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 12, 2015	2015_282543_0014	011112-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

TIFFANY BOUCHER (543), JENNIFER LAURICELLA (542), SYLVIE LAVICTOIRE (603)

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 8-12 & 15-19, 2015

Throughout the inspection, the inspectors directly observed the delivery of care and services to residents in all home areas, conducted resident and family interviews, directly observed dining and meal service, observed fluid and nourishment passes, directly observed medication passes, reviewed resident health care records, reviewed staffing patterns for RNs and RPNs and reviewed various home policies and procedures.

The following logs were inspected concurrently with this RQI:
-10212-15
-11627-15
-6393-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Assistant Director of Care, Registered Staff (RNs and RPNs), Personal Support Workers (PSW), Dietary Manager, Dietary Staff, Registered Dietitian, Support Services Manager, Maintenance Staff, Residents and Family Members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

On June 16, 2015, Inspector #603 observed resident #009 lying in bed with half side rails engaged on each side of the bed. On review of the plan of care, there was no mention of side rails to be utilized. During an interview with S#115 and #120, both staff members confirmed the use of side rails for safety while the resident is in bed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in the plan.

On June 11, 2015, Inspector #542 completed a health care record review for resident #021. The care plan accessible to the direct care team indicated that the staff were to apply a bed alarm while in bed and then to move the device to the resident's chair while up in the chair. Inspector spoke with S#122 who stated that resident #021 was to have the alarm put on the chair and clipped to the resident when the resident was up to assist with preventing falls.

On June 16th, 2015, Inspector #542 observed resident #021 sitting in their chair in their room. The alarm was attached to the chair but it was not clipped to the resident, making it ineffective. Inspector #542 asked S#126 and S#127 if they could check if the chair alarm was functioning correctly for this resident. Both staff members agreed that it needed to be clipped to the resident in order for it to work properly and alert the staff if the resident was attempting to stand on their own. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for resident #009 sets out clear directions to staff and others providing care to this resident; and to ensure that the care set out in resident #021's plan of care is provided to them as specified in their plan, to be implemented voluntarily.

WN #2: 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 the home's Falls Prevention and Management Program was complied with.

Inspector #543 reviewed resident #041's health care record which identified that in May 2015 this resident had a fall. They were found by Personal Support Workers on the floor beside their bed.

Inspector #543 spoke with S#106 regarding this resident related to falls who stated that when a resident falls a checklist is completed, the Registered Nurse will complete a head-to-toe assessment to determine the status of the resident. This staff member stated that if a fall is un-witnessed or the resident hit their head the resident will be placed on a Clinical Monitoring Record which needs to be initiated. S#106 confirmed there was no

Clinical Monitoring Record for this resident for the fall they sustained on May 14, 2015.

Inspector #543 reviewed the home's policy-Falls Prevention and Management Program (RESI-10-02-01) which stated that if a resident hits their head or is suspected of hitting their head (i.e. an unwitnessed fall) a clinical monitoring record needs to be completed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's Falls Prevention and Management Program (RESI-10-02-01) was complied with.

Inspector #543 reviewed critical incident #2590-000014-15 whereby resident #044 was allegedly transferred incorrectly, sustained a fall that resulted in injuries and a transfer to the hospital.

The inspector reviewed the home's policy-Falls Prevention and Management Program (RESI-10-02-01) which indicated that a member of the registered staff will immediately complete an initial physical and neurological assessment of the resident and a post falls assessment within 24hours of a fall. Upon reviewing resident #044's health care record, the inspector identified that the registered staff were not made aware of the fall until 3 days later, which resulted in a delay in the assessments. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the policy, Bed Entrapment And Proper Use of Bedrail Devices, was complied with.

On June 16, 2015, Inspector #603 observed resident #009 laying in bed with half side rails engaged on each side of the bed. On review of the home's policy, Bed Entrapment And Proper Use of Bedrail Devices, a written consent and physician's order must be in place and followed for any situation, in which a resident cannot independently release a safety device, resulting in restricted freedom of movement. In this situation, there was no consent for side rails. Inspector interviewed S#115 who confirmed that there was no consent for the side rails.

On June 11, 2015, Inspector #603 observed resident #009 sitting in a chair with a restraint applied. On review of the home's policy Physical Restraints, there is to be a physician's order for any restraint and the home needs to obtain consent from the resident, where possible, or the POA/SDM. In this case, there was no consent for the restraint. Inspector interviewed S#115 who confirmed that there was no consent. [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 the home's Falls Prevention and Management Program and Bed Entrapment And Proper Use of Bedrail Devices policy are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, that the resident has been assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On June 10th, 2015, Inspectors #542, #543 & #603 observed residents #009, #022 & #041 in bed with bed rails in the raised position. A health care record review was completed for these residents and the most current care plan accessible to the direct care team indicated that the side rails were used for bed mobility. Inspector #542 identified that the home completed bed system evaluations, however the home did not assess the residents for the use of the bed rails.

Inspector #542 spoke with the S#115 and S#123 who confirmed that the home has not assessed residents for the use of bed rails. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, other safety issues related to the use of the bed rails are addressed, including height and latch reliability.

Inspector #542 was informed by the Director of Care that the maintenance department completes the assessments on the bed systems and that they would be the staff to speak to regarding this.

Inspector #542 spoke with S#123 who stated that they completed assessments on the bed systems (entrapment zones and mattresses) where bed rails are used with regards to the entrapment zones and showed this inspector the documented results of the assessments. The inspector asked S#123 if they also addressed the height and latch reliability of the bed rails who stated that this was not being done. Inspector #542 spoke with S#107 who verified that the home was not addressing other safety issues related to the use of bed rails, including height and latch reliability. [s. 15. (1) (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 that where bed rails are used, that the resident has been assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident and that other safety issues related to the use of the bed rails are addressed, including height and latch reliability, 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 its furnishings in the third floor's dining room are kept clean and sanitary.

On June 8, 2015, Inspector #603 observed the lunch dining services in the third floor's dining room. The dining services on this unit has two sittings for lunch. In between sittings, there was no cleaning conducted in the dining room other then the dietary aide changed some of the table cloths and utensils but was not able to change all of them because the second sitting residents were arriving and positioning themselves at their table. The inspector observed residents utilizing unclean utensils and were drinking out of left over cups on the table. During an interview with S#100, they stated there is just no time to change all table cloths and reset the tables before the second sitting residents arrive. The inspector spoke with S#111, who stated the minimum requirement is to have all table cloths changed and table reset before the second sitting arrives. Staff #111 explained that the dietary aides have access to cleaning supplies if needed and the staff are not expected to clean the chairs and tables in between sittings. [s. 15. (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 furnishings in the third floor's dining room are kept clean and sanitary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff are provided training in falls prevention and management.

Inspectors #543 and #542 reviewed the education/training documents provided related to the home's Falls Prevention and Management Program (RESI-10-02-01) which indicated that 89% of direct care staff received training for the year 2014.

The inspectors spoke with S#130 who stated that going forward, the home has initiated a new program related to falls and all direct care staff in the home will be educated. They stated that for the year 2015 approximately 50% of all direct care staff have been educated to date. [s. 221. (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 all direct care staff are provided training in the home's Falls Prevention and Management Program, to be implemented voluntarily.

WN #6: 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 10, 2015, the inspector observed S#102 handling unclean dishes and serving food to different residents without performing hand hygiene. Staff #111 explained that the staff are to perform hand hygiene after handling unclean dishes and prior to serving food . On review of the home's Hand Hygiene Program, all staff are required to perform hand hygiene before and after preparing, handling, and serving food.

On June 18, 2015, Inspector #603 observed S#128 administer medications to residents on the fourth floor unit. Staff #128 was observed putting on gloves in order to perform a blood test on a resident. Once completed S#128 removed the gloves and did not perform hand hygiene. Staff proceeded to prepare and administer various medications. Once completed, the staff moved on to the next resident where they administered medications without performing any hand hygiene. On interview with S#128 about the home's expectation for hand hygiene while administrating medication, they explained that staff are to perform hand hygiene in between residents and did agree that they did not perform any hand hygiene between the different residents and procedures. The inspector reviewed the home's Hand Hygiene Program, which indicated that the staff are to perform hand hygiene between different procedures on the same resident; before and after contact with any resident; before putting on and after taking off gloves. [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 that all staff participate in the implementation of the home's Infection Prevention and Control program, specifically the Hand Hygiene Program, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure the residents' rights to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity were fully respected and promoted.

On June 10, 2015, Inspector #603 observed S#110 to provide total assistance with breakfast to resident #015. Staff #110 was observed abruptly bringing the cup to the resident's mouth in a hurried manner, without any notice of their action to the resident who responded with a surprised expression each time and with their head tilted back from force. There were no interactions between the staff and resident. Once the staff member noticed the inspector present, the demeanor changed and they started to interact with the resident and slowed down the process of feeding.

Inspector #603 also observed S#109 offering meal choices to the residents. Their approach was abrupt and very hurried, leaving very little time for residents to respond. Staff #109 was then observed to provide total assistance with breakfast to resident #014. Staff #109 was observed abruptly bringing the cup to resident's mouth in a hurried manner, without any notice of their action to the resident and resident #014 responded with a surprised expression each time. Resident #014 had barely swallowed the beverage when S#109 would bring the cup to their mouth again, surprising the resident. Staff #109 demonstrated the same hurried manner for wiping the resident's face with a napkin, surprising the resident each time.

No conversation was observed by S#109 with any of the four residents seated at the table and they kept getting up and leaving the table to do other things such as filling a cup with milk. Inspector #603 approached S#109 regarding being rushed and abrupt and the staff explained that they just needed a day off. [s. 3. (1) 1.]

WN #8: 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 has failed 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 centimeters.

On June 8, 2015 at 1030, Inspector #603 conducted an initial tour of the home and observed window #6 in the fourth floor's dining room/lounge opened 76.2 centimeters. At that time, there were 4 residents and one staff member present in the dining room/lounge. Inspector #603 interviewed S#104 who explained that the window has been opening like this for some time. Inspector #603 brought forward safety concerns and for this reason, S#104 reported this concern to maintenance who came and fixed the window.

On June 9, 2015, Inspector #603 observed in a particular room, a window that opened 22.8 centimeters and would not close completely as the latch was broken. The inspector reported this to S#123 who was able to fix the window that same day. [s. 16.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

On June 9, 12, and 16, 2015, Inspector #603 observed resident #009 laying in bed with half side rails engaged on each side of the bed. The resident is unable to remove the side rails. Inspector noted that there is no restraint plan of care which includes side rails or any physician order by the physician or the registered nurse in the extended class for side rails which are being utilized as a form of restraint.

Inspector #603 reviewed the home's policy on Bed Entrapment And Proper Use Of Bedrail Devices which indicated: Extendicare considers that any situation, in which a resident cannot independently release a safety device, resulting in restricted freedom of movement, is deemed a restraint. Written physician's orders, and written consent must be in place. On interview with S#120, the resident has half side rails up for security. [s. 31. (2) 4.]

2. The licensee has failed to ensure that the restraint plan of care included the consent by the resident or if the resident is incapable, by the SDM.

On June 11, 2015, Inspector #603 observed resident #009 with a restraint while up in a chair, tilted back with a seat belt on and on June 16, 2015, the resident was laying in bed with half side rails engaged on each side of bed. Inspector #603 reviewed the resident's health care record and noted that there was no consent for the use of restraints. Staff #115 confirmed that there were no consent from the resident or SDM for the use restraints. [s. 31. (2) 5.]

WN #10: 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by the registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration were implemented.

During stage one of the Resident Quality Inspection, resident #021 was observed to have skin integrity issues. Inspector #542 completed a health care record review which indicated that the resident had impaired skin integrity. It was also noted that a referral was sent to the Registered Dietitian (RD) in May 2015 by the nursing department related to impaired skin integrity. Inspector spoke with the Registered Dietitian who acknowledged that they should have reviewed the referral and assessed the resident. The inspector identified that on June 18, 2015, there was no assessment completed for the resident's impaired skin integrity by the RD. [s. 50. (2) (b) (iii)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items offered were available at each meal.

On June 8, 2015, Inspector observed the lunch dining services in the third floor dining room. The menu included bread sticks for lunch, however there were none to be served. Staff #103 confirmed that there were no bread sticks but they had whole wheat bread to offer the residents. The posted menu offered no substitution for the bread sticks nor was it communicated to the residents. On interview with staff #111, they explained that there were no bread sticks and they forgot to communicate this and change the menus for the residents. Staff #111 explained that they usually communicate any change by putting an asterisk beside the substitution on the posted menu. [s. 71. (4)]

WN #12: 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: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are monitored during meals.

On June 8, 2015, Inspector #603 interviewed S#101 who explained that there is to be a registered staff that monitors the dining services and this process rarely happens. In an interview, S#111 also confirmed that it is the responsibility of registered staff to monitor residents during meals.

On June 8, 2015, during the lunch meal there were no registered staff monitoring the dining room, in fact the only registered staff present for most of the meal service was calling out the food and was standing beside the food cart which was positioned in the unit's hallway beside the dining room. The registered staff was not monitoring the dining services and agreed that they could not do this based on other functions they were responsible for.

On June 8, 2015, Inspector #603 observed resident #004 feeding cake to resident #005 because they were hungry. Inspector observed resident #006 eating out of resident #007's soup as they were hungry and waiting to be served. The inspector observed resident #004 putting their paper napkins in their soup and they started to eat soup when the inspector advised staff of the incident. Throughout the meal services, it was evident that the attending staff were busy feeding residents and were not monitoring others. [s. 73. (1) 4.]

2. The licensee has failed to ensure that sufficient time is provided for residents to eat at their own pace.

Inspector #603 observed the lunch dining services in the third floor dining room. At 1235, all residents were sitting in the dining room. The meal service was to start at 1245 and did not start until 1302. At 1345, some of the residents from the first sitting were still eating on their own and some were still being fed by staff when the second sitting residents were now walking or being wheeled into the dining room for their meal that was to start at 1345. At 1400, some residents from the second sitting were still waiting for their table and chair as residents from the first sitting were still eating. The staff were rushing some of the residents away from their table in order to make room for the second seating of residents and there was no opportunity for a second serving as requested by resident # 004 and denied. [s. 73. (1) 7.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later that one business day of the incident that occurred on May 6, 2015, whereby resident #044 fell and sustained an injury for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Inspector #543 spoke with S#106 who stated that on May 9, 2015, they were informed that on May 6, 2015, resident #044 was allegedly transferred incorrectly which resulted in injuries for which the resident was transferred to the hospital.

The inspector reviewed the critical incident #2590-000014-15 report which indicated that the Director was informed on May 12, 2015. [s. 107. (3) 4.]

2. The licensee failed to ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall inform the Director of the incident no later than three business days after the occurrence of the incident.

Inspector #542 reviewed Critical Incident (CI) # 2590-000005-15 that was submitted to the Director March 19th, 2015. The CI indicated that resident #024 had a fall on March 15, 2015 which resulted in a transfer to the hospital. Inspector #542 reviewed the resident's progress notes which indicated that the resident returned from the hospital on March 15, 2015 with no apparent injuries. Over the course of the next few days the progress notes revealed that resident #024 continued to complain of pain, refused to leave their bed and eat or drink at times. This then resulted in an additional assessment at the hospital on March 18, 2015. On March 19, 2015, results received from the hospital indicated that the resident sustained an injury that resulted in a significant change in their health status. [s. 107. (3.1) (b)]

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

Issued on this 24th day of August, 2015

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

Original report signed by the inspector.