Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2016	2016_380593_0012	008280-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

CARLINGVIEW MANOR
2330 CARLING AVENUE OTTAWA ON K2B 7H1

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

GILLIAN CHAMBERLIN (593), ANANDRAJ NATARAJAN (573), KATHLEEN SMID (161)

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 18, 2016 - May 3, 2016.

In addition, 12 intakes were inspected during the RQI. Nine reported critical incidents including logs #009757-16, #004480-16, #003085-16, #034641-15, #024779-15 and #009757-16 related to alleged resident abuse, log #005243-16 related to falls, logs #003246-16 and #002010-16 related to a change in condition; and three complaints including logs #011031-16 and #011031-16 related to resident care and log #012798-16 related to resident personal equipment.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Clinical Managers, Nutrition Manager, Registered Nursing Staff, Dietary Staff, Activation Staff, Maintenance Staff, Personal Support Workers (PSW), residents and family members.

The Inspector (s) observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of resident #054 so that their assessments are integrated and are consistent and complement each other [log #012006-16].

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to a witnessed incident of resident to resident sexual abuse. It was reported by the home that a PSW witnessed resident #054 sexually abusing resident #053.

During a record review by Inspector #593, an earlier incident was found documented in the progress notes where sexual abuse by resident #054 was witnessed towards another resident.

A review of resident #054's plan of care found no documented interventions prior to early 2015, where a point of care task for behaviours was updated by RPN #113 to 'Behaviours, resident #054 will touch residents inappropriately at times'. Prior to this the task was documented as 'Behaviours'. Prior to the date of the most recent incident, resident #054's care plan had no entries related to sexual abuse toward residents or inappropriate behaviour toward residents.

During an interview with Inspector #593, May 2, 2016, RPN #113 reported that resident #054 had a history of touching or trying to touch residents inappropriately. RPN #113

further reported that most of the time they were able to redirect the resident before any abuse actually occurred however there was an incident that happened 'awhile' ago where they were found with their hands on another resident. RPN #113 believes that interventions were in place prior to the most recent incident.

During an interview with Inspector #593, May 3, 2016, the DOC reported that they were not aware of the earlier incident and if they had been aware they would have reported the incident and completed an investigation. The DOC further added that the incident was not likely reported to the management team, which is why it was not investigated and there were no interventions in place to prevent further occurrence of abuse. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in the plan [log #034641-15].

A CI was submitted to the MOHLTC related to a witnessed incident of resident to resident sexual abuse. As documented in the CI, an intervention was implemented to protect resident #021, which included 'deterrent device placed at threshold of resident #021's room so as to discourage resident #028 from resident #021's room'.

A review of resident #021's current care plan found an intervention documented 'deterrent device placed in front of resident #021's room'.

Multiple observations by Inspector #593 on April 28 and 29, 2016, found resident #021 in their bed without the deterrent device in place. Furthermore, the doorway to resident #021's room did not have the hardware applied to allow the use of the type of deterrent devices that are used in the home.

During an interview with Inspector #593, April 29, 2016, PSW #137 reported that resident #021 does not have a deterrent device nor have they ever had one in place that they were aware of.

During an interview with Inspector #593, April 29, 2016, Clinical Manager #130 reported that the intervention with the deterrent device was definitely not in place and they were unsure why this was never implemented after the incident. [s. 6. (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 ensuring that all care as specified in the plan of care is provided to residents as per the plan and all staff and others involved in different aspects of care, collaborate with each other in the assessment of residents so that their assessments are based on the care needs of the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with fluids that are safe.

During the lunch meal service in the dining room April 21, 2016, Inspector #593 observed PSW #134 prepare two thickened fluids. PSW #134 used a regular teaspoon to scoop one teaspoon of thickener into each 8oz cup. They added juice to the cup and stirred. The fluids were served to residents #057 and #058. Both fluids were observed by the Inspector to be thinner than nectar consistency.

During the lunch meal service in the dining room April 21, 2016, Inspector #593 observed PSW #135 prepare two thickened fluids. PSW #135 used a regular teaspoon to scoop one teaspoon of thickener into each 8oz cup. They added water to the cup and stirred. The fluids were served to residents #057 and #058. Both fluids were observed by the Inspector to be thinner than nectar consistency.

During the lunch meal service in the dining room April 27, 2016, Inspector #593 observed PSW #136 prepare two thickened fluids. PSW #136 used a regular teaspoon to scoop

one teaspoon of thickener into each 8oz cup. They added apple juice to the cup and stirred. The fluids were served to residents #057 and #058. Both fluids were observed by the Inspector to be thinner than nectar consistency. PSW #136 further prepared two thickened waters in the same way and provided these to residents #057 and #058.

Inspector #593 examined the container of thickener and found that there was no measuring spoon available.

During an interview with Inspector #593, April 27, 2016, PSW #136 reported that residents #057 and #058 required thickened fluids, however they were unsure about the level required and responded "a little bit thick, not too thick". PSW #136 further reported that it was one spoon of thickener per cup of fluids for both residents and this was what they were told during training. PSW #136 was not aware of any documented instructions related to the preparation of thickened fluids.

A review of resident #057's current care plan found an intervention documented related to a choking risk 'provide specific thickened fluids'.

A review of resident #058's current care plan found an intervention documented related to swallowing difficulty 'provide specific consistency thickened fluids'.

A review of the diet roster located in the dining room on level 2, found that resident #057 was to receive specific thickened fluids and resident #058 was to receive a different specified thickened fluids.

During an interview with Inspector #593, the Interim Dietary Manager #121 reported that there should be a chart in the dietary binders with the fluid to thickener ratios. They further reported that the ratios they use were one teaspoon for nectar, two teaspoons for honey and three teaspoons for pudding which were the ratios provided by the supplier of the thickener. #121 also confirmed that the smaller plastic cups that were used were 4oz and the larger plastic cups were 9oz, however they did not fill to the top so they were actually equivalent to 8oz. #121 further reported that they did not use the measuring scoops to measure out the thickener as they are no longer supplied with the thickener.

Note: 4oz = 114ml, 8oz = 227ml.

A review of the two sets of instructions provided by the Interim Dietary Manager found the following:

Note: both sets of instructions are to thicken the same types of fluids.

1. Volume: 175ml, Nectar 1.5 teaspoons thickener, Honey 3 teaspoons thickener, Pudding 4.5 teaspoons thickener. Confirmed by the Inspector, these were the correct instructions as provided by the supplier. These instructions indicated to use a 5ml measuring scoop.

2. Volume: 250ml, Nectar 2 teaspoons thickener, Honey 3 teaspoons thickener, Pudding 4 teaspoons thickener. The ratios are incorrect. These instructions documented to 'use the scoop included in tin'.

As observed by Inspector #593, the cup size used for residents #057 and #058 was the 8oz or 227ml size. As reported by PSW #136 and observed by Inspector #593, three staff members were observed to use one unmeasured teaspoon of thickener for an 8oz cup for residents requiring different consistencies of thickened fluids, which was an insufficient amount of thickener to achieve the correct and safe consistency. [s. 11. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all necessary staff are aware of the correct procedure to prepare thickened fluids and that the recipe and method used to prepare thickened fluids is as per the supplier of the thickener. Furthermore all staff that provide direct care to residents requiring thickened fluids are required to be aware of the residents thickened fluid requirements, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, the home's communication and response system was maintained in a safe condition and in a good state of repair.

During stage one of the RQI, the communication and response system in multiple resident rooms was found to be in disrepair. The communication and response system located in resident washrooms consisted of a white plate attached to the wall with a plastic pull cord that was inserted into the plate. The pull cord had a plastic toggle at the end for the resident to hold during use. The cord had a separator toward the top of the cord where the cord could be separated from the wall. The communication and response system located in resident rooms consisted of a blue pad attached to a long cord attached to the wall. There was a button on the blue pad, which when pressed, placed a call. The plate that the cord was attached to on the wall, had a light that illuminated to indicate that a call had been placed.

Further inspection of resident areas April 25 – 26, 2016, found the following:

Room 209- the button on the blue pad was pressed. The light did not illuminate and there were no auditory sounds indicating that a call had been placed. The button was pressed two more times and a call was still not able to be placed.

Room 302- there was no pull cord attached to the base plate in the resident's washroom. A call was unable to be placed.

Room 403- the pull cord attached to the base plate in the residents washroom was very short. This was not typical of the usual type of pull cord in the washrooms. A call could be placed however only if the short cord was within reach of the resident.

Room 518- the pull cord attached to the base plate separated when force was applied. This occurred before the call could be placed, and as a result a call was not placed as the amount of force required to pull the cord, caused the cord to separate.

Room 620- the pull cord attached to the base plate separated when force was applied. This occurred before the call could be placed, and as a result a call was not placed as the amount of force required to pull the cord, caused the cord to separate.

Room 627- the button on the blue pad was pressed. The light did not illuminate and there were no auditory sounds indicating that a call had been placed. The button was pressed two more times and a call was still not able to be placed.

During an interview with Inspector #593, April 26, 2016, resident #051 reported that the call bell in their washroom did not work. They added that when they used the washroom, the staff gave them the cord to use when finished but when they pulled it, it broke at the separator and did not work. The resident further reported that they have had to wait for up to an hour for staff to come back to assist them and they have told them that their callbell does not work but it still has not been fixed.

During an interview with Inspector #593, April 26, 2016, the Environmental Manager #119 reported that the homes communication and response system was part of the monthly preventative maintenance schedule. This involved all call bells to be tested on a monthly basis to ensure they are working or if any were in disrepair. #119 further added that if staff noticed that a call bell was not working or in disrepair then they were required to complete an electronic work order so that the maintenance team were aware of the issue and it could be fixed. #119 reported that they were not aware of any call bells in the home that were currently in disrepair.

A review of the home's policy titled "Quarterly routines nurse call system, Index ID ES E-75-05", last revised January 2015, found that the ESM or designate is required to inspect the nurse call system on a monthly basis which included inspecting all call bell cords, signal lights and audio signals. [s. 15. (2) (c)]

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair [log # 003246-16].

Resident #047's health care record identified that the resident required the use of two

bed rails for bed mobility. In a review of resident #047's nursing progress notes, it was documented that a PSW found the resident sitting on the edge of their bed with both legs trapped between the bed rail and bed frame. Further it was indicated that assistance was provided by the staff to remove both the resident legs from the bed rail. Resident #047 sustained bruising to bilateral lower legs and a skin tear on the left lower leg.

On April 29, 2016, Inspector #573 spoke with Maintenance staff #138 who indicated that on January 30, 2016, they observed resident #047's bed rails and identified that the left side of the bed rail in the bed system was loose, the bed rail was tightened immediately.

During an interview with the home's Environmental Service Manager (ESM), it was indicated that the home has a routine preventive maintenance schedule in place for the month of February, April and June 2015 to ensure that resident #047's bed rails were maintained in good state of repair. Inspector #573 requested for the documents related to routine maintenance audits and maintenance work orders related to resident #047's bed rails. The ESM was unable to provide documents since February 2015, that resident #047's bed rails were audited for any routine and preventive maintenance. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all components of the home's communication and response system and bed rails are maintained in a safe condition and in a good state of repair, to allow use of the communication and response system for all residents at all times and safe use of bed rails at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions [log # 005243-16 / log # 003246-16].

On April 28, 2016, Inspector #573 observed resident #048 and resident #055 sitting with a safety device attached to the resident's garment with a paper clip.

On April 29, 2016, Inspector #573 observed resident #047 sitting with a safety device attached to the resident's garment with a paper clip. The safety device was used for resident's #047, #048 and #055 as a safety intervention.

The assistive device featured a mechanism that was attached to the resident's garment. When an unassisted exit takes place, the device alerts staff in the area. One end of the pull string is connected to a metal clip which is firmly secured and attached to the resident's garment. Inspector #573 spoke with PSW #131 and RN #123, who both indicated that the metal clip in the pull string was damaged and it was replaced by a paper clip to attach the cord to the resident's garment. Inspector #573 observed resident's #048 and #055 in the presence of PSW #131 and RN #123, with the paper clip attached to the resident's garment not firmly secured.

Inspector #573 reviewed the manufacturers' instructions for safety information which indicated changes or modification affecting compliance that is not expressly approved by the manufacture could void user's authority to operate the equipment.

Inspector #573 spoke with the DOC who indicated that when safety device metal clip is damaged, it should be replaced and staff members are not to modify or replace the metal clip with the paper clips. Further the DOC indicated that the expectation of the staff was to follow safety information in the manufacturers' instructions for the safety device. [s. 23.]

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 ensuring that all equipment, supplies, devices, assistive aids and positioning aids in the home are used by staff only in accordance with the instructions from the manufacturer, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On April 18, 2016, at 1109 hours, on the third floor secured unit in a residents shared bathroom, Inspector #573 observed a bladed putty knife approximately two inches wide on the bathroom sink counter. Immediately the Inspector brought this to the RPN #108 and Housekeeping staffs #107 attention on the unit. The putty knife was removed immediately from the residents' shared bath room.

Inspector #573 spoke with the housekeeping staff #107, who indicated that the putty knife was used as a scraping tool for cleaning surfaces. The staff #107 stated to the Inspector that she was searching for the putty knife at the start of her morning shift, since it was missing from the housekeeping cart. Further the staff #107 indicated that she did not report to the nursing staff in the unit regarding the missing putty knife.

During an interview, the home's Executive Director (ED) indicated to the Inspector that the housekeeping staff should have immediately reported the missing putty knife to the registered nursing staff in the unit, so that they would have initiated a safety check in the resident areas. Further the ED indicated that the putty knife could be considered as a potential weapon and that poses a safety risk to the residents in the secured unit. [s. 5.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with [log #012006-16].

A review of the home's policy titled "Resident Non-Abuse Ontario, Index LP-C-20-ON", last revised September 2014, found that any staff member or person, who became aware of and/or had reasonable grounds to suspect abuse or neglect of a resident must immediately report the suspicion and the information upon which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior supervisor on shift at that time.

A CI was submitted to the MOHLTC related to a witnessed incident of resident to resident sexual abuse. It was reported by the home that a PSW witnessed resident #054 sexually abuse resident #053.

During a record review by Inspector #593, an earlier incident was found documented in the progress notes where sexual abuse by resident #054 was witnessed towards another resident. This incident was not reported to the Director.

During an interview with Inspector #593, May 3, 2016, the DOC reported that they were not aware of the earlier incident and if they had been aware they would have reported the incident and completed an investigation. The DOC further added that the incident was not likely reported to the management team, which is why it was not investigated. [s. 20. (1)]

WN #7: 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 has failed to ensure that resident #048 may only be restrained by a physical device if the restraining of the resident was included in the resident's plan of care [log # 005243-16].

Resident #048's health care record identified that the resident was at high risk for falls and had a history of multiple falls since admission approximately six months earlier.

A review of resident #048's current physiotherapy assessment indicated that the resident was at a high risk of falls due to impaired standing balance and poor standing tolerance. Further the assessment identified resident #048 as a high risk for falls, since resident #048 tried to transfer on their own.

On April 27, 2016, resident #048 was observed sitting with two safety devices in place. Inspector #573 observed that resident #048 was able to remove one of the safety devices.

On April 27, 2016, Inspector #573 spoke with resident #048's primary PSW #122, who indicated that resident #048 was used one of the safety devices to assist in preventing falls. During a separate interview, RN #123 stated to Inspector #573 that the safety device was used for resident #048's safety to prevent from falls. Further the RN #123 indicated that resident #048 tried to self transfer if the safety device was not in place.

On April 27, 2016, RN #123 reviewed resident #048's health care records in the presence of Inspector #573 and indicated that the use of the safety device for resident #048 as a restraint was not included in the resident's written plan of care. [s. 31. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a personal assistance services device (PASD) as described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Inspector #573 observed resident #001's bed with quarter bed rails in use on both sides of the bed frame. The two quarter bed rails were placed in the middle of the bed frame. Inspector #573 reviewed resident #001's health care record which identified that the resident was at high risk for falls and had a history of multiple falls due to self-transfers.

On April 22, 2016, during an interview, RPN #113 indicated that the two quarter bed rails were used to assist with resident #001's bed mobility as a PASD. Inspector #573 reviewed resident #001's health care record with the RPN #113 and there was no information in the resident's plan of care to indicate the use of the two quarter bed rails as a PASD.

On April 22, 2016, the Clinical Coordinator #102 reviewed resident #001's health care records in the presence of Inspector #573 and confirmed that the use of the two quarter bed rails as a PASD was not included in the resident's written plan of care. [s. 33. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs included height upon admission and annually thereafter.

A review of resident height data in the home found numerous residents that did not have a height measurement recorded on an annual basis since admission to the home.

The height data of 20 residents in the home was reviewed and the following residents did not have annual heights documented since admission:

Resident #001- last height documented 2013
Resident #004- last height documented 2011
Resident #005- last height documented 2010
Resident #011- last height documented 2012
Resident #016- last height documented 2013
Resident #017- last height documented 2011
Resident #018- last height documented 2009
Resident #019- last height documented 2014
Resident #020- last height documented 2013
Resident #021- last height documented 2010
Resident #023- last height documented 2010
Resident #024- last height documented 2010
Resident #025- last height documented 2009
Resident #026- last height documented 2013

During an interview with Inspector #593, April 25, 2016, the DOC reported that the heights were completed for each resident upon admission and indicated that there was no process currently in place to ensure that the heights were completed annually thereafter for each resident.

A review of the home's policy titled "Height Measurement and Weight Management" LTC-G-60, revised June 2014, found that all homes will have a process in place to measure height upon admission and, at a minimum, annually thereafter. [s. 68. (2) (e) (ii)]

WN #10: 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 ensure that the required information in the Act section 79 (3) (c) and (g) was posted in the home, with accordance to the requirements.

During the initial tour of the home, Inspector #573 observed that the home's policy and procedures required for the purposes of Subsection (1) and (2) were kept in a public information binder near the home's front entrance.

On April 28, 2016, upon review it was noted by Inspector #573, that the home's policy to promote zero tolerance of abuse and neglect, dated October 2009, and the home's policy related to the restraint reduction program, dated July 2010, in the binder did not reflect the home's current policies.

Following a discussion with the home's ED on April 28, 2016, they indicated to the Inspector that the home's policy to promote zero tolerance of abuse and neglect and the home's policy related to the restraint reduction program in the binder at home's front entrance were not up to date. Further the ED ensured that the public information binder would be updated with the current policies and procedures as required. [s. 79. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that home's written Least Restraint policy under section 29 of the Act dealt with O.Reg 79/10, s.109 (a), (b), (d), (e) and (f).

In accordance with the LTCHA 2007, s.29 and O.Reg 79/10, s.109 every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act dealt with (a) use of physical devices (b) duties and responsibilities of staff, including, (i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device, (ii) ensuring that all appropriate staff are aware at all times of when a resident was being restrained by use of a physical device, (d) types of physical devices permitted to be used, (e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act was to be obtained and documented, (f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach.

On April 28, 2016, at the request of Inspector #573, home's policy titled "Least Restraints LTC-K-10", revised date March 2013, was provided by the home's ED. Inspector #573 and Inspector #161 reviewed the policy in the presence of the ED, who indicated that the Least Restraint policy under section 29 of the Act did not deal with O.Reg 79/10, s.109 (a), (b), (d), (f) and (e) how consent to the use of PASDs as set out in section 33 of the Act is to be obtained and documented.

Further the home's ED indicated to Inspector #573 that the corporate office would be contacted and the home's Least Restraint policy would be updated in accordance to the legislative requirements. [s. 109.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug was administered to resident #049 in accordance with the directions for use specified by the prescriber [log #009757-16].

On January 12, 2016, the attending physician of resident #049, prescribed a medication; a dose to be applied to the resident's skin before applying an additional medication. A family member observed RPN #120 administer the medication by inhalation to resident #049, rather than onto the resident’s skin. The home conducted an immediate investigation and confirmed that the medication was not administered as per the directions for use specified by the prescriber. As a result, RPN #120 received re-education regarding medication administration. [s. 131. (2)]

Issued on this 6th day of May, 2016

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

Original report signed by the inspector.