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
Jan 19, 2015	2014_271532_0037	L-001592-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE ELLIOTT GROUP
170 Metcalfe Street GUELPH ON N1E 4Y3

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

THE ELLIOTT COMMUNITY
170 METCALFE STREET GUELPH ON N1E 4Y3

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

NUZHAT UDDIN (532), DEBORA SAVILLE (192), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)

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): December 5, 8,9,10,11,12,16,17, 2014

Concurrent CIS were completed: 003253-14,000248-14 and 002387-14

During the course of the inspection, the inspector(s) spoke with The Chief Operating Officer, Administrator, Director of Care, Director of Environmental Services, Director of Human Resources, Director of Dietary Services, Director of Recreation and Volunteer Services, Restorative Care Coordinator, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary aide, Recreation Care Aide, Housekeeping and Maintenance staff , Family and Resident Council Representatives, Family Members and Residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

14 WN(s)
7 VPC(s)
1 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 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, received immediate treatment and interventions to promote healing as required.

A) Clinical record was reviewed and it indicated that an identified resident had an altered skin integrity.

A Record review identified the resident as at risk for altered skin integrity.

Another clinical record identified the resident as at high risk for altered skin integrity.

A Registered Nurse indicated that the identified resident was able to change the position and that staff check on the resident frequently.

The identified resident denied changing the position and shared that the staff assisted the resident occasionally with the repositioning.

Observations revealed that the identified resident was sitting up and there was no therapeutic surface on the bed and/or on the chair.

Record review revealed that the identified resident was not provided with the pressure relief therapeutic surface, no referral or a seating assessment was completed and there was no referral completed for an Enterostomal Therapists (ET) nurse.

The home's policy titled Skin and Wound Care Program, stated the following:
6. Ensure that the resident was provided with the pressure relief therapeutic surface
7. Obtain a seating assessment if the resident has an ulcer on a sitting surface
9. Make a referral to Enterostomal Therapist (ET) nurse or Wound Care Specialist if available (for Stage3, 4 and unstageable ulcers only.)

The policy was reviewed with the Restorative and Wound Care Coordinator, who confirmed that the above interventions were not in place to promote healing, however, she could make a phone call to the maintenance staff and they could bring the therapeutic surface up for the resident and further indicated that she would make referrals for the seating assessment and to the ET nurse.

The Director of Care and Restorative and Wound Care Coordinator confirmed that the interventions to promote healing as noted above were still not implemented. [s. 50. (2) (b) (ii)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A) A staff member was overheard raising their voice to an identified resident.

The resident had responsive behaviours related to their diagnosis.

The staff member who heard these comments immediately reported this incident to the Director of Care.

A review of the investigation records and an interview with the Director of Care confirmed that the identified staff did not treat the resident with courtesy and respect and did not respect the resident's dignity.

B) An identified resident in interview indicated that staff were rough when providing care.

Record review indicated that resident had multiple diagnosis and were receiving analgesic for pain.

The Director of Care reported that she was not aware of any alleged incidents of rough treatment involving this resident.

The identified resident confirmed that they told the staff to stop providing care and the request was ignored repeatedly and they confirmed that they were not treated with respect and dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the residents' right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was respected and promoted.

A) An identified resident was observed as not groomed. On two different occasions the resident was again observed not groomed.

Record review indicated that the identified resident required assistance for the maintenance of appearance related to impaired physical mobility.

Interview with the identified resident indicated that the resident preferred to be properly groomed.

Interview with a Personal Support Worker (PSW) confirmed that the resident was not groomed and that it would be the expectation.

Interview with the resident indicated they had not refused care and that the staff had not offered.

Interview with the Registered Nurse confirmed that the identified resident was not resistive to care, was unlikely to have refused care offered and that it would be expected that when a resident refuses care, registered staff would be notified. The registered staff member indicated that it was not reported that the resident had refused any care and documentation review with the registered staff member identified no recorded refusal of care.

B) An identified resident was observed to have discharge from both eyes. Interview with a PSW and record review confirmed that the resident had received a bath.

The RN indicated it would be expected during bathing that the identified resident would have their face washed and discharge removed from the residents eyes.

The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs were fully

respected and promoted. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A) Record Review revealed that an identified resident was to wear an assistive device.

Upon observation of the identified resident it was noted that they were not wearing the assistive device.

Upon interview with a Personal Support Worker it was reported that the identified resident never wore the assistive device and other interventions were used to accommodate the resident.

The Registered Practical Nurse/Resident Assessment Instrument Coordinator confirmed that the care plan should been reviewed and revised to reflect that the resident's care needs had changed and/or were no longer necessary.

B) Record review for an identified resident indicated that the resident had medical device in place related to their diagnosis.

A review clinical record indicated that the identified resident was experiencing symptoms related to their diagnosis.

The identified resident sustained a fall resulting in an injury. The resident was assessed and interventions were put in place.

The identified resident sustained a second fall resulting in another injury and a change in condition was noted.

A clinical record review indicated that the resident was not assessed at the identified times.

A review of the clinical record indicated that there was no reassessment of the resident despite the resident exhibiting a change in condition. The Director of Care confirmed that there was no reassessment of the resident when the resident's care needs changed. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was
complied with.

A) The Home's Head Injury Routine (HIR) policy indicated that neurological checks and vital signs were to be taken and documented every 15 minutes for one hour; every 30 minutes for one hour; every hour for four hours; every four hours for 24 hours, every six hours for 24 hours and every eight hours for 24 hours.

An identified resident sustained a fall resulting in an injury. An assessment was completed and interventions were put in place and the resident sustained a second fall.

The Director of Care and a Registered Practical Nurse confirmed that the HIR should have been initiated.

Record review indicated that the HIR for the identified resident's was not done.

The Director of Care confirmed that HIR should have been taken and recorded at the identified times.

The licensee failed to ensure that the home's HIR policy was complied with. [s. 8. (1) (a),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, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

A) The health record for the identified resident indicated that the resident had multiple diagnosis.

A review of the resident's clinical record indicated that the Registered Dietitian identified that the resident had extensive interventions in place in collaboration with Speech Language Pathology to minimize the resident's risk of aspiration.

A review of the clinical record indicated the resident was to receive a specific diet and avoid certain food items.

During meal observations it was observed that staff were providing the identified resident with food items that were not prescribed.

Upon observation it was noted that the documentation posted did not include the interventions.

Interview with the Director of Dietary Services confirmed that the documentation did not include these interventions and confirmed that the resident should not have received identified food items.

The licensee failed to ensure that safe foods were provided to minimize the risk of aspiration for this resident. [s. 11. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and cannot be opened more than 15 centimetres.

A) During the initial tour of the home of the Resident Quality Inspection (RQI), it was noted that two of the dining room windows were opened more than 15 cm.

Observations made again on an identified date, in the presence of the Director of Care, revealed that there were another windows that opened 22.5 cm and another window that opened 20 cm and two other windows that opened 24.5 cm and 17.5 cm.

Observations made in the presence of the Director of Care, revealed that in the dining room there was one window that opened 26 cm, one window opened 17cm, and one window opened 29.5cm.

Observations made in the presence of the Director of Care, revealed that in the dining room there was one window that opened 20 cm.

Windows in the identified rooms were checked and found to have windows opening more than 15 cm.

The Director of Care confirmed these measurements on the unit dining rooms, recreation rooms, and resident rooms.

The Director of Environmental Services indicated that an audit was completed about 2 months ago and he ordered 100 stoppers to be placed on the windows that opened too much, however, he confirmed that another audit of the windows was needed to ensure that the windows cannot be opened more than 15 centimetres. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #7: 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 has failed to ensure that the resident who is incontinent has received an assessment that included 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.

A) Record review stated the following for identified resident:

Quarterly review assessment showed a change in urinary continence as compared to the last assessment.

Resident Assessment Protocol stated that the resident had been incontinent of bladder and required the use of incontinent products for containment.

The Director of Care indicated that any change in continence of bowel or bladder would result in completion of a continence assessment.

However, a Registered Practical Nurse reported that they were not aware that they were to complete a continence assessment with a change in continence.

A review of the clinical record indicated that there was no continence assessment completed for the resident.

The Director of Care confirmed that there was no continence assessment completed for the resident with the recorded changes.

B) An assessment of an identified resident indicated that there was a change in bowel continence from the previous assessment.

Interview with the registered nurse indicated that any change in continence of bowel or bladder would result in completion of a continence assessment.

Record review, including the medical record and interview with the Registered Nurse confirmed that no continence assessment was completed for the resident with recorded changes in continence.

The home's policy related to Continence Care and Bowel Management Program, policy number J-015B dated as last reviewed November 2014 indicated that the interdisciplinary team was to conduct a bowel and bladder continence assessment on admission, quarterly (according to the RAI-MDS 2.0 schedule) and after any change in status that may affect bladder or bowel continence.

The licensee failed to ensure that resident #004 and #008 were assessed for continence. [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 has received an assessment that included 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 #8: 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 of the long term care home failed to ensure that staff apply the physical device in accordance with any manufacturer's instructions.

A) The Director of Care provided the manufacturer's specifications and reported that the home's expectation would be that a physical device be applied as per manufacturer's specifications.

On number of observations the identified resident was observed to be in their wheelchair with a physical device positioned loosely.

In an interview the resident's family member reported that the resident's physical device had been applied loosely on other occasions.

Interview with the Director of Care confirmed that the resident's physical device was not applied in accordance with the manufacturer's instructions. [s. 110. (1) 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 staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #9: 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 failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in good state of repair.

A) An identified resident's equipment was observed as not in good state of repair.

The Restorative Care Coordinator reported that nursing staff document the identified equipment concerns that require fixing in the binder on the home area. The service company visits weekly and will repair the equipment.

A review of the binder indicated that resident's equipment was not documented as requiring repairs.

A Personal Support Worker (PSW) confirmed that the resident's equipment was not in good state of repair and that it should have been reported and documented in the binder. The PSW confirmed that the repairs required for the resident was not reported in the binder to be fixed at the time of the interview.

Another resident's personal equipment was noted as not in good state of repair.

A review of the binder indicated that the identified resident equipment was not documented as requiring repairs.

The Director of Care confirmed that the resident's equipment was significantly damaged and required repairs.

The licensee did not ensure that the equipment was maintained in a safe condition and in good state of repair. [s. 15. (2) (c)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

A) An identified resident was observed to be seated by the window, diagonal to the bed. The call bell was not accessible.

The registered staff interviewed identified that the identified resident would not be able to get to the call bell.

Clinical record for the identified resident, indicated that the call bell should be within reach.

The licensee failed to ensure that the resident could easily access and use the resident-staff communication system at all times. [s. 17. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practises and, if there are none, in accordance with prevailing practises.

A) Interview with the Director of Care and Administrator confirmed that the Continence Care and Bowel Management Program was not evaluated and updated in 2013.
It is noted that a 2014 evaluation was in progress but has not yet been completed. [s. 30. (1) 3.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record relating to the nursing and personal support services staffing plan evaluation including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented were kept.

A) The Administrator reported that an evaluation of the staffing plan occurred and changes to the personal support services staffing plan were planned to be implemented in January 2015 however, there was no record kept that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 31. (4)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A) An identified family member in an interview shared that they were not aware of concerns being addressed within 10 days and indicated that the home usually answered the questions at the following meeting.

Number of Family Council meeting minutes were reviewed and it was noted that the Family Council had expressed concerns , however the concerns were not addressed and no response was documented.

Restorative Care Coordinator and the Assistant to the Family Council confirmed that concerns were not responded to in writing within 10 days of receiving Family Council concerns or recommendations. [s. 60. (2)]

WN #14: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

A) An identified resident interview indicated that the resident did not recall discussing meal and snack times at the Residents' Council meeting.

2014 Resident Council meeting minutes indicated that a review of meal and snack times were not completed.

The Director of Recreation /Volunteer Services confirmed that the meal and snack items were not reviewed by the Resident Council. [s. 73. (1) 2.]

Issued on this 20th day of January, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), DEBORA SAVILLE (192), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_271532_0037
Log No. / Registre no:	L-001592-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 19, 2015
Licensee / Titulaire de permis :	THE ELLIOTT GROUP 170 Metcalfe Street, GUELPH, ON, N1E-4Y3
LTC Home / Foyer de SLD :	THE ELLIOTT COMMUNITY 170 METCALFE STREET, GUELPH, ON, N1E-4Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TREVOR LEE

To THE ELLIOTT GROUP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that every resident of the home receives immediate treatment and interventions to promote healing as required.

Grounds / Motifs :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to promote healing as required.

A) Clinical record was reviewed and it indicated that an identified resident had an altered skin integrity.

A Record review identified the resident as at risk for altered skin integrity.

Another clinical record identified the resident as at high risk for altered skin integrity.

A Registered Nurse indicated that the identified resident was able to change the position and that staff check on the resident frequently.

The identified resident denied changing the position and shared that the staff assisted the resident occasionally with the repositioning.

Observations revealed that the identified resident was sitting up and there was no therapeutic surface on the bed and/or on the chair.

Record review revealed that the identified resident was not provided with the pressure relief therapeutic surface, no referral or a seating assessment was completed and there was no referral completed for an Enterostomal Therapists (ET) nurse.

The home's policy titled Skin and Wound Care Program, stated the following:
6. Ensure that the resident was provided with the pressure relief therapeutic surface
7. Obtain a seating assessment if the resident has an ulcer on a sitting surface
9. Make a referral to Enterostomal Therapist (ET) nurse or Wound Care Specialist if available (for Stage3, 4 and unstageable ulcers only.)

The policy was reviewed with the Restorative and Wound Care Coordinator, who confirmed that the above interventions were not in place to promote healing, however, she could make a phone call to the maintenance staff and they could bring the therapeutic surface up for the resident and further indicated that she would make referrals for the seating assessment and to the ET nurse.

The Director of Care and Restorative and Wound Care Coordinator confirmed that the interventions to promote healing as noted above were still not implemented. [s. 50. (2) (b) (ii)] (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

Service Area Office /
Bureau régional de services : London Service Area Office