducted and gowns were present in the drawer of the cart.

At 1:05pm in an interview #S128 stated that she did not use a gown when providing morning care to resident #022 but she should have.

On a date in September 2014 at 8:42am PSW #S127 was observed by Inspector #556 wearing disposable gloves while pushing #025's wheelchair in the hall toward the dining room.

On a date in August 2014 at 3:26pm a contact precaution sign was observed outside an identified room stating hand hygiene before and after entering the room, gloves and long sleeve gown for providing direct care.

Resident #026 resides in the identified room and a review was conducted of the resident's care plan which indicated an infection and that staff were to follow P/P for Universal precautions while rendering care.

On a date in August 2014 at approximately 3:30pm Inspector #556 observed 2 PSW's in the identified with the resident, one PSW was positioned on either side of the bed and the resident was uncovered exposing the resident's brief.

In an interview after exiting the resident's room PSW #S130, and #S131 both stated they wear gloves when providing care to #026.

In an interview the Resident Care Coordinator (RCC) who is the Infection Control Lead in the home stated that mandatory infection control training is done annually and all staff are required to review the policies on hand hygiene, cleaning and disinfecting, use of PPE, and modes of transmission. The RCC reviewed the results of the mandatory training and determine that #S127, #S128, #S130, and #S131 all completed the training in 2014.

The RCC stated that it is not acceptable for staff to be pushing a wheelchair in the hall while still wearing gloves. She further stated the staff should be taking the gloves off as soon as they are finished providing care to the resident. The RCC also stated that getting a resident up out of bed and in and out of the chair is considered direct care and it is expected that the staff will wear gowns and gloves when a resident's condition requires contact precautions to be in place. [s. 229. (4)]

2. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On an identified unit, meal service was observed at supper on August 25, 2014 and at lunch on August 26, 2014.

S #129 was interviewed and stated that at meal time one PSW is assigned to serve residents and clear their tables between courses.

Throughout the dinner meal on August 25, 2014, S #122 was observed to be clearing used dishes and cups and using soiled utensils to scrape the plate. No hand hygiene in between completing these tasks and serving residents food was observed. S #122 was observed to have picked up used glasses by the lip and not wash her hands. She then unwrapped a sandwich, picked it up with her hand and placed it into Resident #024's hand.

Throughout the lunch meal on August 26, 2014, S #129 was observed to be clearing used dishes and cups and using soiled utensils to scrape the plate. No and hygiene in between completing these tasks and serving residents food was observed. S #129 was observed to scrape plates and not wash her hands. She then opened the

packaging of Resident # 021's ice cream bar and placed it in the resident's hand. [s. 229. (4)]

3. The licensee failed to ensure that all staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On September 4, 2014 the Resident Care Coordinator (RCC), who is the Infection Control Lead in the home, provided Inspector #556 with proof of tuberculosis screening for 2 out of 3 staff who were hired in the previous 12 months. The RCC stated that tuberculosis screening was not conducted on a staff member who was hired in May 2014. The RCC further stated that the home missed screening the staff member when that department was being covered by a temporary manager. [s. 229. (10) 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 staff participation in the implementation of the infection prevention and control program is monitored to ensure compliance on the identified units, to be implemented voluntarily.

WN #6: 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. (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 has failed to ensure that Resident #002 is reassessed and the plan of care reviewed and revised when the resident's care needs change.

On a date in August 2014 Resident #002 fell and sustained a two fractures. The Resident was sent to hospital and returned to the home several days later in August 2014. The Physician's orders indicated that the resident was non-weight bearing for 6 weeks.

On the morning of a date in August 2014, Resident #002's plan of care was reviewed by Inspector #161. The Resident's plan of care did not reflect the changes in the Resident's medical condition, ambulation, bed mobility, transfers, toileting, risk of falls, and pain status.

This was confirmed by Resident Care Coordinator #S112 [s. 6. (10) (b)]

WN #7: 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 comply with O. Reg. 79/10 s.8 (1)(b) 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 to be complied with, in that the home failed to ensure compliance with the following policy.

As per O.Reg79/10, 52(1) the licensee's pain management program must, at a minimum, provide for the following:

1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures.
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Review of the home's policy titled Pain Assessment and Management in the Older Adult ICPG-007 issue date July 2013 provided by Resident Care Coordinator #S112 was reviewed by Inspectors #161 and # 601. The policy indicates that Registered Nurses will do the following:

1. Ensure initial pain assessment is completed using the Pain Assessment and Management Flow Map: upon return from hospital, initiation of analgesic, new on-set of pain, diagnosis of painful disease, receiving pain medication for greater than 72 hours.
2. Assess/re-assess resident's pain management weekly.
3. Appropriate documentation of pain assessments.
4. Assess pain daily and ensure this is documented in the Pain Management flow chart and in Point Click Care.
5. Ensure that non-pharmacological interventions are also used to manage pain.

On a date in August 2014 Resident #002 fell and sustained two fractures. The Resident was sent to hospital and returned to the home several days later in August 2014. The Physician's orders indicated that the resident was non-weight bearing for 6 weeks and to receive an opoid every 4 hours when required; and Acetaminophen 500 mg every six hours when required. Inspectors #161 and #601 reviewed Resident # 002's health care record from the date in August 2014 when the Resident returned to the home until September 4, 2014. The following were noted:

There was no documentation in Resident #002's health care record of the following:
1. An initial pain assessment completed using the Pain Assessment and Management Flow Map: upon return from hospital, new on-set of pain, and the diagnosis of painful disease,
2. A weekly assessment/re-assess the Resident's pain management,
3. Documents pain assessment appropriately on the Pain Management Flow record,
4. Daily pain assessments documented in the Pain Management flow chart and in

Point Click Care,
5. That non-pharmacological interventions were also used to manage pain.

This was confirmed by Resident Care Coordinator #S112 [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Concerns were raised during Stage 1 of the Resident Quality Inspection, on August 26th, 2014, during a family interview, related to low ambient air temperatures, with a focus on areas in the 3A care unit.

On September 2, 2014, Inspector #133 met with the Environmental Services Supervisor (ESS) to discuss air temperatures in the home. The ESS informed that every morning, one of the maintenance workers takes air temperature and humidity readings. This is done within each of the 6 care units, mid-way down each of the two corridors within each care unit, and also within each care unit dining room and servery, for a total of 20 reading a day. The ESS explained that in an effort to manage humidity levels, air temperature levels throughout the home are kept low in the summer. The ESS, Inspector #133 and a maintenance worker who does the temperature and humidity monitoring, staff member #S135, looked at the most current documented temperatures together. It was noted that the vast majority of temperatures documented for August 31st, September 1st and September 2, 2014, were 21 degrees Celsius (21 C). Five documented temperatures were 20 C and two were 22 C.

The ESS, Inspector #133 and staff member #S135 proceeded to the 2A unit, A hallway (RHA2A-A), outside of bedroom #A211. Staff member #S135 demonstrated use of the temperature and humidity monitoring device. The monitoring device registered 21.4 C. Staff member #S135 explained that when he documents a temperature, he rounds up or down, and that he would document 21.4C as 21C. Staff

member #S135 agreed that 21 C is the typical temperature he finds in all areas monitored. The ESS, Inspector #133 and staff #S135 then proceeded to the end of the hallway, the temperature was measured at 21.7C, which would be recorded by staff #S135 as 22C.

Following this interaction, Inspector #133 proceeded to monitor temperatures in the following areas, with the following results:

RHA3A-A: outside of bedroom #311A – 21.4C
RHA3A – dining room: at table in centre of room – 21.4C
RHA1A – AA: outside of bedroom #140A – 21.4C
RHA2A – A: outside of A211 – 21.6C
RHA2A – A: end of hallway – 21.5C

Later that afternoon, on September 2, 2014, the ESS provided Inspector #133 with documented air temperatures for the weeks of July 27th, August 3rd, August 17th and August 24th, 2014. The majority of documented temperatures were 21C or 20C, depending on the week.

On September 3, 2014, Inspector #133 interviewed the family member who had raised the concern about ambient air temperatures within RHA3- A, which is a secured care unit. The family member informed that they visit every day, and said "my family member (resident #028) is always cold, and you only need look around to see all the residents in sweaters to know that people are cold here". The family member said that the care unit activity room seems to be the coldest area of the care unit.

Following this discussion, Inspector #133 proceeded to the RHA3A activity room and found the air temperature, taken at the center table, to be at 20.7 C. [s. 21.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to offer an annual dental assessment and other preventive dental services to residents.

The resident admission package was reviewed. In the Purchase Service Agreement there is a consent for Dental Hygiene Services.

RN, S #118 was interviewed and stated that if dental hygiene services were declined upon admission, residents are not re offered the service on a regular or annual basis. S #118 stated that she prints the consents to be reviewed at the annual care conference (ACC) and that a consent for dental assessment and other preventive services is not among them.

RPN, S #108 was interviewed and stated that she attends the scheduled ACCs. She stated that if the dental assessment and other preventive services were declined on admission that they were not re offered on an annual basis.

A Resident Care Coordinator, S #112 was interviewed and stated that an oral assessment is completed by the RN with the Minimum Data Set (MDS) assessment. She stated that residents are not offered a dental assessment and other preventive dental services on an annual basis. [s. 34. (1) (c)]

WN #10: 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 failed to ensure that each resident of the home has his or her personal items, including personal items labelled.

On August 27, 2014, Inspector #161 observed the following unlabelled items the Spa of unit 1A: a tube of lip stick, three combs with strands of hair, a hair brush, four sticks of roll on deodorant, two pairs of nail clippers with debris and two electric razors.

On August 27, 2014, Inspector #161 observed the following unlabelled items the Spa of unit 1B: three combs with strands of hair and a pair of nail clippers with debris.

On August 26, 2014, Inspector #551 observed the following unlabelled items in a washroom shared by residents in an identified room: a bottle of mouth wash, four toothbrushes, a hairbrush and hand towels.

On August 25, 2014, Inspector #551 observed the following unlabelled items in a washroom shared by residents in an identified room:: three pairs of nail clippers, two toothbrushes, a soap dish with a bar of soap, a hair brush and an tube of ointment.

On August 26, 2014, Inspector #551 observed the following unlabelled items in a washroom shared by residents in an identified room:: one toothbrush, a pair of nail clippers, a tube of lip stick, a bar of soap and three hand towels.

On August 26, 2014, Inspector #551 observed the following unlabelled items in a washroom shared by residents in an identified room: a stick of roll on antiperspirant, two loofahs and towels.

On August 25, 2014, Inspector #556 observed the following unlabelled items in a washroom shared by residents in an identified room: combs, a hairbrush, a safety razor and a soap dish with a bar of soap.

On August 26, 2914, Inspector # 556 observed the following unlabelled items in a washroom shared by residents in an identified room: a box of denture cleaner, a soap dish with a bar of soap and a pair of glasses.

On August 26, 2914, Inspector #556 observed the following unlabelled items in a washroom shared by residents in an identified room: a toothbrush, a comb, a soap dish with a bar of soap and a bottle of mouthwash with an upside down plastic cup over the lid .

On August 26, 2914, Inspector #556 observed the following unlabelled items in a washroom shared by residents in an identified room: a bottle of cologne, an electric razor, a tube of body lotion, a bottle of mouthwash, a bottle of shaving cream, a toothbrush, a stick of deodorant, a soap dish with a bar of soap, a comb and two safety razors.

On August 26, 2014, Inspector #541 observed the following unlabelled items in a washroom shared by residents in an identified room: two electric razors.

On September 4, 2014, the Resident Care Coordinator, S #112 was interviewed and stated that it was her expectation that all residents' personal care items be labelled.

On September 5, 2014, S #130 was interviewed and stated that the PSWs are expected to label all of the residents' personal care items in shared washrooms. She stated that the staff use a permanent marker and have a label maker for dentures and glasses. [s. 37. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On a date in June 2014 according to the progress notes on the health care record resident #027 was discovered on the floor in her/his bedroom with a large hematoma over the right eye. The resident was not able to follow directions, or answer questions. The home contacted the POA who decided not to have resident #027 transferred to the hospital.

Approximately 3 hours after the fall resident #027 was examined by the Nurse Practitioner who documented in the progress notes: "sig. head injury with developing hematoma, possible underlying skull or orbital fracture." The physician was contacted by the Nurse Practitioner and the Registered Nurse and "Comfort care measures were instituted, and orders were received for pain and, if needed, for agitation."

Inspector #556 reviewed the health care record for resident #027and noted that at the time of the fall the resident ambulated independently with the assistance of a walker, and had been assessed in February 2014 as being at moderate risk for falls and had safety interventions in place.

In an interview staff member #S137, who is a member of the home's falls committee, stated that anytime a resident falls the registered staff are to complete a risk management incident report which looks at where the fall happened, the resident's activity prior to the fall; a nursing description of what happened; a resident description of what happened; a description of the actions taken; any injuries sustained in the fall; environmental factors; physiological factors; and any predisposing situations. The incident report also documents any witnesses to the incident; actions such as contacting the family and the physician; any progress notes written about the fall; and any changes made to the care plan as a result of the fall.

Staff member #136, also a member of the home's falls committee, stated that the expectation is that a risk management incident report is to be completed after every fall, and the reports go to the Resident Care Coordinator (RCC), and to the Director of Care (DOC).

In an interview the Director of Care stated that for every resident fall the registered staff are expected to complete an internal resident incident report, which is what the home considers to be the post fall assessment. The DOC reviewed resident #027's health care record and was not able to locate a post fall assessment for the fall sustained by resident #027 on an identified date in June 2014. The DOC further stated that under the circumstances a post fall assessment should have been completed. He stated that a clinical assessment was completed but not an internal incident report/post fall assessment. As such when resident #027 sustained a fall on a date in June 2014, the licensee failed to ensure that a post-fall assessment was conducted. [Log #O-000691-14] [s. 49. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On August 27, 2014 discussion held with RCC #S112 and the DOC who indicated that Nursing Secretaries #S110 and #S111 have keys to the drug storage room on Unit C.

On August 27, 2014 Nursing Secretary #S110 indicated to Inspector #161 that both she and Nursing Secretary #S111 have keys to the drug storage room on Unit C. [s. 130. 2.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and a physician or a pharmacist.

Policy #P-025 titled "Medications – Removal from Supply/Discharged/Death/Discontinued" revised June 6, 2014 was provided to inspector #161 by Resident Care Coordinator (RCC) #S112. This policy indicates that narcotics that are to be destroyed and disposed of are taken to the Resident Care Coordinator to be secured until the Pharmacist removes them in a waste receptacle out of the home for destruction.

On August 27, 2014, RCC #S112 and the DOC indicated to inspector #161 that all controlled substances to be destroyed are removed from their original packing and

discarded into a specified waste receptacle by an RCC/DOC and the home's pharmacy service provider. The waste receptacle containing the controlled substances is sealed and subsequently taken from the home by the pharmacy service provider and brought to the pharmacy. The pharmacy has a contract with Stericycle Inc., which will destroy the controlled drugs.

The controlled substances are not destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and a physician or a pharmacist [s. 136. (3) (a)]

2. The licensee has failed to ensure that drugs must be destroyed by a team acting together and composed of, when the drug is not a controlled substance, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care. For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

Policy #P-025 titled "Medications – Removal from Supply/Discharged/Death/Discontinued" revised June 6, 2014 was provided to inspector #161 by Resident Care Coordinator (RCC) #S112. This policy indicates that all discontinued medications that are to be destroyed and disposed of are taken to the Resident Care Coordinator to be secured until the Pharmacist removes them in a waste receptacle out of the home for destruction.

On August 27, 2014, RCC #S112 and the DOC indicated to inspector #161 that all discontinued medications to be destroyed are removed from their original packing and discarded into a specified waste receptacle by an RCC/DOC and the home's pharmacy service provider. The waste receptacle containing the drugs to be destroyed is sealed and subsequently taken from the home by the pharmacy service provider and brought to the pharmacy. The pharmacy has a contract with Stericycle Inc., which will destroy the discarded drugs.

The drugs are not destroyed by a team acting together and composed of, when the drug is not a controlled substance, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care. [s. 136. (3) (b)]

Issued on this 11th day of September, 2014

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