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

Division de la responsabilisation et de la performance du système de santé
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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
Aug 13, 2015	2015_395613_0009	011138-15	Resident Quality Inspection

Licensee/Titulaire de permis

VALLEY EAST LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ELIZABETH CENTRE
2100 Main Street Val Caron ON P3N 1S7

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

LISA MOORE (613), JENNIFER KOSS (616), LYNN PARSONS (153), PEGGY SKIPPER (160), SARAH CHARETTE (612), SHEILA CLARK (617)

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): June 15 to 19 and June 22 to 26, 2015.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Co - Director of Care, Nutrition Dietary Manager, MDS/Staff Educator, Resident Family Services Coordinator, Housekeeping Supervisor, Life Enrichment Coordinator, Life Enrichment Aide, Dietary Aide, Laundry Aide, Maintenance Aide, Registered Staff (RN/RPNs) and Personal Support Workers, Residents and Family Members.

During the course of the inspection, the inspector(s) made direct observations of the delivery of care and services to the residents, conducted a walk through of the home, reviewed health care records and various policies and procedures of the Home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
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
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

14 WN(s)
8 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On June 22 and June 23, 2015, Inspectors #616 and #617 observed S#126 and S#100 dispose of the emptied labelled medication packages into the general garbage receptacle on the medication cart. The housekeeper was then observed to empty the receptacle into their garbage for disposal.

Inspectors interviewed S#124 and S#100 who both confirmed staff practice is to dispose of residents labelled medication packaging in the garbage receptacle on the medication cart and then housekeeping staff provide regular disposal which is not for confidential waste.

Inspectors reviewed the home's policy title, Classic care Pharmacy Policy and Procedure #5.8 Medication disposal dated July 2014. The policy indicated "Resident confidentiality is to be respected at all times"; Procedure for the pail/bucket system: #2 indicates, prescription labels are removed for prescription containers and placed in the designated drug destruction container or residents' names are rendered illegible and disposed in the garbage, thus respecting confidentiality.

On June 25, 2015, Inspector #613 met with Director of Care (DOC)and reviewed procedure from Pharmacy Manual. DOC confirmed the staff were not following the home's policy. [s. 3. (1) 11. iv.]

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 has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. (Residents' Bill of Rights 3.(1) 11 iv. by all registered staff following procedure for medication disposal and respecting resident confidentiality, to be implemented voluntarily.

WN #2: 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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

Inspector #612 reviewed resident #006's care plan and noted the following Intervention: Use two person transfer and use turn sheet to avoid friction/ shearing of resident's skin.

Inspector #612 observed personal care provided to resident #006 on June 22, 2015, in the morning. Inspector noted that S#118 and S#127 did not utilize a turn sheet to position the resident. Inspector #612 also observed personal care provided to resident #006 later on the evening shift. Inspector noted that S#116 and S#117 did not utilize a turn sheet to position resident.

Inspector #612 spoke with S#116, S#117, S#118 and S#127 who confirmed that they are often out of turn sheets and therefore not able to utilize them when providing care to the residents.

Inspector #612 interviewed Co-Director of Care, S#115 who confirmed that the turn sheets should be available at all times for staff to utilize for positioning residents. [s. 6. (7)]

2. The licensee failed to ensure that all staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Inspector interviewed front line staff, S#118 and S#127, who confirmed that they access the kardex for residents' care, not the full care plan. S#118 and #127 confirmed that they leave the sling under resident #006 while they are up in their wheelchair and that this information should be on the kardex. S#118 and #121 confirmed that use of the turn sheet was used to avoid friction/shearing of resident's skin and that information should be on the kardex.

Inspector interviewed registered staff S#119 and S#120, who confirmed that the front line staff only have access to the Kardex, not the full care plan. The care plans are located on Point Click Care and the PSWs' do not have access. The PSWs' have access to Point of Care which only provides the kardex.

Inspector #612 interviewed S#115 who confirmed that the interventions from the care plan are pulled over to the kardex. S#115 confirmed that the Personal Support Workers reference the kardex for resident's care requirements. However, Inspector reviewed the care plan and kardex with S#115 who confirmed the following:
- use of the turn sheet was missing from the kardex
- the direction to leave the sling under resident while up in the wheel chair was missing from the kardex and care plan
- the resident's impaired skin integrity should be listed on the kardex. [s. 6. (8)]

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 care set out in the plan of care is provided to resident #006 as specified in the care plan and that the plan of care sets out clear direction for staff who provide care to resident #006, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #612 reviewed resident #006's wound assessment notes in Point Click Care. Inspector noted that a stage 2 pressure ulcer was identified on March 9, 2015 and treatment was initiated on March 10, 2015.

Inspector #612 was unable to locate wound assessment notes between the following dates:
- March 19, 2015 and April 8, 2015
- May 9, 2015 and May 20, 2015

Inspector #612 reviewed the assessment tab in Point Click Care (PCC), June 24, 2015, and noted that a wound assessment and treatment record was completed March 10, 2015, when the initial treatment was initiated. Inspector reviewed a wound note dated June 13, 2015 which identified resident #006 now had two wounds, a stage 2 and stage 3. Inspector was unable to locate any other wound assessment and treatment records in PCC when there was a change in the resident's wound.

Inspector confirmed with the Co-Director of Care, S#115 who is the skin and wound lead, that the wound assessments are documented electronically on Point Click Care (PCC) under the heading wound note and are to be completed at least weekly, as per the homes policy. S#115 confirmed that if the notes are not documented there then the assessment was not completed.

S#115 confirmed that when there is a change in wound status, including a new wound or

a change in stage of the wound, registered staff are responsible to notify S#115 by calling or completing a paper form, titled New Wound, which is available on all units. S#115 confirmed that they were not made aware of the additional stage 2 wound identified June 13 and 17, 2015 and did not receive any form indicating a change in wound.

Inspector #612 reviewed the home's policy titled Resident Rights, Care and Services- Required Programs- Skin and Wound Care Program, effective date September 16, 2013 which identified that for a resident with an alteration in skin integrity, the registered staff will complete a wound progress note, weekly. This will reflect the weekly assessment of the resident related to wound status. The policy also outlined that registered staff will complete a wound assessment and treatment record in PCC under the assessment tab with initiation of impaired skin integrity and with any change in treatment. The completion of this form will serve as the referral to the skin and wound care lead of the resident's change in skin integrity and/or treatment. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the home's Infection Prevention and Control Program was complied with.

On June 23, 2015 at 1130hrs during a medication administration, Inspector #613 observed a member of the registered staff S#124 fail to perform hand hygiene before and after monitoring blood glucose and injection medication administration to resident #040 .

Inspector #613 interviewed S#124 who confirmed that staff are expected to perform hand hygiene practices before and after resident care and that hand sanitizer is kept on the medication cart for staff use.

On June 23, 2015 at 1613hrs during observation of an injection medication administration pass for resident #021, Inspector #616 observed a member of registered staff S#100 fail to practice hand hygiene prior to and following the administration of medication.

Inspector #616 spoke with S#100 who confirmed their understanding to wash hands before and after resident contact using hand sanitizer provided on medication cart.

Inspector #612 reviewed the policy titled Operations of Homes- Infection Control Hand Hygiene Program which identified that hand hygiene program shall be based on the Just

Clean Your Hands Program and include the "4 Moments of Hand Hygiene", including:
- before initial patient/patient environment contact;
- before aseptic procedure;
- after body fluid exposure risk; and
- after patient/patient environment contact.

Inspector #612 interviewed the Infection Control Lead S#112 on June 25, 2015 about the above incidents. They confirmed that registered staff are to utilize the 4 moments of hand hygiene when administering medication. [s. 8. (1)]

3. 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 failed to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

On June 22, 2015 at 1700hrs, Inspector #617 observed S#126 administer two injections to resident #040. Inspector #617 observed S#126 obtain two syringes from the resident's bin inside the medication cart that were not labelled with resident #040's name. Registered staff S#126, reported that they identify the syringes for the resident as they sit in the resident's bin on the medication cart. On June 24, 2015, Inspector #617 interviewed S#124 who confirmed that both syringes for resident #040, were unlabelled in the resident's bin on the medication cart. S#124 showed Inspector #617 that the stocked syringes are stored in the fridge in the medication room in a box sent from pharmacy with a prescription label including the resident's name.

Inspector #617 reviewed the home's Classic Care Pharmacy policy titled, Administration, Documentation and Storage, revised July 2014, which indicated that medication should remain in the original labelled pharmacy packaging until just before administration to a resident.

On June 25, 2015, Inspector #613 interviewed DOC who confirmed that medicated syringes are supposed to be labelled as all residents have their own specific syringes. DOC confirmed this is the home's expectation.

Inspector #617 reviewed the medication reconciliation and admission order form for resident #040 which indicated that a nurse's signature for a second check was not done. The Medication Administration Record (MAR) and Physician's Order Sheet was compared and an error in transcription was identified for two different medications that

were ordered once per day. The physician's order indicated that the medications were to be administered at 0800hrs. However, the MAR indicated the medications were administered at 1600hrs.

Inspector #617 also noted that the home's Classic Care Pharmacy policy titled Ordering and Receiving Medication, revised on July 2014, indicated that the medication reconciliation and the form(s) will be signed and dated by the registered personnel responsible for preparing the form.

On June 25, 2015, Inspector #613 interviewed DOC who confirmed with the Med Reconciliation orders that the nurse that receives the orders has to call the physician and confirm the orders. Then two other nurses have to double check orders and provide their signatures. DOC confirmed that this was not done when resident #040 arrived as per expectations. [s. 8. (1) (a)]

4. The licensee failed to ensure that the home's policy title, Classic care Pharmacy Policy and Procedure #5.8 Medication disposal dated July 2014 was followed by registered staff.

On June 22 and June 23, 2015, Inspectors #616 and #617 observed S#126 and S#100 dispose of the emptied labelled medication packages into the general garbage receptacle on the medication cart. The housekeeper was then observed to empty the receptacle into their garbage for disposal.
Inspectors interviewed S#124 and S#100 who both confirmed staff practice is to dispose of residents' labelled medication packaging in the garbage receptacle on the medication cart and then housekeeping staff provide regular disposal which is not for confidential waste.

Inspectors reviewed the home's policy title, Classic care Pharmacy Policy and Procedure #5.8 Medication disposal dated July 2014. The policy indicated "Resident confidentiality is to be respected at all times"; Procedure for the pail/bucket system: #2 indicates, prescription labels are removed for prescription containers and placed in the designated drug destruction container or residents names are rendered illegible and disposed in the garbage, thus respecting confidentiality.

On June 25, 2015, Inspector #613 met with Director of Care (DOC) and reviewed procedure from Pharmacy Manual. DOC confirmed the staff were not following the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place and all staff comply with Infection Control Policy, Skin and Wound Policy and Administration of Medication Policy, to be implemented voluntarily.

WN #4: 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, furnishings and equipment are kept clean and sanitary.

On June 15, 2015, between 1400-1600hrs, the following observations were noted by Inspector #617:

Resident Washroom
- soiled toilet seat

Tub Room
- soiled seat on shower chair with feces, buckets on the floor.

On June 16, 2015, at 1455hrs, the following observations were noted by inspector #617 for resident #023:

- resident's basins sitting on the floor in the bathroom
- soiled urinal on the floor in the bathroom.

On June 16, 2015, at 1447hrs, the following observations were noted by Inspector #617 for resident #024:

- raised toilet seat was dirty with dry feces in resident bathroom
- used urinal sitting on counter in bathroom has dried up urine stain and has a foul smell.
[s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

1. On June 15, 2015, Inspectors #612 and #617 observed in an Activity RM a missing floor tile in the doorway coming in from outside and posing a potential tripping hazard.

2. On June 15, 2015, Inspectors #612 and #617 observed on a Janitor RM, a tag on door dated Sept 17, 2014 stating “Danger do not use” due to 'moldy smell and water leaking'. Floor tiles inside the janitor room observed with baseboard hanging off of the wall, a section of wall cut out with pipe exposed and floor tiles damaged. Inspector #613 met with DOC on June 25, 2015 to determine if signage needs to remain on door due to resident risk. DOC was not sure if signage is still needed.

3. On June 15, 2015, Inspectors #612 and #617 observed in the Activity RM, the corner of doorway leading to secure patio had noted damage to the wall, approximately 10 cm in length by 3 cm width gouge out of wall. The call bell pull station in the Activity Room was observed with no call bell cord.

4. On June 15, 2015, Inspectors #612 and #617 observed the Shower RM that ceramic tile was missing on the corner of the room and a large hole was observed on the flooring in the shower area, approximately 8cm by 8cm in circumference. The staff had to maneuver a resident in a shower chair around the hole in the floor to complete a shower.

5. On June 24, 2015 Inspector #613 reviewed the maintenance log book form from January 1 to June 25, 2015 and noted that there were four documentations by staff

reporting the hole in floor (March 27, 2015, April 25, 2015, May 5, 2015 and May 26, 2015.) It was documented by the Maintenance Manager that Administrator is aware and awaiting estimates.

6. On June 24, 2015 Inspector #613 observed eight wall tiles, approximately 11cm by 11cm each tile size, missing in tub room located on Unit 2. The damaged area was covered with plastic and duct tape. Inspector #613 interviewed Housekeeping Supervisor S#122 covering for Maintenance Manager who acknowledged the maintenance issues, however was unaware of the status plan for repairs. [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 to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items labelled within 48hrs of admission and of acquiring, in the case of new items and cleaned as required.

On June 15, 2015, between 1400-1600hrs, the following observations were noted by Inspector #617:

Shower Room
- unlabelled dirty blue brush with hair found in sink
- unlabelled blue hair brush dirty with hair found in cupboard, two unlabelled used nail clippers in cupboard

Tub Room
- unlabelled black comb dirty with hair and dandruff; used unlabelled nail clippers in storage cupboard; unlabelled used personal products such as used stick deodorant, used unlabelled shaving cream.

Tub Room
- unlabelled used razor found with hair on it

Tub Room
- used nail clippers in the cupboard; two used men's stick deodorants not labelled

Shower Room
- nail clippers in sink unlabelled and used; grey hair brush dirty with hair

During Stage 1 observations on June 16 and 17, 2015, Inspector #616 observed unlabelled personal care items including combs, brushes, electric shaver, toothbrushes stored in residents' shared bathrooms for some resident rooms.

Inspector #612 spoke with the Infection Control Lead, S#112, who confirmed that resident's personal items are to be labelled with the resident's name. S#112 confirmed that staff are responsible to clean residents nail clippers of any visible debris and soak them. [s. 37. (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 has his or other personal items labelled within 48 hrs of admission and new items cleaned as required, 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:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. 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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

On June 23, 2015, Inspector #617 reviewed resident #010's care plan dated March 12, 2015, which indicated the use of two full side rails when in bed at all times as a restraint. The side rails can be removed only when providing care. The resident #010 was to be repositioned every two hours when side rails were up: and PSW to document the resident's response to restraint every hour. Resident #010 kardex dated September 12, 2013, indicated application of two full side rails when in bed (used as a restraint). Inspector #617 reviewed the resident #010's health care records which indicated that a physician's order dated June 3, 2015, and a signed consent dated February 16, 2015 for the use of the two full bed rails as a restraint.

On June 24, 2015, at 1415hrs, Inspector #617 interviewed registered staff S#124, who reported that registered staff do not re-assess or document the effectiveness of resident #010's side rail use and that it is documented by the PSW staff. On June 24 2015, inspector #617 reviewed resident #010's progress notes, Point of Care, Medication Administration Record and Treatment Administration Record for the month of June 2015 which did not indicate that the registered staff documented on the reassessment of the effectiveness of the restraint.

Inspector #617 reviewed the Jarlette Health Services Policy entitled Resident Rights, Care and Services Minimizing of Restraining - Documentation of Restraint Use, revised April 23, 2015, which indicated that a registered staff member will reassess and document every shift for the effectiveness of the restraint. On June 25, 2015, Inspector #617 interviewed S#115 who reviewed the policy and confirmed that registered staff are not currently re-assessing the effectiveness of the side rail restraint or documenting the effectiveness at least every eight hours. [s. 110. (2) 6.]

2. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

On June 25, 2015, Inspector #617 reviewed resident #013's care plan dated June 8, 2015 and kardex which indicated the use of two full side rails when the resident is in bed at all times for prevention of injury and to monitor resident #013's skin every shift for signs of pressure areas. Inspector #617 reviewed the RAI-MDS assessment which indicated that resident #013 required extensive assistance with a two person assist for

bed mobility and used two side rails.

On June 23, 2015, at 1410hrs, Inspector #617 observed resident #013 in bed with both side rails up. It was also observed that there was a logo above the resident's bed indicating the use of two side rails as a restraint.

On June 24, 2015, Inspector #617 interviewed registered staff member S#120, who confirmed that the resident #013 used both full length side rails while in bed as a restraint. Registered staff member S#120 reported that they do not re-assess or document the effectiveness of resident #013's side rail restraint and was not aware that an assessment was required for side rail restraint. On June 25, 2015 Inspector #617 reviewed resident #013's progress notes, Point of Care, Medication Administration Record and Treatment Administration Record for the month of June 2015 which did not indicate that the registered staff documented the reassessment of the effectiveness of the restraint every eight hours. [s. 110. (2) 6.]

3. The licensee failed to 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 failed to ensure that the documentation of every release of the device and all repositioning for resident #010.

On June 22, 2015, at 1530hrs and on June 23, 2015, at 1410hrs, Inspector #617 observed resident #010 lying in bed with both full length side rails in the up position and the logo above the bed indicated that two side rails were used and classified as a restraint.

On June 23, 2015, Inspector #617 reviewed the health care record for resident #010 which indicated that the care plan last updated on March 12, 2015, a physician's order for side rail restraint dated June 3, 2015, and a signed consent for side rail restraint dated February 16, 2015, identified the use of two full side rails while in bed at all times for prevention of falls and injury to self. The kardex for resident #010 dated September 12, 2015, indicated that when resident #010 is in bed, the restraint of two side rails are to be applied, resident #010 is repositioned every two hours and the restraint response is to be documented every hour.

On June 23, 2015, Inspector #617 interviewed S#107 and S#129 who reported that two full side rails were used when resident #010 was in bed for safety as they can roll out of bed and fall unto the floor. S#107 reported that they find the information to care for

resident #010 for the use of bed rails in the Kardex, posted logo on top of the bed, and shift report. Documentation of the use of the side rails for resident #010 is in Point of Care (POC).

On June 25, 2015, Inspector #617 reviewed resident #010's POC from June 1 to 22, 2015, for documentation of restraint response every hour and restraint positioning every two hours. The review of the documentation indicated that the resident response and restraint removal were not documented. S#128 and the Director of Care confirmed the missing documentation of the resident response and removal of the side rails for resident #010. [s. 110. (7) 7.]

4. The licensee has failed to 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 failed to ensure that documentation of every release of the device and all repositioning.

On June 23, 2015, Inspector #617 observed resident #013 in bed with both side rails up and logo above resident's bed indicated that they used two side rails as a restraint.

On June 23, 2015, Inspector #617 interviewed S#127 who confirmed that when resident #013 was in bed both full side rails were to be up and the documentation is completed in Point of Care (POC) as two full side rails, are used as a restraint. S#127 showed Inspector #617 the tasks for resident #013 which are identified as restraint response and restraint positioning for two side rails for resident documentation.

Inspector #617 reviewed the health care records for resident #013 which indicated that the kardex, care plan last updated June 8, 2015, a physician's order for a side rail restraint dated April 29, 2015, and a consent for side rail restraint dated March 25, 2015, identify the use two full side rails as a restraint while in bed at all times for prevention of injury to self. Monitor resident #013's skin every shift for signs of pressure areas, re-position every two hours and document the restraint response every hour. Inspector #617 reviewed the RAI-MDS assessment which indicated that resident #013 required extensive assistance with a two person assist for bed mobility and used two side rails.

On June 25, 2015, Inspector #617 reviewed the resident #013's documentation from June 1 to 22, 2015, for restraint response every hour and restraint removal which indicated that the resident response and restraint had not been documented. S#128 and DOC confirmed the missing documentation of the resident response and removal of the

side rails for resident #013.

Inspector #617 reviewed the home's Jarlette Health Services policy titled, Resident Rights, Care and Services-Minimizing of Restraining-Resident Care, revised September 16, 2013, which identified that bed side rails are a type of restraint permitted for use in the home. [s. 110. (7) 7.]

5. The licensee has failed to ensure that resident #006 was repositioned every two hours or more frequently as required.

Inspector #612 reviewed resident #006's care plan and noted that resident #006 is to return to bed after meals as per power of attorney's request.

The interventions listed included:

- Apply two full side rails when in bed as all times (restraint). Can remove rails when providing care.
- Restraint re-positioning every two hours when restraint is in place. Remove restraint (two full siderails) and reapply after re-positioning.

Inspector #612 interviewed S#118 who confirmed that they assist resident back to bed after meals. They then get resident up, between 1100hrs-1130hrs, for lunch and after lunch, between 1300-1330hrs, resident returns to bed until evening shift assist resident out of bed for supper. S#118 stated that on night shift the staff reposition resident every two hours. Inspector #612 spoke with S#117 who confirmed that on evening shift they get resident up for supper, usually between 1600-1630hrs and right after supper resident is returned to bed for the night around 1800- 1830hrs. S#117 confirmed that they do not know the last time resident is repositioned from the day shift.

Inspector #612 reviewed the documentation related to repositioning the resident every two hours with registered S#115.
- June 16th- signed at 2339hrs, 1030hrs, 1353hrs and 2226hrs
- June 17th – signed at 0202hrs, 0406hrs, 0531hrs, 1604hrs, 1605hrs, 2053hrs, and 2231hrs
- June 18th – signed at 0534hrs, 0535hrs x3, 2248hrs x4.

Registered S#115 confirmed that documentation is to be completed before the end of the shift and if it's not signed for by staff then the care was not provided. [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 residents #010 and #013 condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other times when necessary based on the residents condition or circumstances, to be implemented voluntarily.

WN #7: 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 the drugs are administered to residents in accordance with the directions for use specified by the prescriber as evidenced by resident #040 not receiving medications as ordered by physician.

On June 22, 2015, at 1200hrs, Inspector #613 observed the medication pass for resident #040 administered by S#124 in which the resident did not receive two medications as per physicians orders noted on the Pharmacy Reconciliation Sheet (dated June 15, 2015). The electronic medication administration record (EMAR) for resident #040 was reviewed noting two scheduled medications were not transcribed onto the EMAR consistent with the physician orders dated June 15, 2015.

On June 23, 2015, Inspector #613 reviewed resident #040 health records noting a letter dated June 23, 2015, was faxed to Pharmacy by registered staff S#125 including copy of the original medication reconciliation (dated June 15, 2015) requesting clarification on orders that were not processed.

On June 25, 2015, Inspector #613 interviewed the DOC who confirmed a transcribing error occurred and that a registered staff should have double checked the orders and confirmed the orders with the physician on admission. The DOC further stated that the physician and the pharmacy were notified of the error and incident report was initiated. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

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

On June 23, 2015 during observation of an injection medication administration pass for resident #021, Inspector #616 observed S#100 fail to practice hand hygiene prior to and following the medication administration. During interview with S#100 confirmed their understanding to wash hands before and after resident contact using hand sanitizer provided on medication cart. [s. 229. (4)]

2. On June 23, 2015, at 1130 during a medication administration on unit 3, Inspector #613 observed a member of the registered staff S#103 fail to perform hand hygiene before and after monitoring blood glucose and an injection medication administration to resident #040. S#103 was observed to proceed to administer medication to another resident without performing hand hygiene.

Interview with #124 confirmed that staff are expected to perform proper hand hygiene practices before and after resident care and that hand sanitizer is kept on the medication cart for staff use. [s. 229. (4)]

3. Inspector #612 observed S#116 and S#117 at 1600hrs providing personal care to resident #006. Inspector noted that the S#116 threw the soiled personal care product onto the resident's floor. S#116 picked up the personal care product once the care was provided to the resident and walked down the hallway to the dirty utility room to dispose of it.

Inspector #612 interviewed registered S#112, the Infection Control Lead, who confirmed that staff should be placing the soiled personal care product into the resident's garbage can in their room and then transporting the bag to the dirty utility room to dispose of it. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: 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 failed to ensure that the home was a safe and secure environment for its residents.

Inspector #612 conducted a tour of the home on June 15, 2015 at 1415hrs. During the tour the inspector was able to access over fifty boxes of testing solution for mask fit testing that were left in an unlocked cabinet in the activity room in home area Unit 4. The solution had a WHMIS label on the bottles, indicating a toxic substance.

The Administrator was notified on June 15, 2015 who confirmed that the solution should not be left accessible in the cabinet. [s. 5.]

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

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff.

Inspector #612 conducted a tour of the home on June 15, 2015. Inspector was able to push open the following doors that were equipped with a locking mechanism without entering the code and no staff were present in the area:

Soiled Linen Room
- contained bleach and other cleaning products

Equipment Storage Room
- contained oxygen concentrator and oxygen cylinders.

Equipment Storage Room
- contained an ex'n'flex machine, wheelchairs and walkers.

On June 22, 2015, Inspector #612 was able to push open the door to the soiled linen room without entering the code, no staff were present.

On June 22, 2015, Inspector #612 was able to push open the equipment storage room without entering the code, no staff were present.

Inspector #612 spoke with the Administrator who confirmed that the soiled linen room and equipment storage room doors should all be closed, locked and not accessible to the residents. [s. 9. (1) 2.]

WN #11: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #612 reviewed resident #006's wound assessment notes in Point Click Care. Inspector noted that a wound was identified on March 9, 2015, and treatment was initiated on March 10, 2015.

There were no weekly wound assessments found between the following dates:
- March 19, 2015 and April 8, 2015
- May 9, 2015 and May 20, 2015

Inspector confirmed with the Co-Director of Care S#115 that the wound assessments are documented electronically in Point Click Care (PCC) under the heading wound note. Confirmed that if the notes are not documented there then the assessment was not completed. [s. 50. (2) (b) (iv)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2)

Inspector #617 reviewed the minutes for the Residents' Council meetings which occurred on April 20, 2015; May 4, 2015; and June 1, 2015 provided by the Administrator. The issues recorded at each of the meetings were responded to by the Administrator, dated April 27, 2015; May 14, 2015; and June 12, 2015.

On June 23, 2015, inspector #617 interviewed resident #022, who reported that they did not yet receive the minutes from June's meeting or the licensee response. Resident #022 reported that the meeting minutes are posted in the activity room on unit 2 and submitted to them by S#130. Inspector #617 observed the posted minutes which were missing June's minutes and response.

On June 24, 2015, Inspector #617 interviewed S#130 who reported that they complete the Resident Council meeting minutes and email the minutes to the Administrator. S#130 reported that they sent an email with the June meeting minutes attached to Administrator on June 7, 2015. A copy of the email was provided to Inspector #617 that confirms the Administrator received the minutes. S#130 reported that they posted and submitted to Resident Council President, the minutes and the response on June 24, 2015.

On June 25, 2015, Inspector #617 interviewed S#131, and the Administrator who both confirmed that the process for submitting the Resident's Council minutes to the Administrator is by email. The Administrator reported that they email their response to S#131 for posting. The Administrator confirmed that they received the Resident Council June minutes on June 7, 2015, completed the response and posted them in the front lobby; however they did not send an email response to S#131 for June. The response back from the Administrator was not within the 10 day time frame. Resident Council meeting occurred on June 1, 2015 and response from Administration was not received until June 24, 2015. [s. 57. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

On June 25, 2015 at 11:03, Inspector #617 interviewed the Administrator, who reported a new process for surveying family and resident satisfaction, using the abaqis tool which was implemented in 2013. The abaqis surveys are completed by the administration staff and volunteers ensuring that all residents are surveyed annually. A report is completed and shared with Residents' Council annually. A copy of the minutes for the meeting in May 2014 was submitted to Inspector #617 indicating that the survey results were shared. The Administrator confirmed that the Resident's Council was not involved in the development of the survey implemented in 2013. [s. 85. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented to ensure that residents' personal items and clothing are labeled in a dignified manner within 48 hours of admission and of acquiring in case of new clothing.

On June 24, 2015, Inspector #613 observed several unlabelled articles of clothing belonging to three residents #004, #005 and #007.

On June 24, 2015, Inspector #613 interviewed the Environmental Supervisor S#122 and Laundry Staff #123 who stated residents' clothing is to be brought to the laundry department in a labelled bag by the nursing staff to be labelled upon admission.

On June 25, 2015, Inspector #613 reviewed the home's policy titled, Clothing Identification and Labelling (April 2010) that stated upon admission of a resident all clothing is to be gathered by the nursing department and brought to the laundry department. As well, the policy stated any new clothing is to be sent to laundry department immediately to be labelled with the resident's name.

On June 25, 2015, Inspector #613 interviewed the DOC who confirmed that staff are expected to bring residents clothing to the laundry department and that clothing articles are to be labelled.

The licensee did not ensure all resident's clothing was labelled as per policy. [s. 89. (1) (a) (ii)]

2. The licensee failed to ensure that procedures are implemented to ensure that there is a process to report and locate resident' lost clothing and personal items.

On June 23, 2015, Inspector #613 interviewed residents #004, #005 and #007 who reported missing clothing articles that had previously been reported to staff and remain missing.

Inspector #613 interviewed S#122 and S#123 who explained the home's policy and procedures for lost articles, and confirmed that the laundry department has not received any lost article forms regarding the three residents. They also stated the policy is not consistently followed by staff and that there is poor communication between departments when articles are found or remain missing.

Inspector #613 reviewed the home's policy titled, 'Lost Clothing' (April 2010)which identified staff are to complete the lost clothing form and communicated to all of the home areas that a piece of clothing is missing so the missing clothing can be looked for. Nursing staff to check resident's home area, laundry staff to look through clothing in their department, environmental staff to search as well. All staff are to continue the above steps until item is found. However, nursing staff did not complete the form or communicate to all staff the residents missing clothing items.

On June 24, 2015, Inspector #613 reviewed the home's lost clothing records of lost articles for 2014 and 2015. The lost articles reported by resident's #004, #005 and #007 were not identified.

In an interview with the DOC, they acknowledged one of the missing clothing articles for resident #004, and that staff did not follow the home's procedures and process to report and locate the resident's lost clothing. [s. 89. (1) (a) (iv)]

Issued on this 14th day of September, 2015

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

Original report signed by the inspector.