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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 3, 2014	2014_196157_0008	O-000204-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

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

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE, PETERBOROUGH, ON, K9J-6B4

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

PATRICIA POWERS (157), MARIA FRANCIS-ALLEN (552), PATRICIA BELL (571)

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): March 18, 19, 20, 21, 24, 25, 26, 27 and 28, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator(Adm), Director of Care(DOC), Best Practice Coordinator(BPC), Clinical Coordinator(CC), RAI Coordinator(RAI), Dietary Manager(DM), Program Manager(PM), Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Environmental Aides(EA), Activity Aides(AA), Family members, Residents, Resident Council President

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of resident care, observed staff to resident interactions, observed infection control practices, observed meal service, observed medication program/procedures, reviewed clinical health records for identified residents,reviewed meeting minutes for Family Council, Resident Council, CQI, medication committee, reviewed program evaluations, employee files, education programs, activity and recreation programs, policies related to restraints, abuse prevention, infection control, continence management, communication systems, responsive behaviours management, personal support services, activity/recreation services, pain management, staffing and complaint management.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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:
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).

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 is properly cared for in a manner consistent with his or her needs.

In an interview with inspector #571, a family member expressed concern that the resident was put on the toilet and left unattended for extensive periods of time before staff returned to provide assistance.

A review of the plan of care for the resident indicated the following:
- The resident requires "extensive assistance" for toilet use.
- Staff are directed to provide verbal cues throughout the day as reminders to void in the toilet.

In an interview, staff #103, identified that the following system is in place for call bell

response:
- The call initially rings to the PSW pager.
- If there is no response to the call after three minutes, it is directed to the RPN pager.
- If there is no response to the call after 10 minutes, it is directed to the RN pager.

A review of the home call answer monitoring record, "Callpoint Detailed Activity Report by Location" for the period January 1, 2014 to March 27, 2014 indicated the following:
- On 7 occasions the call bell in the identified resident's room, rang for a period greater than 15 minutes before being answered. On February 25, 2014 at 1251 hrs the call bell rang for 30 minutes before being answered.
- On 29 occasions the call bell in another identified room rang for a period greater than 15 minutes before being answered. On February 11, 2014 at 1715 hrs the call bell rang for 51 minutes before being answered.
- On 112 occasions the call bell in another identified room rang for a period greater than 15 minutes before being answered. On February 25, 2014 at 1745 hrs the call bell rang for one hour and 15 minutes before being answered.

Facility policy - Communication Systems - "Nurse Call System" - RESI-08-02-01 directs that staff are responsible to respond to calls in a "rapid and courteous manner".

The licensee failed to monitor call response times and take corrective action when deficiencies were identified. [s. 3. (1) 4.]

2. The licensee failed to ensure resident's 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.

On March 27, 2014, inspector #571, during observation of the 1200 hrs medication pass witnessed registered nursing staff discarding empty medication pouches with the following personal health information stamped on them, into a clear garbage bin on the side of the medication cart:
- resident's name
- medication and dosage
In interviews conducted on March 28,2014 registered nursing staff #104 and #133 confirmed that empty med pouches with residents' confidential information are disposed of in clear garbage bags and then disposed of in the garbage bin at the back of building. [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:
- every resident is properly cared for in a manner consistent with his or her needs
- every resident has his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, 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. (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).

Findings/Faits saillants :

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

Related to Resident #1935
The plan of care for resident #1935 fails to set out clear directions to staff and others who provide direct care to the resident related to the use of a physical restraint.
The resident's plan of care directs the following:
Positioning in Wheelchair
- Lap tray to be applied on tilt wheelchair with buckle belt for positioning
- Wheelchair to be placed on moderate to maximal tilt position with the exception of meals and 30 minutes after meals when wheelchair is to be in full upright position

The plan of care for resident #1935 fails to identify the risks associated with application of the physical restraint and set out clear direction related to the resident's

need for repositioning, monitoring and safety checks. [s. 6. (1) (c)]

2. Related to resident #1986
The plan of care for resident #1986 fails to set out clear directions to staff and others who provide direct care to the resident related to the resident's oral care requirements.

The plan of care for resident #1986 directs the following related to oral care:
Oral Care:
- Natural teeth loss and no dentures
- Resident mouth will be cleaned at least 2 times per day while the resident has no dentures
- When dentures are replaced, they must be labelled and kept in a specific area

Review of Kardex posted in the resident's room directed the following:
- The resident has dentures
- Needs daily oral hygiene

In an interview on March 25, 2014, staff #107 advised:
- Resident #1986 has no dentures or natural teeth
- Oral hygiene is provided for the resident once during the day shift

The plan of care provides conflicting information related to the resident's oral status and as a result fails to set out clear direction related to resident #1986's oral care needs. [s. 6. (1) (c)]

3. Related to resident #1935
The plan of care for resident #1935 fails to set out clear directions to staff and others who provide direct care to the resident related to the resident's oral care requirements.

The plan of care for resident #1935 directs the following related to oral care:
Personal Hygiene:
"Resident does not have any teeth. Resistive to oral care. Staff do a water rinse"

Dental Status:
Dentures
"monitor to ensure dentures fit and are in mouth correctly"
"remove and soak dentures every night"

In an interview with the resident's SDM, it was confirmed that the resident does not have dentures.

The plan of care provides conflicting information related to the resident's oral status and as a result fails to set out clear direction related to resident #1935's oral care needs. [s. 6. (1) (c)]

4. Related to resident #001
The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to the monitoring of a physical restraint.
On March 24, 2014 1200 hrs resident #001 was observed to be wearing a front closing lap belt in a wheelchair. The lap belt was appropriately applied, the resident was unable to undo the belt when asked by the inspector.

The plan of care for resident #001 directs the use of a lap belt restraint but fails to set out clear direction:
- related to the resident's need for hourly safety checks and every two hourly repositioning.
- for the need for a physical restraint related to the risk for falls, as identified on the "Restraint Assessment" completed by registered nursing staff. [s. 6. (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 residents' plans of care set out clear directions to staff and others who provide direct care to the resident, 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. LTCHA, 2007, S.O.2007, c.8, s. 29(1) requires every licensee of a long term care home to ensure there is a written policy to ensure that restraining is done in accordance with the Act and Regulations and shall ensure that the policy is complied with.

The licensee failed to ensure that the following policies were complied with:

Policy: Physical Restraints - Reference #RESI-10-01-01 - Version November 2012
Policy directs the following:
Registered Nursing Staff are Responsible to:
- Ensure that at minimum the resident's response to the restraint and the need for continued use of the restraint must be evaluated each shift and documented either on the Restraint Record or where e-documentation is in place.
Care Staff are responsible to:
- Ensure that Restraint Record is completed.
- Monitor restraint use must be completed with hourly safety checks and two hourly position changes which requires the release of the restraint and documented on the restraint record or in e-documentation (POC)
- Follow care plan for application and release of the restraint with special attention to care needs during restraint use.
Required documentation:
- A comprehensive interdisciplinary assessment of the resident prior to (re)application of a restraint that includes description of behaviour and environment in which it occurs, resident physical, emotional, psychosocial and nutritional assessments
- (re)Assessments for the use of restraint
- Resident's reaction to restraint use
- Care plan to include special care needs during restraint use
- Length of time the restraint will be used

- Conditions under which the restraint will be applied
- Frequency of monitoring checks while restraint is in use
- Scheduled release of restraint and repositioning for purposes of skin assessment and/or exercises

Policy: Physical Restraint Monitoring - Reference #RESI-10-01-04 - Version November 2012
Directs the following:
Documentation related to restraints shall include:
Care staff shall:
- Document on POC tablet the monitoring of the physical restraint
- Record safety checks every hour while the restraint is in use
- Record the release of the restraint and repositioning of the resident every two hours while the restraint is in use
- Record the removal of the restraint
- For each entry, the resident's response to the restraint shall also be recorded
- Document hourly safety checks and two hourly position changes [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to resident #001
Resident #001 was observed to be wearing a front closing lap belt restraint in the wheelchair.
There is no evidence of the required documentation for resident #001's physical restraint related to:
- The maintenance of a Restraint Record
- Monitoring of the resident with hourly safety checks and every two hourly position changes which requires the release of the restraint
- The care plan does not provide direction for application and release of the restraint
- A comprehensive interdisciplinary assessment of the resident prior to (re)application of a restraint
- (re)Assessments for the use of restraint
- Resident's reaction to restraint use
- The resident's plan of care does not include special care needs during restraint use
- Scheduled release of restraint and repositioning for purposes of skin assessment and/or exercises while the restraint is in use
- The removal of the restraint [s. 8. (1) (a),s. 8. (1) (b)]

3. Related to resident #1935

Resident #1935 was observed to be wearing a lap belt restraint, with a lap tray and a tilt chair.
There is no evidence of the required documentation for resident #1935's physical restraint related to:
- The resident's response to the restraint and the need for continued use of the restraint each shift
- Monitoring of the resident with hourly safety checks and two hourly position changes which requires the release of the restraint
- A comprehensive interdisciplinary assessment of the resident prior to (re)application of a restraint
- (re)Assessments for the use of restraint
- Resident's reaction to restraint use
- The resident's care plan does not include special care needs during restraint use
- The length of time the restraint will be used
- Scheduled release of restraint and repositioning for purposes of skin assessment and/or exercises [s. 8. (1) (a),s. 8. (1) (b)]

4. Related to resident #2019
Resident #2019 was observed to be wearing a lap belt restraint.
There is no evidence of the required documentation for resident #2019's physical restraint related to:
- The resident's response to the restraint and the need for continued use of the restraint each shift
- Monitoring of the resident with hourly safety checks and two hourly position changes which requires the release of the restraint
- A comprehensive interdisciplinary assessment of the resident prior to (re)application of a restraint
- (re)Assessments for the use of restraint
- Resident's reaction to restraint use
- The resident's care plan does not include special care needs during restraint use
- The length of time the restraint will be used
- Scheduled release of restraint and repositioning for purposes of skin assessment and/or exercises [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 the licensee's written policies related to physical restraints are complied with, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Related to resident #2019:
Resident #2019's clinical health record indicates a physician's order dated March 6, 2014 directing the following:
"Please d/c wheelchair clasp belt not medically required at this time"
On March 18 and March 26, 2014 the resident was observed to be wearing a clasp wheelchair restraint belt. [s. 31. (2) 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 a resident is restrained by a physical device only when a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, to be implemented voluntarily.

WN #5: 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:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

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:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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).

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:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident is being restrained by a physical device, 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.

Related to resident #2019:
Medication Administration Records (MAR) indicate the following related to reassessment of the physical restraining device every eight hours:
February, 2014 - daily reassessments were documented by registered nursing staff at 0630, 1430, 2230
March, 2014 - reassessments documented by registered nursing staff at 0630, 1430, 2230 on March 1, 2, 3, 4, 5, 6. March 7 to March 27, the MAR was coded as "D" indicating the use of the restraint had been discontinued.

Physician's orders indicate the use of the physical restraint had been discontinued on March 6, 2014.

PSW records indicate the physical restraint continued to be applied daily after March 6, 2014.

Inspector observed the resident with the lap restraint applied on March 18 and March 26, 2014. [s. 110. (2) 6.]

2. The licensee failed to ensure that alternatives to the use of a physical restraint were considered and why those alternatives were inappropriate were documented.

Related to Resident #1935, #2019:
Residents #1935 and #2019 were observed to be wearing lap belt restraints.
There is no documented evidence that alternatives to a restraint for resident #1935 or #2019 were considered and why those alternatives were inappropriate. [s. 110. (7) 2.]

3. The licensee failed to ensure that the person who applied a physical restraining device and the time of application of the device were documented.

Related to resident #01:
Resident #01 was observed to be wearing a lap belt restraint.
There is no evidence of documentation to identify who applied the device or when it was applied. [s. 110. (7) 5.]

4. The licensee failed to ensure that with every use of a physical restraining device, all assessments, reassessments and monitoring including the resident's response are documented.

Related to resident #01:
Resident #01 was observed to be wearing a lap belt restraint.
There is no evidence of documentation related to assessments, reassessments and monitoring, including the resident's response.

Related to resident #2019:
Resident #2019 was observed to be wearing a lap belt restraint.
Documentation does not consistently reflect hourly monitoring and safety checks of resident #2019 while wearing a physical restraint.
Point of Care (POC) documentation completed by PSW's indicates the following examples:
March 17, 2014
0834 hrs - applied
1412 hrs - safety check, repositioned/ambulated
1424 hrs - repositioned/ambulated

1907 hrs - safety check
1941 hrs - removed

March 18, 2014
1130 hrs - applied
1130 hrs - safety check
1323 hrs - safety check
1444 hrs - safety check
1910 hrs - safety check - removed

March 19, 2014
0823 hrs - applied
1006 hrs - safety check
1046 hrs - safety check
1329 hrs - safety check - removed [s. 110. (7) 6.]

5. The licensee failed to ensure that with every use of a physical restraining device, every release of the device and all repositioning is documented.

Related to resident #01:
Resident #01 was observed to be wearing a lap belt restraint.
There is no evidence of documentation to reflect the release of the restraining device and repositioning of the resident.
POC documentation records do not identify this as a task to be completed.

Related to resident #1935:
Resident #1935 was observed to be wearing a lap belt restraint.
The every two hourly release of the restraining device and repositioning of the resident is inconsistently documented.
POC documentation completed by PSW's indicates the following examples:
(Directions indicate that the code to be entered for repositioning/ambulation is "Repositioned/Ambulated")
March 15, 2014
1136 - applied, safety check
1404 - repositioned/ambulated, removed
2017 - applied, removed

March 16, 2014

0927 - applied
0928 - safety check
1116 - safety check
1121 - safety check
1337 - safety check, removed

March 20, 2014
0739 - applied
0946 - safety check
1107 - safety check
1421 - safety check, removed
1537 - applied
1615 - safety check
1824 - safety check
1825 - removed

Related to resident #2019:
Resident #2019 was observed to be wearing a lap belt restraint.
The every two hourly release of the restraining device and repositioning of the resident is inconsistently documented.
POC documentation completed by PSW's indicates the following examples:
(Directions indicate that the code to be entered for repositioning/ambulation is "Repositioned/Ambulated")
March 17, 2014
0834 hrs - applied
1412 hrs - safety check, repositioned/ambulated
1424 hrs - repositioned/ambulated
1907 hrs - safety check
1941 hrs - removed

March 18, 2014
1130 hrs - applied
1130 hrs - safety check
1323 hrs - safety check
1444 hrs - safety check
1910 hrs - safety check - removed

March 19, 2014

0823 hrs - applied
1006 hrs - safety check
1046 hrs - safety check
1329 hrs - safety check - removed [s. 110. (7) 7.]

6. The licensee failed to ensure that with every use of a physical restraining device, the removal or discontinuance of the device, including time of removal or discontinuance and the post restraining care, is documented.

Related to resident #01:
Resident #01 was observed to be wearing a lap belt restraint.
There is no evidence of documentation related to the removal of the restraining device, including the time of removal or discontinuance and the post restraining care. [s. 110. (7) 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 following information during the use of a physical device to restrain a resident is documented:
- a physician's order for the use of the device
- alternatives to the use of the restraint and why those alternatives were inappropriate
- the person who applied a physical restraining device and the time of application of the device
- all assessments, reassessments and monitoring including the resident's response
- every release of the device and all repositioning
- the removal or discontinuance of the device, including time of removal or discontinuance and the post restraining care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

In an interview with registered nursing staff on March 27, 2014, the following procedure was reported to be in place for discontinued medications:
- Discontinued medications are put in a container in their original packaging in the medication room at each nursing station.
- Medications are placed in the container through a large cap on top.
- When the container is full, it is placed in locked room for Stericycle, a medical waste removal company, to remove from the facility for destruction.

On March 27, 2014, registered nursing staff stated that discontinued narcotics are destroyed by the Pharmacist and registered nursing staff and confirmed the following procedures:
- Discontinued narcotics are placed in their original packaging in a box lined with plastic.
- Lactulose syrup is poured all over the contents and the plastic liner is tied in knot.
- The box is closed and sealed with packing tape and labelled with blue "RX" labels.
- The narcotics are stored in a locked room for Stericycle to remove from the facility for destruction.

Medications for destruction are not altered or denatured to such an extent that their consumption is rendered impossible or improbable. [s. 136. (6)]

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 when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to offer dental services, subject to payment being authorized by the resident or the resident's substitute decision maker, if payment is required, when a resident complained of tooth pain.

In an interview on March 20, 2014, an identified resident reporting having a sore tooth.

- In an interview on March 24, 2014, staff reported that the resident did complain of a tooth ache within the last month.
- A family member of the resident had informed staff.
- Staff stated that the physician was informed and the information was charted in the progress notes.
- In a review of the resident's clinical health record, there was no evidence of communication with the physician related to the resident's tooth pain and no charting to indicate that the issue had been assessed or addressed.
- An interview with staff on March 24, 2014, indicated that the resident had complained of sore bottom teeth.

There is no evidence that dental services were accessed or that any other interventions were put in place to manage the resident's tooth pain. [s. 34. (1) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident receive preventive and basic foot care services, including the cutting of toenails to ensure comfort and prevent infection.

In an interview, a family member of an identified resident expressed the following concerns about the residents nail care:
- Nail care not being provided to the resident for four months.
- The current foot care provider was unable to provide care for the resident because of the outbreak and the care provider chose not to provide services.

- The identified resident requires advanced foot care services.
- PSW's advised the resident's family member that the resident's toe nails were long and are in need of care.
- Resident did not receive nail care until March, 2014.

In an interview registered nursing staff indicated:
- The home provides basic foot care services.
- There are residents who receive advanced foot care through a contracted service provider.
- In the event that the home is in outbreak, the external foot care provider is advised and they determine if they wish to continue to provide services during the outbreak.
- Advanced foot care services from external care providers are arranged by family members.
- During an outbreak, if the external service provider does not continue to provide services, the nurse practitioner assesses the resident's needs.
- PSW are able to send alerts related to resident's nail care needs to the registered nursing staff through the point of care charting system.

Review of assessment completed by service provider indicates that the resident's nails are thick, ingrown and fungal.

On observation of and interview with an identified resident indicated that the resident's toe nails are very long but the resident denied any discomfort.

The plan of care for the resident does not provide any direction related to the resident's need for advanced foot care provided by an external service provider. The point of care documentation system does not identify that the resident requires advanced foot care services.

There is no evidence that any action was taken to assess the resident's nail care needs or to access or provide alternative nail care for the resident during the absence of the external service provider. [s. 35. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

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

In an interview a family member of an identified resident identified concerns that the resident is not always dressed in clothes but is wearing night clothes. Staff explain that the resident is not dressed because it is the resident's bath day or the resident was incontinent.
On March 24, 2014, Inspector #157 observed the resident in the dining room dressed in night clothes at lunch time. Staff advised the inspector the resident was not dressed because the resident was scheduled for a bath.
The Resident was not appropriately dressed for the time of day and according to the resident's preferences. [s. 40.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

A family member of an identified resident stated in an interview that staff put the resident to bed immediately after supper, which is too early and not in keeping with the resident's desired routines.

The plan of care for the resident directs that the resident likes to have an afternoon rest from 1330 to 1630hrs on days family does not visit and likes to retire to bed for the night at 2000hrs.
On March 24, 2014 at 1448 hrs, the resident was observed to be seated in a wheelchair.

In an interview on March 24, 2014, staff indicated that:
- The resident goes back to bed everyday after lunch for a rest except for bath day on Monday.
- The resident is left up on bath day because the bath is scheduled for after lunch and staff feel they are "doing a favour for evening staff" by getting this completed so that evening staff do not have to get the resident out of bed as a two person mechanical lift is required.

In an interview on March 24, 2014, staff indicated that:
- The resident goes to bed before 1830hrs because that is a good time for staff to put residents who require extensive assistance to bed.

In an interview on March 24, 2014, another staff member, confirmed that the resident goes to bed before 1900 hrs.

The resident's desired bedtime and rest routines have not been supported and individualized. [s. 41.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On March 18, 2014 and March 27, 2014 three prescription topical medications were observed on an identified resident's bedside table. In an interview on March 2, 2014, registered nursing staff reported that the resident does not self administer the identified medications and the medication should not have been at the resident's bedside.
The prescription medications identified were not stored in an area that is secured or locked. [s. 129. (1) (a)]

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 23rd day of April, 2014

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

Pat Rowe #157.