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

Division de la responsabilisation et de la performance du système de santé
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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
Oct 6, 2014	2014_250511_0019	H-001169-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

DOUGLAS H. RAPELJE LODGE
277 PLYMOUTH ROAD, WELLAND, ON, L3B-6E3

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

ROBIN MACKIE (511), CATHY FEDIASH (214), THERESA MCMILLAN (526)

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): September 2, 3, 4, 5, 9, 10, 11, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director Resident Care (DRC), Associate Director of Resident Care(ADRC), Administrator's Assistant(AA), Manager of Housekeeping, Laundry and Dietary, Manager of Resident and Community Programs, RAI Coordinator, registered staff, Personal Support Workers (PSW), dietary and housekeeping staff, residents and family members.

During the course of the inspection, the inspector(s) reviewed clinical records, applicable policy, procedures, practices and meeting minutes, staffing schedules, applicable cleaning, maintenance, dietary and program lists and schedules and the observation of resident care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the

licensee to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

A review of the home's Skin and Wound Care program, #MP00-006, revised June 7, 2013 indicated that:

a) The registered staff responsible would notify the wound care team of the wound and document in multidisciplinary notes that the wound care team was notified
b) The registered staff to review efficacy of treatment (every 2 weeks) and was to be assessed and changed by or in consultation with the wound care team
c) The registered staff to update the plan of care
d) The registered staff to complete Weekly Skin assessment rash, scaly scalp, skin and reddened areas

A review of the clinical records for resident #107, who had multiple wounds at different stage levels throughout January 2014-September 10, 2014, had not indicated that the wound care team was notified of the wound in the multidisciplinary notes and the efficacy of treatment (every 2 weeks) was not assessed and changed by or in consultation with the wound care team as per the policy. Interview with the wound care nurse and DRC confirmed this documentation and review did not take place.

A review of the resident #107's recent plan of care for August, 2014 indicated small open areas to an area of the resident's body. Interview with registered staff indicated these open areas were no longer present and could not confirm when these areas had healed. Interview with the skin and wound care nurse confirmed the registered staff did not update the plan of care when the wounds healed. The Weekly Skin assessments were completed by the registered staff three times in January, three times in April, twice in May, and once in August, 2014. Interview with the Administrator confirmed Weekly Skin assessments for resident #107 were not completed. Interview with the Administrator and Director of Resident Care confirmed the home did not ensure that the plan, policy, protocol, procedure, strategy or system, for skin and wound care was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with. A review of the home's policy, Temperature, Presentation, Taste Recording (DAT03-016) indicated the following:
a) Mandatory recording of food temperatures in dining room at the end of meal

service.
b) Document on temperature report form (see Appendix A)

A review of the Meal Temperature Report form indicated that on August 31, 2014, mandatory recording of food temperatures at the end of the meal service had not been recorded for 25 out of 28 food items served and on September 1, 2014, mandatory recording of food temperatures at the end of the meal service had not been recorded for 25 out of 28 food items served. A review of the temperature report form that the home had used and titled, Meal Temperature Report, was not the same form that the home's policy referred to in Appendix A and titled, Food Service Temperature Report. The form that was required to be used as per the home's policy, contained an area for staff to record the temperatures of hot and cold beverages while the form that the home was currently using, had not.
An interview with the Dietary Manager confirmed that the home had not completed the mandatory recording of food temperatures at the end of meal service on the dates identified; had not used the required form for recording of food service temperatures and that the home's policy had not been complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure to ensure that where the Act or this Regulation required the licensee to have, instituted 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, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A review of resident #105's written plan of care indicated that they required the use of two bed rails in the raised position for safety when in bed. Resident # 105 was observed in bed with two quarter bed rails in the raised position on a day in September, 2014. A review of the resident's clinical health record did not include an assessment of the bed rails being used. The DOC confirmed that the home did not have a formalized assessment for the use of bed rails in place. (511)

B) A review of resident #102's clinical records indicated that they required the use of two full bed rails as requested by the family. A review of the resident's clinical health record did not include an assessment of the bed rails being used. The Administrator confirmed that the home did not have a formalized assessment for the use of bed rails in place. (214)

C) On a day in September, 2014 resident #109's bed was observed to have a one half length bed rail in the up position on one side of an unoccupied bed. The resident's Minimum Data Set (MDS) dated June, 2014 indicated that the resident had "Other types of [bed] rails used" and that the bed rail was used for bed mobility or transfer. The document the home referred to as resident #109's 'Care Plan' directed staff to "Put 2 full bed rails up at all times/when in bed".
The registered staff confirmed that they could not locate an assessment for the use of bed rails. During interview, the Resident Assessment Inventory (RAI) Coordinator confirmed that there had not been an assessment of resident #109 to determine why the bed rails were in place and the bed system evaluated to minimize risk to the resident. (526) [s. 15. (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 that when bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A review of the annual Minimum Data Set (MDS) completed for resident #100 in September, 2013, indicated that the resident was occasionally incontinent of their bladder. The quarterly MDS completed for this resident in November, 2013, indicated that the resident was frequently incontinent of their bladder. A review of the resident's assessments indicated that no continence assessment had been completed when the resident's continence status had changed. The RAI Coordinator confirmed that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for continence, when the resident's continence status had

changed. (214)

B) A review of resident #109's MDS dated June, 2014 indicated that the resident had inadequate bladder control with multiple daily episodes of urinary continence patterns that had not changed since the last assessment dated April, 2014. Review of the resident's health records indicated that the home had not assessed the resident's continence in terms of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument specifically designed for the assessment of continence. The Administrator confirmed that the home did not use a clinically appropriate assessment tool specifically designed to assess the issues noted above regarding continence for residents in the home. (526)

C) A review of resident #105's clinical record confirmed they were incontinent of bowels and had a history of constipation. A review of the medical administration record indicated the resident had an increase in frequency of constipation between the first quarter and second quarter of 2014. This change in condition required the increase in suppository use between the first quarter 2014, and the second quarter of 2014. Interview with the registered staff confirmed the resident's condition had changed and an assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. (511)

D) A review of the MDS quarterly assessment for March and June, 2014 for resident #110 indicated that the resident was frequently incontinent of their bladder. There was no evidence in the clinical records of an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. An interview with the RAI Coordinator confirmed the resident was incontinent of their bladder and a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence was not used. (511) [s. 51. (2) (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 resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that training was provided to all staff who applied physical devices or who monitored residents restrained by physical devices regarding the application, use and potential dangers of these physical devices.

Review of the home's training of direct care staff who applied or monitored residents with physical devices in place did not include information regarding the application, use and potential dangers of these physical devices. Interview with the ADRC and a Registered Nurse confirmed that the home's "Least Restraint" training did not include instruction regarding the safe application, use or potential dangers of physical devices for residents. [s. 221. (1) 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 training is provided to all staff who apply physical devices or who monitor residents restrained by physical devices regarding the application, use and potential dangers of these physical devices, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

On a day in September, 2014, resident #105 was observed to be laying in bed in the afternoon. Interview with the registered staff in September, 2014 confirmed the resident required a suppository, received a suppository in the morning and the

resident's planned care was for them to remain in bed for the day due to incontinence of stool after the suppository. Interview with registered staff in September, 2014 confirmed the resident frequently required a suppository and the care provided was to have resident #105 remain in bed after they received a suppository due to ongoing incontinence of stool. A review of the resident's written plan of care did not identify the routine care provided to resident #105 on days they were provided a suppository. Interview with the registered staff confirmed the written plan of care for resident #105 did not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

On a day in September, 2014 resident #109 was observed to have a urine odour. Resident #109's June, 2014 MDS indicated that the resident had inadequate bladder control with multiple daily episodes of incontinence and required the use of a continence brief. Section H3 of the MDS assessment indicated that the resident was on a scheduled toileting plan. The resident's document the home refers to as the "Care Plan" completed in July, 2014 and the Kardex used by staff who provided direct care to resident #109 indicated that the resident was on an Activity of Daily Living (ADL) program and that staff were to "see POC [Point Of Care] schedule for restorative toileting program". Interview with a personal support worker (PSW) indicated that POC directed staff to toilet the resident at three different, specified times. The PSW stated that this did not clearly direct them about times to toilet the resident and that they did not use the schedule indicated in POC. Interview with a Registered Practical Nurse (RPN) confirmed that the plan of care did not set out clear directions to staff who provided direct care to resident #109. [s. 6. (1) (c)]

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

Resident #105 clinical records identified the resident had a history of constipation. The Resident Assessment Protocol (RAP) dated September, 2014 indicated the resident had a bowel frequency of every four or more days. The September, 2014 Minimum Data Set (MDS) Annual assessment indicated the resident had a bowel frequency of at least one movement every three days. Interview with the Administrator confirmed that staff and others involved in the different aspects of care had not collaborated with each other in the assessment of the resident so that their assessments were

integrated, consistent with and complement each other. [s. 6. (4) (a)]

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

A) Resident #105 was observed on a day in September, 2014 to be in bed with two quarter bed rails in the raised position. The bed was in the lowest position, without a floor mat in place beside the bed. Resident #105's clinical record identified them as a high risk for falls and stated a floor mat was to be placed at the bedside when the resident was in bed. Interview with the PSW confirmed the resident was to have a floor mat in place as specified in the plan. (511)

B) On two separate days in September, 2014, resident #109 stated to the Inspector that they were lonely. On one of these days in September, 2014, the resident stated that they would like to have one on one visits from recreation as they were reluctant to join group activities. The document the home referred to as resident #109's "Care Plan" completed in July, 2014 indicated that the resident should receive at least four one to one recreation social visits per month and that staff were to encourage one on one leisure pursuits. Inspection of the resident's 'Recreation Look Back Report' indicated that between June, 2014 and August, 2014, resident #109 had less than four occasions of one on one recreation sessions per month, each lasting 15 minutes. The Manager of Resident and Community Programs confirmed that resident #109 did not receive one on one recreation social visits according to the resident's plan of care. (526)

C) Clinical record review for resident #110 indicated they were at a high risk for falls. The most recent plan of care indicated the resident was to have a call bell necklace in place and to have a call bell to be within reach at all times. On observation on a day in September, 2014, resident #110 was sitting in a recliner chair with the leg rests up. The resident was not wearing a call bell necklace and the call bell was secured to the bed rail of the resident's bed, approximately 2 feet away, out of reach of the resident. Interview with the PSW confirmed the resident was a high risk for falls, did not have a necklace call bell and that the call bell, attached to the bed rail, should have been attached to the recliner within reach of the resident. (511) [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A) A review of resident #100's clinical records indicated in November, 2013, that they had gone from being occasionally incontinent of bladder to frequently incontinent of bladder. A review of this resident's written plan of care, dated November, 2013, indicated that the interventions in place to manage their bladder incontinence remained the same, even when the resident demonstrated a decline in their bladder incontinence. An interview with the RAI Coordinator confirmed that the resident's plan of care was not revised when their care needs changed. (214)

B) Resident #107 was observed to be in bed on a day in September, 2014 with their foot elevated on a pillow. Interview with the PSW stated the resident has been on bed rest for approximately one month due to a wound to the resident's lower body in order to promote comfort. This was also confirmed by the RPN on duty on a day in September, 2014. Review of the plan of care did not indicate the resident was on bed rest. Interview with the registered staff on a day in September, 2014 confirmed the care plan was not reviewed and revised when the resident's care needs changed. (511)

C) A review of resident #110's MDS Quarterly assessment for March, 2014 indicated the resident demonstrated an increase in responsive behaviours that included daily resistance to care that could not be easily altered. Specifically, the resident had been identified as a high risk for falls and would self transfer and not wait or call for staff assistance with ambulation or transfers. The last documented behavior of this occurred in April, 2014 where the resident was self transferring and ambulating without staff present. A review of the plan of care contained previous behaviours, dated September, 2012, where the resident refused to push themself to and from the dining room and insisted the staff push them. An interview with the RAI coordinator confirmed the resident's plan of care was not reviewed and revised when the resident's needs changed. (511) [s. 6. (10) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of resident #102's clinical record indicated that the resident was incontinent of bladder and bowel and that staff were to check and change their incontinence product routinely (before and or after meals, at bedtime and when needed) and that staff would also check the incontinent product on rounds during the night. An interview with front line nursing staff on September 11, 2014, confirmed that they were aware of the resident's routine for checking and changing of the incontinence products. A review of the Point of Care (POC) documentation from September 1-8, 2014, indicated that not all required checks and changes of the resident's incontinent product, were documented. Specifically,no documentation was provided for:

September 1,2014: day shift
September 2, 2014: evening and night shift
September 3, 2014 : day shift
September 4, 2014: evening and night shift
September 5, 2014: day and night shift
September 6, 2014: evening shift
September 7, 2014: day, evening and night shift
September 8, 2014: days shift

An interview with the RAI Coordinator confirmed that the home only documented this task on Monday, Wednesday and Fridays for the evening shift; Monday, Wednesday and Saturday for the night shift and Tuesday, Thursday and Saturday for the day shift and that not all actions taken with respect to a resident, were documented. [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was dressed appropriately, suitable to the time of day and in keeping with his or her preferences.

Resident #108 was cognitively impaired and observed on two days in September, 2014 to be dressed in a shirt that was cut/torn up the back and the resident's skin of their upper back was revealed on both occasions. The shirt, on one of the days in September, appeared torn in two different sections with ragged and frayed edges. Interview with the registered staff confirmed the shirts were cut up the back to aid in dressing the resident however were not applied appropriately, allowing the resident's body to be exposed. [s. 40.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including a wound [redacted], received a skin assessment by a member of the registered nursing staff.

On four days in September, 2014 resident #112 was observed to have an alteration in skin integrity on their face. The resident complained about this alteration in skin integrity and that it wasn't getting better. On inspection of the resident's health record, no assessment was found regarding this wound. A registered nurse and registered nursing assistant confirmed that they were not aware of the alteration in skin integrity and that it had not been assessed by registered staff using a clinically appropriate skin assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that any resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.

Resident #107 had three different alterations in skin integrity identified in the clinical record through January to April 2014.

Interview with the Manager of Housekeeping, Laundry and Dietary confirmed the registered dietitian, who was a member of the staff of the home, had not completed assessments on these alterations in skin integrity.[s. 50. (2) (b) (iii)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that for each resident that demonstrated responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of resident #102's clinical record indicated that the resident demonstrated known responsive behaviours that included resistance to treatment and care, specifically, refusing medications. A review of the resident's Medication Administration Record for the month of August 2014 indicated that the resident refused their prescribed medications on several days in August, 2014. A review of the resident's clinical record for the month of August 2014 indicated that no documentation had occurred on the identified dates with regards to what actions were taken to respond to the needs of the resident and the resident's response to any interventions provided. An interview with the RAI Coordinator confirmed that the resident did demonstrate behaviours of restiveness to medications and that documentation had not occurred on the identified dates regarding what actions were taken to respond to the need of the resident and the resident's response to the intervention. [s. 53. (4) (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had and that the staff of the home complied with a cleaning schedule for all the equipment related to the food production system and the dining and snack areas.

A review of the home's policy for the safe use and cleaning of dietary equipment, titled, Description and Use of Equipment (DAT03-001 and dated May20, 2013) indicated the following with regards to the proper and safe cleaning of food carts:

a) Bi-weekly, the food carts were to be cleaned with power hose starting at top and working towards the bottom.
b) Daily, the food carts were to be brought close to the sink, washed all interior and exterior surfaces, wiped with cloth soaked in anti-bacterial solution and let to air dry.

A review of the home's daily cleaning schedule indicated that there was no schedule in place for the cleaning of the food carts. An interview with the Manager of Housekeeping, Laundry and Dietary confirmed that the cleaning schedule had not included a task to clean the food carts, as identified in the home's policy. [s. 72. (7) (b)]

2. The licensee failed to ensure that the home had and that the staff of the home complied with a cleaning schedule for the food production, servery and dish washing areas.

A review of the home's policy for the safe use and cleaning of dietary equipment, titled, Description and Use of Equipment (DAT03-001 and dated May20, 2013) indicated the following with regards to the proper and safe cleaning of dishwashers:

a) After each use: Turn off machine. Drain all tanks. Remove and clean all scrap trays. Clean the pump screens. Check and clean overflows. Flush inside of machine with pressure spray. If possible, use spray which is connected with a detergent sanitizer. Clean top and sides of machine. Scrub all dish room work surfaces with detergent and water. Rinse.
b) Daily: Wash and inspect wash arms to make sure they are free of obstructions. Clean walls and floor with detergent and water. If possible, use a detergent sanitizer.

A review of the home's daily cleaning schedule indicated that daily, the dishwashers were to be wiped down; however, did not indicate to clean the walls and floor with detergent and water. The daily cleaning schedule also did not include the task to clean the dishwashers after each use. An interview with the Manager of Housekeeping, Laundry and Dietary confirmed that the cleaning schedule for the dishwashers had not included all the required tasks, as identified in the home's policy. [s. 72. (7) (c)]

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).

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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents.

On September 2, 2014, during observation of the lunch hour meal service on the secured unit, the television screen that the home used to display the daily menu was not in working order. Front line nursing staff indicated that the television screen had not been working for approximately four days. The home also post's a paper copy of the weekly menu, which contained each day's menu, on a bulletin board. This weekly menu was noted to be posted on week one, however the home was working from the menu on week two. The paper copy also did not contain any dates beside the daily menu, making it difficult to know what meal was being served on what day. [s. 73. (1) 1.]

2. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: dining room tables at an appropriate height to meet the needs of all residents.

During the lunch hour meal service on September 2, 2014, resident #302 was observed sitting in their wheelchair and reaching upwards to their dining table in order to access their food and beverages. An interview with front line nursing staff indicated that the resident's wheelchair was lower than their dining chair, and that the dining room table was too high to meet their needs. [s. 73. (1) 11.]

WN #12: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a physical device was applied according to the manufacturer's instructions.

The home's manufacturer's instructions from Body Point Designs titled "Practical considerations in selecting and fitting wheelchair positioning belts and harnesses" dated August, 1997 stated the following: "Much of the control is lost if a belt is pulled too far away from the pelvis...The positioning value of a belt will much improved... when allowances are made for the belt to wrap as closely around the pelvis as possible."

On a day in September, 2014 residents #111, #400, #401 and #402 and on a second day in September 2014, residents #400 and #401 were observed to have lap belt physical devices that were applied at least 10 centimetres (cm) away from the resident's pelvic area and not according to manufacturer's instructions. When questioned about safe application of the lap belts, according to manufacturer's instructions, two health care aids and a registered nurse stated that they were not aware that the lap belt devices were not applied according to manufacturer's instructions.

The Assistant Director of Resident Care (ADRC) and registered nurse and the home's Administrator confirmed that lap belt physical devices should be applied to two finger widths (or three cm) from a resident's pelvic area. They confirmed that the lap belt physical devices for residents #111, #400, #401 and #402 were not applied in accordance with the home's expectations or with the manufacturer's instructions. [s. 110. (1) 1.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

It was observed on September 3, 2014, in the hallway of House 400 that resident's prescribed treatment creams were stored in an individual pouch system that was hung on the outside of the linen cart. An interview with front line nursing staff confirmed that the prescription treatment creams were always stored in this manner so that they were accessible to the front line nursing staff to apply. On September 5, 2014, it was observed by two inspectors in the hallway of House 500, that resident prescription creams were stored in the individual pouch system on the outside of the linen carts. No registered or front line nursing staff were in view of the prescribed treatment creams, which were accessible. An interview with the Administrator confirmed that the prescription treatment creams were not stored in a manner that was secure or locked. [s. 129. (1) (a)]

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. (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:
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 ensure that all staff participated in the implementation of the Infection, Prevention and Control program.

During the lunch hour meal service on September 2, 2014, front line nursing staff were observed to be feeding a resident and then leaving their seated position to clear dirty plates from two tables and then return back to assist the resident with feeding. This was observed twice during this lunch hour meal service and each time, the front line nursing staff did not wash their hands in between the task of clearing the dirty plates and feeding the resident. An interview with the Manager of Housekeeping, Laundry and Dietary confirmed that the home does have a hand hygiene program in place and that the staff member should have washed their hands, prior to feeding the resident. [s. 229. (4)]

2. The licensee has failed to ensure that residents were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

Health records for residents #109 and #111 were reviewed and no documentation that these residents were offered pneumoccocus, tetanus and diphtheria immunizations were found. During interview, the Infection Control Person (ICP) could not confirm that residents #109 and #111 had been offered these vaccinations in accordance with the publicly funded immunizations schedules. The Administrator confirmed that pneumoccocus, tetanus and diphtheria immunizations were not routinely offered during 2011, the year the residents had been admitted to the home. The Administrator confirmed that residents #109 and #111 had not been offered or received these immunizations given the home's previous approach to immunizing residents and as evidenced by the absence of documentation in the resident's health records. [s. 229. (10) 3.]

Issued on this 31st day of October, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Lisa Vink for Robin Mackie