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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 2014	2014_295556_0016	O-000274-14	Resident Quality Inspection

Licensee/Titulaire de permis

Kemptville District Hospital
2675 Concession Road, P.O. Bag 2007, KEMPTVILLE, ON, K0G-1J0

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

KEMPTVILLE DISTRICT HOSPITAL
2675 CONCESSION ROAD, P. O. BAG 2007, KEMPTVILLE, ON, K0G-1J0

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

WENDY PATTERSON (556), AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 30, May 1, 2, 5, 6, & 7, 2014 onsite

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (Administrator), Nursing Manager (Director of Care), Nutritional Manager/Registered Dietitian (NM/RD), Infection Control and Occupational Health Designate, Manager of Corporate Affairs and Operational Development, Activation Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers (FSW), and Residents.

During the course of the inspection, the inspector(s) reviewed resident health care records, the home's admission package, the infection control policies, the resident restraint policy, observed resident care areas, observed several meal services, observed medication administration, reviewed the planned menu cycle including both meals and snacks, diet list and associated information, activity calendar, observed resident to resident interaction, and staff to resident interaction.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 8 (1) (a) in that the licensee did not ensure that the policy to minimize the restraining of residents was in compliance with applicable requirements of the Act.

In accordance with section 29 (1) (a) of the Act and section 109 of the Regulations the home is required to have a written policy to minimize restraining of residents.

Inspector #556 requested the homes policy to minimize the restraining of residents and the Nursing Manager provided policy VII-20 entitled Least Restraint Last Resort with an approved date of March 2014.

The restraint policy was reviewed and the policy indicated that Registered Nurses are able to order approved physical and environmental restraints. In accordance with section 31 (2) 4 of the Act and 110 (2) 1 of the Regulations restraints are to be ordered or approved by a physician, or registered nurse in the extended class.

The restraint policy also indicated that in non-emergency situations the options of chemical least restraint initiatives are to be considered, however, in accordance with section 30 (1) 4. of the Act no resident is to be restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.

The restraint policy also indicated that four point restraints are available for use in the home, however, section 112 of the Regulations indicates that four point extremity restraints are a prohibited device. [s. 8. (1) (a)]

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 the homes policy related to minimizing of restraints is compliant with applicable requirements under the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and

whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

The licensee failed to comply with O.Reg 79/10, s. 26 (3) 2, 6, 13,14, 16, 21 and 22, whereby the licensee did not ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of those issues outlined in this provision.

The plan of care for an identified resident was reviewed. The plan of care does not include cognition ability, psychological well-being, nutrition and hydration status, activity patterns and pursuits, sleep patterns and preferences, cultural, spiritual and religious preferences and age related needs and preferences. The resident's health care record, including the Minimum Data Set (MDS) Assessment and progress notes, indicated that the resident was having difficulty dealing with his/her upcoming discharge to another facility, that the resident had risks related to nutritional care and occasional difficulty sleeping at night. These items have not been included in the resident's plan of care. [s. 26. (3)] (148)

2. The licensee failed to comply with O.Reg 79/10, s. 26 (4) (a) and (b), whereby the licensee did not ensure that the registered dietitian for the home completed a nutritional assessment for residents #701, #090, and #098 on admission and assessed matters related to nutritional status and any risks relating to nutritional status for residents #701 and #090.

An identified resident was recently admitted to the home in early 2014, the resident resides in a bed that the home has designated as convalescent care. A review of the resident's health care record demonstrated that no nutritional assessment had been completed by the home's registered dietitian, upon admission of this resident. On May 5, 2014 the home's NM/RD confirmed that a nutritional assessment had not been completed for this resident to date. The NM/RD further confirmed that she does not complete initial nutritional assessment for those residents residing in the 8 convalescent care beds.

During a review of the health care record for an identified resident, the Inspector found documentation to support that the resident required a low salt diet due to cardiac disease, as was indicated by the MDS Assessment on admission. Additionally, the

resident was noted to have a food allergy, as indicated by the document titled Individual Care Plan. As of May 5, 2014 the home's NM/RD had not assessed these two matters as it relates to the resident's nutritional status and risks related to nutritional status. During an interview with the home's NM/RD it was determined that the NM/RD was not aware of the resident's food allergy or need for a low salt diet. [s. 26. (4) (a),s. 26. (4) (b)]

3. Resident #090 was admitted to a Long Term Care interim bed on a specified date, and was identified during a resident quality inspection as having a low body mass index, and weight loss.

The resident's plan of care states that Resident #090 was at a potential for impaired nutritional status related to dementia as evidenced by missed meals.

A review of the progress notes indicates frequent refused meals and snacks dating back to the date of admission.

The health care record indicates that the resident was on a diabetic diet and had difficulty swallowing.

In an interview PSW #108 stated that Resident #090 often refused his/her meals but the staff made him/her food such as toast or yogurt to make up for the missed meals. PSW #108 also stated that many times the resident was up in the night and the staff would make food and offer it to the Resident.

In an interview the NM/RD stated that when he/she is involved in a resident's care he/she documents on the multi-disciplinary progress notes.

A review of the progress notes was conducted and there was no documentation completed by the NM/RD.

The NM/RD stated he/she has not been doing nutritional assessments for approximately six months because he/she is behind on his/her work and as a result has not completed an assessment on Resident #090. [s. 26. (4)]

4. The licensee has failed to ensure that an RD who is a member of the staff of the home completed a nutritional assessment of Resident #098 on admission.

Resident #098 was admitted to the home on a specified date with a diagnosis of weight loss not yet diagnosed, and dementia.

During a review of the multi-disciplinary progress notes since Resident #098's admission it was noted that there was no documentation in the progress notes by the NM/RD.

In an interview the NM/RD stated that he/she has not completed a nutritional assessment for Resident #098. [s. 26. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Registered Dietitian completes a nutritional assessment on all residents on admission, and assesses matters related to nutrition status and any risks relating to nutrition care, to be implemented voluntarily.

WN #3: 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 :

1. The licensee failed to comply with O.Reg 79/10, s.33, whereby the licensee did not 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.

A review of the Twice Weekly Skin Checklist for Resident #701 for March 2014 indicated the resident was provided one bath per week. The plan of care for this resident was reviewed and there was no indication that the resident was to be offered less than two baths a week.

Inspector #148 interviewed PSW staff member #104, who described the home's current bathing schedule to be as follows: Residents #098, #097, #249, #486 and #932 are scheduled for one bath a week; and Residents #701 and #797 are both scheduled for two baths a week, as per the residents' request. Staff member #104 indicated that residents are offered one bath a week and can have up to two baths a week if they request the second bath. The staff member noted that resident #701 was provided one bath a week up until recently when the resident requested to have two baths per 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 each resident of the home is bathed, at a minimum, twice a week by a method of his or her choice, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 71(1)(b), whereby the home did not ensure that the home's menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks.

On April 30, 2014, Inspector #148 observed the lunch meal service. It was determined that current residents of the home are provided with either a regular, diabetic or cardiac therapeutic diet; at the time of this inspection there were no residents requiring texture modification, although the home has provided texture modification to previous residents of the home. On May 1, 2014, Inspector #148 interviewed the home's NM/RD who indicated that there is a menu for the regular diet for both meals and snacks, however, a menu does not exist for the provision of the diabetic and cardiac therapeutic diets or for texture modification for both meals and snacks. In place of menus, the staff members implementing the diets, or texture modifications, reference the "Diet Cheat Sheets" which described allowable food and fluid items for each therapeutic diet or texture modification.

The home does not have a menu cycle that includes menus for regular, therapeutic and texture modified diets for both meals and snacks. [s. 71. (1) (b)]

2. The licensee failed to comply with O.Reg 79/10 71 (1)(c), whereby the licensee did not ensure that the menu cycle includes alternative choices of vegetable at the lunch meal.

Inspector #148 observed the lunch meal service on April 30, 2014, in which the following was offered to residents: green pea soup, egg salad sandwich with ceasar pasta salad with the alternative choice of chicken stew with a tea biscuit, coffee cake or alternative choice of mandarin oranges. During this meal observation the residents were not offered alternative choices of vegetables.

A review of the planned menu cycle confirmed that the lunch menu for April 30, 2014 (Week 3, Day 17) included the described items above, however, the planned menu did not include alternative choice of vegetable at this meal.

The Inspector reviewed the menu cycle for Week 3, which demonstrated that 4 out of 6 days, excluding the resident choice day, did not have a planned alternative choice of vegetable for the lunch meal.

Inspector #148 also interviewed Resident #701, who indicated that he/she did not feel the menu included enough fruits and vegetables. [s. 71. (1) (c)]

3. The licensee failed to comply with O.Reg 79/10, 71(1) (e), whereby the licensee did not ensure that the home's menu cycle, is approved by a registered dietitian who is a member of the staff of the home.

On May 1, 2014, Inspector #148 interviewed the home's NM/RD who indicated that the planned menu was reviewed by herself and a lead dietary staff member to ensure it is appropriate for both the residents of the long term care home unit and the hospital beds, as the menu serves both populations. An approval could not be provided to the inspector upon request. The NM/RD, who is the registered dietitian for the home, confirmed the menu cycle has not been approved. [s. 71. (1) (e)]

4. The licensee failed to comply with O.Reg 79/10, s.71(3)(b) and (c), whereby the licensee did not ensure that each resident was offered, at minimum, a between meal

beverage in the morning and afternoon and a snack in the afternoon.

Residents #486, #701 and #797 reported to the Inspectors that a beverage pass does not always occur in the morning and a beverage and snack pass does not always occur in the afternoon. Residents indicated that in the evening residents gather in the dining room after the supper meal, at which time a snack and beverage will be offered. The identified three resident's reported that during the day, there is no beverage or snack passes, rather a resident would need to ask for a drink or something to eat and it would be provided.

Over the course of this inspection, Inspector #148 observed beverage and snacks to be offered between meals to those residents in the dining room after an activity, such as the exercise class. On two separate afternoons, resident #097 and #098 were observed in their rooms and did not have a beverage or snack offered. The Inspectors did not observe staff to circulate the unit to ensure that all residents were offered a beverage in the morning and beverage/snack in the afternoon.

On May 1, 2014, Inspector #148 spoke with RPN staff member #103 and PSW staff member #102, who both reported that beverage and snack passes in the morning and afternoon are not completed every day for everyone as the passes have not always been successful in the past, both staff indicated that food and fluid will sit at the resident's bedside. PSW staff member #102, noted that she had provided cookies and juice to those resident who had participated in the exercise program that afternoon, but when asked by the Inspector she confirmed that a snack/beverage pass was not offered to those residents who did not participate. Both staff members indicated that the purpose of the convalescent care program that is being implemented for 8 of the 12 beds in this unit, is to encourage residents to mobilize and care for themselves and is also a reason that they do not offer the snack and beverage pass consistently throughout the day. On May 5, 2014, Inspector #148 spoke with PSW Staff member #104 who also reported that the home no longer offers beverage and snack passes between meals on a regular basis. Staff member #104 reported that it was previously a part of the program when all of the beds were "long term care" but since implementing the convalescent care beds the beverage and snack passes are not always completed.

On May 5, 2014, Inspector #148 spoke with the home's NM/RD who indicated that beverage and food items are provided to the unit for the purposes of the beverage and snack passes. She was not aware how the unit organizes the provision of the

beverage and snack passes but indicated that the expectation would be for all residents to be offered a beverage in the morning and beverage and snack in the afternoon. [s. 71. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle is approved by the Registered Dietitian, and that each resident is offered a minimum of between meal beverages in the morning, afternoon, and evening, and snack in the afternoon and evening, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (1) Every licensee of a long-term care home shall ensure that,
(a) a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted; 2007, c. 8, s. 78. (1).
(b) the package of information is made available to family members of residents and persons of importance to residents; 2007, c. 8, s. 78. (1).
(c) the package of information is revised as necessary; 2007, c. 8, s. 78. (1).
(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or substitute decision-maker of a resident; 2007, c. 8, s. 78. (1).
(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78. (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.78(1)(a), whereby the licensee did not ensure that a package of information that complies with this section was given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident was admitted.

In accordance with LTCHA, 2007 section 78 and O.Reg 79/10 section 224, the home shall provide each resident and substitute decision maker, if any, a package of information that includes the items described within the above provisions.

Inspector #148 interviewed the home's Nursing Manager related to the package of information that is to be provided to residents and substitute decision makers upon admission to the home. The Nursing Manager reported that during her time working with the long term care unit (January 2014) she is not aware of any resident or substitute decision maker receiving a package of information. The Nursing Manager noted that the accommodation agreement is reviewed and signed and items of interest are discussed verbally with the resident and/or substitute decision maker, but that no package of information is provided. This was further exampled, as the Nursing Manager confirmed that resident #701, admitted February 2014, had not been provided a package of information. [s. 78. (1) (a)]

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 package of information is provided to every resident and the substitute decision maker at the time of admission, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

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

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

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

Findings/Faits saillants :

The licensee has failed comply with O.Reg 79/10, s. 110. (2) 1. in that the licensee did not ensure that when Resident #468 was restrained in her/his wheel chair by a seat belt it was ordered or approved by a physician or registered nurse in the extended class.

Resident #468 was observed by Inspector #556 to be sitting in a wheel chair with a seat belt in place. The Resident stated that the staff put the seat belt on because they thought he/she was going to fall out of the chair. The Resident further stated he/she was not able to remove the seat belt due to lack of strength in his/her hands to open the buckle on the seat belt.

In an interview PSW staff member #104 stated that when the resident was admitted he/she was sliding forward in the wheel chair, which was reported to the Physiotherapist. The next time he/she came to work there was a seat belt on the resident's chair.

Following a review of the health care record it was noted that there was no documentation in the Physician's Orders indicating the Resident requires the use of a seat belt restraint. [s. 110. (2) 1.]

2. The licensee has failed to comply with O.Reg 79/10, s. 110. (7) 4. in that the licensee did not ensure that when Resident #468 was restrained in his/her wheel chair by a seat belt the documentation included consent for the use of a physical device to restrain.

While reviewing the resident's health care record it was noted that an unsigned consent for a restraint was attached to the front of the Resident's health care record waiting for the Substitute Decision Maker (SDM) to come to the home to sign. There was no documentation in the multi-disciplinary progress notes indicating that the Resident's SDM had been contacted to obtain consent for the use of a physical restraint.

In an interview the Nursing Manager stated that no verbal consent had been obtained from the SDM. [s. 110. (7) 4.]

3. The licensee has failed comply with O.Reg 79/10, s. 110. (7) 6. in that the licensee did not ensure that when Resident #468 was restrained by a physical device the documentation included all assessments, reassessments, and monitoring, including the resident's response.

Resident #468 was observed by Inspector #556 to be sitting in a wheel chair with a seat belt in place.

Following a review of the Resident's health care record it was determined that there was no documentation indicating that Resident #486 was assessed, reassessed, and monitored, including his/her response.

In an interview RPN staff member #107 stated that residents who are restrained are

monitored, assessed, and repositioned but the process is not currently being documented.

In an interview the Nursing Manager stated that up until now there has been no formal documentation of the assessment, reassessment, and monitoring process for residents using restraints. [s. 110. (7) 6.]

4. The licensee has failed comply with O.Reg 79/10, s. 110. (7) 7. in that the licensee did not ensure that when Resident #468 was restrained in his/her wheel chair by a seat belt the documentation included every release of the device and repositioning.

Following a review of the health care record it was determined that there was no documentation indicating that Resident #486 was released of the seat belt and repositioned.

In an interview PSW staff member #104 stated that currently she/he is not required to document the monitoring or repositioning of residents who are restrained.

In an interview the Nursing Manager stated that up until now there has been no formal documentation of the release and repositioning process for residents using restraints. [s. 110. (7) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff only apply a physical device as a restraint that has been ordered, or approved by a Physician or Registered Nurse in the extended class, and that consent, assessment, monitoring, and repositioning related to restraints are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.17(1)(a), whereby the licensee did not ensure that the home's resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

On April 30, 2014, Resident #932 was observed by Inspector #148, to be in the resident's bed with both side rails in the down position, the resident was awake and had just finished with a visitor. The Inspector observed that the cord attached to the resident-staff communication system was plugged into the bed, near the bottom of the head of bed. At this time the resident did not have access to the communication system, while lying in bed. PSW staff member #102, accompanied the Inspector to review the communication system in this resident's room. Staff member #102, described that the resident-staff communication system is accessible to the resident on a panel located on the resident's side rail. When the Inspector noted that both side rails were in the down position, staff member #102 indicated that she had put the rails down while the resident had visitors as the bed alarm is also connected to the side rail.

During Inspector #148's observations on April 30, 2014 Resident #932 did not have access to the resident-staff communication system, as the side rails were in the down position and the panel on the rail was not accessible to the resident.

On April 30 and May 1, 2014, both Inspectors observed the resident tub room and could not easily locate the resident-staff communication system in this room. When interviewed, PSW Staff member #102 indicated that there was a communication system located in the tub room. Inspector #148, in the company of staff member #102, observed that the communication system was located behind the wardrobe near the tub. The cord attached to the communication system is accessible, however, the communication system in the tub room is not easily seen. [s. 17. (1) (a)]

2. Inspector #556 interviewed PSW staff member #108 who stated that most of the beds on the unit have the communication system located in the bed rail and there is a button on the rail that needs to be pushed to activate the system. She/he further stated that the side rails would never both be down at the same time, ensuring that the resident always had access to the communication system. Staff Member #108 also stated that Resident #097 was not cognitively aware enough to activate the communication system however it should be available anyway.

On two occasions Resident #097 was observed by Inspector #556 to be in bed for an afternoon nap in a bed with the communication system button located in the bed rail. On each occasion both of the bed rails were down giving Resident #097 no access to the communication system activation button. [s. 17. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1.The licensee has failed to comply with O.Reg 79/10, s. 24. (3) (b). in that the licensee did not ensure that there is a care plan for Resident #486 that sets out clear direction to staff and others who provide direct care to the resident.

Resident #486 was admitted to the home on a specified date and in an interview RPN #103 stated that Resident #486 had a stage one pressure ulcer located at the top of his/her coccyx.

A review of Resident #486's health care record indicated that the care plan under the section entitled Treatment and Procedures stated dressing to coccyx - duoderm change. The initial skin assessment completed at the time of the Resident's admission included the notation coccyx-duoderm. There was no physician's order on the Resident's medical record related to wound care.

In an interview RPN #107 stated that the home does not use a treatment administration record, and since direction regarding when and how often to change the dressing on Resident #486's coccyx wss not in the care plan, or in the physician's orders, there was no clear direction regarding the resident's skin care treatment.

In an interview RPN #110 stated that sometimes the wound care direction is documented on the medication administration record (MAR), however after looking at Resident #486's care plan, physician's orders, and MAR, staff member #110 stated that there wss no clear direction on the chart related to what type of dressing and how often wound care was to be provided to Resident #486.

In an interview the Nursing Manager stated that there was no physician's order for the dressing for Resident #486, however there should be a physician's order stating the type of dressing, and the frequency of wound care, which would provide direction to the registered staff. The Nursing Manager further stated that once a physician's order was received the direction was written on the Individual Care Plan, however in the case of Resident #486 that was missed. [s. 24. (3) (b)]

WN #9: 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. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, c.8, s.31(1), whereby the licensee did not ensure that Resident #468's requirement to be restrained by a physical device was included in the Resident's plan of care.

Resident #468 was admitted on a specified date and during a resident quality inspection Inspector #556 observed him/her to be sitting in a wheel chair with a seat belt in place. The Resident stated that the staff put the seat belt on because they thought he/she was going to fall out of the chair. Resident #486 further stated he/she was not able to remove the seat belt because of lack of strength in his/her hands to open the buckle on the belt.

In an interview PSW #104 stated that when the resident was admitted he/she was sliding forward in the wheel chair, which was reported to the Physiotherapist. The next time she/he came to work there was a seat belt on the resident's chair.

Following a review of the health care record it was noted that there was no documentation on the care plan; in the progress notes; in the Physician's Orders; or in the kardex indicating that the resident required the use of a seat belt restraint. [s. 31. (1)]

WN #10: 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 :

The licensee failed to comply with O.Reg 79/10, s. 69 1., whereby the licensee did not ensure that each resident with weight changes of 5% or more, over one month, were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated.

An identified resident was admitted to the home in early 2014, the resident resides in a bed that the home has designated as convalescent care. The resident's weight record was reviewed which demonstrated a loss of body weight of more than 5% over one month.

A review of the resident's documented health care record demonstrated that the weight loss of more than 5% over one month, was not assessed by any staff member nor were any actions taken to address the weight loss. Upon interview of the home's NM/RD it was reported to Inspector #148 that the NM/RD does not currently follow the monthly body weights for residents admitted to the home's convalescent care bed program. The NM/RD was not aware of any weight loss for the identified resident. [s. 69. 1., s. 69. 2., s. 69. 3., s. 69. 4.]

WN #11: 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).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.73(1)1., whereby the licensee did not ensure that the weekly menus were communicated to residents.

On May 1, 2014, Inspector #148 interviewed the home's NM/RD who reported that at this time the weekly menu is not posted in the home nor is the weekly menu communicated in any other way.

Inspector #148, interviewed residents #701 and #797, who both indicate that they have not been communicated the weekly menu.

Inspector #148 reviewed the postings in the home and confirmed that the daily menu is communicated by posting in the dining room, however, there is no posting or other method of communication related to the weekly menus. [s. 73. (1) 1.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.79 (3) (a), (e), (g), (g.1), (h), (i), (j) and (k), whereby the licensee did not ensure that all required information is posted in the home as outlined by this provision.

In accordance with section 225 of the LTCHA, 2007 and section 79 (3) of Regulations 79/10, the licensee shall ensure that required information is posted in the home in a conspicuous and easily accessible location and communicated to residents.

Inspector #148 observed the current information postings within the home and confirmed with the home's Nursing Manager that the following items of information were not posted in the home:
-Residents Bill of Rights, as described in the LTCHA 2007, in both English and French as described by section 225 (3) of the Act.
-The long term care home's procedure for initiating complaints to the licensee
-Notification of the long term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained.
-A copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004
-The name and telephone number of the licensee
-An explanation of the measure to be taken in case of fire
-An explanation of evacuation procedures
-Copies of all inspection reports from the past two years for the long term care home [s. 79. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 225 (1) 1, 2 and 3, whereby the licensee did not ensure that all required information is posted in the home as outlined by this provision.

In accordance with section 225 of the LTCHA 2007 and section 79 (3) of Regulations 79/10, the licensee shall ensure that required information is posted in the home in a conspicuous and easily accessible location and communicated to residents.

Inspector #148 observed the current information postings within the home and confirmed with the home's Nursing Manager that the following items of information were not posted in the home:
-The fundamental principle set out in section 1 of the Act, in both English and French
-The home's license or approval
-The most recent audited report, provided for in clause 243 (1)(a) of Regulations 79/10 [s. 225. (1)]

WN #14: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 229 (10) 3., whereby the licensee did not ensure that residents were offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Inspector # 148 reviewed the charts of residents #097, #098, #701 and #932 and there was no documentation to support that residents of the home were offered either the tetanus or diphtheria vaccine.

During an interview with the home's Nursing Manager and Infection Control/Occupational Health lead, it was reported that residents of the long term care unit are not offered tetanus and diphtheria vaccines. [s. 229. (10) 3.]

Issued on this 3rd day of June, 2014

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