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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 27, 2018	2018_572627_0006	003752-18	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 Timmins
15 Hollinger Lane Box 817 Schumacher ON P0N 1G0

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

SYLVIE BYRNES (627), RYAN GOODMURPHY (638), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 12-16, and March 19 -23, 2018.

The following additional intakes submitted to the Director were inspected during this Resident Quality Inspection:

Follow-Up log related to compliance order #001 issued during inspection #2017_615638_0010, regarding reporting certain matters to the Director,
Follow-Up log related to compliance order #002 issued during inspection #2017_615638_0010, regarding continence care,
Deferred inspection item related to inspection #2017_615638_0010, regarding inappropriate dress,
Six Critical incidents (CIs) related to falls,
Three CIs related to alleged staff to resident abuse,
One complaint related to care concerns,
One complaint related to alleged staff to resident abuse, and
One complaint related to staffing shortages.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator (CC), Food Service Manager, Resident Assessment Instrument/Minimum Data Set (RAI-MDS) Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), Recreational Aide (RA), Maintenance staff, family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
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.
- **8 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2017_615638_0010	638
O.Reg 79/10 s. 51. (2)	CO #002	2017_615638_0010	627

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. (4) The Lieutenant Governor in Council may make regulations governing how rights set out in the Residents' Bill of Rights shall be respected and promoted by the licensee. 2007, c. 8, s. 3 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was cared for in a manner consistent with his or her needs.

During a tour of the home, Registered Nurse (RN) #128 approached Inspector #627 to inform them that resident #024 wanted to voice a complaint regarding care concerns to the Inspector.

Inspector #627 interviewed resident #024 who stated that Personal Support Worker (PSW) #114 had not answered their call bell in a timely manner during a specific time period on several occasions. The resident further stated that when they questioned PSW #114 about the length of time it took to have their call bell answered, PSW #114 "just mumbled".

Inspector #627 reviewed resident #024's written plan of care in effect at the time of the inspection and noted that the resident required assistance for specific activities of daily living (ADLs).

Inspector #627 reviewed the home's policy titled "Nurse Call System", #RC-08-01-01, dated April 2017, which indicated: "respond to call bells in a timely and courteous manner".

Inspector #627 reviewed the call bell report, provided to them by the Administrator and noted that during a specific time period, on five separate occasions, PSW #114 had responded to resident #024's call bell in 24:04 minutes to 32:03 minutes.

Inspector #627 interviewed PSW #117 who stated that they worked the night shift regularly on a part time basis. They indicated that it usually took approximately 30

seconds to answer a call bell. On busy shifts, it may have taken them up to five minutes, at the most. PSW #117 could not recall a time when it had taken them 15 minutes or more to answer a call bell.

Inspector #627 interviewed the Director of Care (DOC) who stated that the expectation when a resident rung their call bell was for the staff to answer the call bell as soon as possible. The DOC indicated that taking 15 minutes to answer a call bell was too long and that they would question "what was going on and why it took so long to answer a call bell".

Inspector #627 interviewed the Administrator who stated that they had spoken with resident #016 on the day they had voiced their complaint. They had reviewed the call bell report and correlated it with the shifts PSW #114 had worked, and determined that on many occasions, PSW #114 had taken more than 30 minutes to respond to the call bell and this was not acceptable. The Administrator further stated that for this reason and others, PSW #114 had received disciplinary action.

The licensee has failed to ensure that every resident was cared for in a manner consistent with his or her needs as PSW #114 had not responded to resident #024's call bell in a timely manner to provide the assistance required by the resident. [s. 3. (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 is cared for in a manner consistent with his or her needs by ensuring that call bells are answered in a timely manner, 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 any policy instituted or otherwise put in place was complied with.

Section 49, subsection 2 of O. Reg. 79/10 indicates that the long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A critical incident system (CIS) report was submitted to the Director, in regards to a fall that resulted in a significant change in the resident's health status. The report indicated that resident #002 had a specified number of unwitnessed falls on a specified date. The family voiced concerns and requested specific care for the resident.

Inspector #627 reviewed the home's policy titled "Falls Prevention and Management Program", #RC-06-04-01, dated 2017, which indicated that neurological (neuro)-vital signs (if had/brain injury suspected or the fall was unwitnessed), vital signs and pain level were to be monitored every hour for four hours then every eight hours for 72 hours after a fall.

Inspector #627 reviewed the "Clinical Monitoring Record" for resident #002 , the vital signs documented in Point Click Care (PCC) and progress notes in PCC which revealed that the resident's neuro-vital signs had not been assessed on five occasions, their vital signs were not assessed on four occasions and their pain level had not been assessed on five occasions.

Inspector #627 interviewed Registered Practical Nurse (RPN) #131 who stated that when a resident had an unwitnessed fall, a head to toe assessment was completed immediately, the resident was assessed every 15 minutes for the first hour, then hourly for four hours, then every eight hours for 72 hours. The RPN further stated that if the resident had more than one fall, then, more than one "Clinical Monitoring Records" should have been initiated, and that the resident should have been monitored every hour for the first four hours, then once per shift for 72 hours after each fall. RPN #131 could not recall if they had completed more than one "Clinical Monitoring Records" as the resident had sustained more than one fall. RPN #131 indicated that the resident had not been monitored hourly as they should have been.

Inspector #627 interviewed the DOC who stated that when a resident had an unwitnessed fall, they were to be monitored every hour for four hours, then every eight hours for 72 hours, including neuro-vitals, vital signs and pain. They further stated that as the resident had more than one fall, the resident should have been assessed hourly after each fall for four hours, then once per shift for the following 72 hours. The DOC was unable to locate more than one "Clinical Monitoring Record" for the specific date. The DOC identified that the home's policy titled "Falls Prevention and Management Program" had not been complied with.

The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with as resident #002 had not had their pain level, neuro and vital signs assessed for four hours following an unwitnessed fall, on two occasions. [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 home's policy titled "Falls Prevention and Management Program", #RC-06-04-01, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director on a specific date, related to an incident of alleged staff to resident physical abuse. The report indicated that PSW #116 had physically abused resident #006.

Inspector #638 reviewed the internal investigation notes which indicated that PSW #116 denied the physical abuse; however, they voiced their intent of wanting to do harm to resident #006. PSW #116 received disciplinary action.

Inspector #638 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" last revised April 2017, which indicated that the home had zero tolerance for abuse and neglect and that any form of abuse or neglect by any person, whether through deliberate acts of negligence, were not tolerated.

Inspector #638 interviewed PSW #112 who indicated that they had witnessed the incident of staff to resident physical abuse between resident #006 and PSW #116 on the specified date.

Inspector #638 interviewed RN #111 who indicated that RPN #113 informed them that PSW #112 witnessed PSW #116 physically abuse resident #010 during care. The RN indicated that PSW #116's actions had not been an effective means of intervention.

Inspector #638 interviewed the DOC who indicated that PSW #116 received disciplinary action as a result of the investigation, because although they denied doing so, they verbalized their intent of wanting to do harm to resident #006. The DOC indicated that PSW #116 was not compliance with the home's policy that promoted zero tolerance of abuse and neglect of residents. [s. 20. (1)]

2. On a specifc date, during a resident interview, resident #019 shared with Inspector #627 an incident whereby, PSW #139 had been verbally abusive and had refused to provide them with the care they required. The resident informed the Inspector of the specific date and time of the incident.

Inspector #627 reviewed the progress notes for resident #019 which revealed a progress note from RN #140, dated the following day of the alleged incident, indicating that they had spoken to the resident regarding the occurrence.

Inspector #627 reviewed the home's policy titled "Review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", #RC-02-01-01, which indicated that any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect was to report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time.

Inspector #627 interviewed RN #140 who stated they had been made aware of the incident by RPN #123 and resident #019 on the following day of the alleged incident. Resident #019 reported to RN #140 that PSW #139 had been verbally abusive and had refused to provide them with the care they required. RN #140 stated that they had reported the incident to the Administrator immediately.

Inspector #627 interviewed RN #141 who informed the Inspector that RPN #123 had made them aware of the alleged incident at a later time, on the day of the alleged incident. The RPN had reported to them that the resident had not been provided with the assistance they required. RN #141 indicated that it was reported to them by the RPN that the resident was visibly upset. RN #141 had not reported the incident that day as PSW #139 had already left. RN #141 indicated to the Inspector that the home's policy specified that all alleged incident of abuse and neglect were to be reported right away to the administration on call, and that this incident may have been neglect.

Inspector #627 interviewed the Administrator who indicated that they had been made aware of the alleged incident on the following day and had submitted a CIS report immediately. The Administrator indicated that the alleged incident had occurred on a specific date; however, it was only reported to them the following day. The Administrator indicated that the home's policy directed staff to report any alleged incident of abuse or neglect immediately to management and that the policy had not been complied with.

The licensee failed to ensure that the a written policy to promote zero tolerance of abuse and neglect of residents was complied with as RN #141 had not reported an alleged incident of abuse or neglect immediately to a supervisor, and PSW #116 was found to have been abusive towards resident #010. [s. 20. (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 the home's written policy that promoted zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Resident #018 was identified as having an altered body mass index (BMI) during a staff interview.

Inspector #681 observed a meal service on a specific date. Resident #018 was served a certain food item at a specified time; however, no staff member was available to provide assistance to this resident for five minutes, when the DOC sat down beside resident #018.

On a specific date, at a specific time, Inspector #681 observed resident #018 in their room, with a beverage and food item in front of them. No staff were present in resident #018's room at this time. Resident #018 stated to Inspector #681 that they were unsure if they had eaten. At a later time, PSW #135 entered resident #018's room and physically assisted them to consume their food and beverage.

Inspector #681 reviewed resident #018's written plan of care in effect at the time of the inspection, which indicated that resident #018 required a specific level of assistance for eating.

Inspector #681 reviewed the home's policy titled "Tray Service" last revised November 2013, which indicated that care staff were to ensure that assistance was provided to the residents as per their care plan and that residents who required assistance with drinking or eating only be served beverages and food items when someone was available to provide the required assistance.

Inspector #681 interviewed PSW #135 who stated that resident #018 required a certain amount of assistance with their meal. They further stated that they had previously assisted resident #018 to eat a bit of their meal and that they had then gone to assist resident #025 with their meal. PSW #135 stated that the home's process was to stay with the resident that they were assisting until that resident had finished eating their meal.

Inspector #681 interviewed RPN #134 who indicated that once a staff member started assisting a resident with their meal, the staff member should remain with that resident until they had finished eating. RPN #134 stated that a plate of food should never be left in front of a resident who required feeding assistance without a staff member present to assist that resident.

Inspector #681 interviewed Dietary Manager #129 who indicated that residents who required feeding assistance should not be served their meal until a staff member was available to provide the necessary assistance. Dietary Manager #129 stated that resident #018 should not have been left with food in front of them while PSW #135 went to assist another resident.

The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident, as resident #018 was provided with a meal on two occasion

when no one was available to provided assistance to the resident. [s. 73. (2) (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 all residents who require assistance with eating and drinking are served their meal only when someone is available to provide the assistance required by the residents, to be implemented voluntarily.

WN #5: 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

Resident #016 was identified as having had an infection from their most recent minimum data set (MDS) assessment.

Inspector #627 reviewed the progress notes for resident #016 and identified that the resident had been placed on isolation precautions for a specified number of days. A progress note indicated that the resident remained on isolation precautions. No other documentation indicated when the resident had been placed on isolation precautions. A progress note indicated that the resident remained on isolation precautions that evening, and a progress noted the following day indicated that the resident had attended the dining room for the a meal service. No other documentation indicated when the resident had been removed from isolation precautions.

Inspector #627 reviewed resident #016's electronic records and was unable to find any

documentation of resident #016's symptoms on five occasions during the time that resident #016 was placed on isolation precautions.

Inspector #627 reviewed the home's policy titled "Infection Surveillance and Control" #IC-030101, dated 2015, which indicated to "record on the Daily 24-hour Symptoms Surveillance form any symptoms that may determine an infection and/or the possible presence of a communicable disease outbreak".

Inspector #627 interviewed PSW #122 who indicated that direct care staff monitored residents for signs and symptoms of infection and notified registered staff if there were any changes in a resident's status. The PSW indicated that registered staff monitored and documented the resident's symptoms. The PSWs recorded the symptoms a resident exhibited on a shift report and submitted this to the RPN for every resident who was on isolation precautions.

Inspector #627 interviewed RPN #123 who stated that when a PSW made them aware that a resident had signs of infection, they received an assessment by the RPN. If the resident had two or more symptoms, they were placed on isolation precautions. The "Infection Process" form was followed which guided the staff to add the resident's name to a surveillance sheet, initiate isolation precautions, notify family, update the written care plan as needed, provide a note to the kitchen and the housekeeping department and post the information at nursing desk. Daily assessments of the resident were to be documented in Point Click Care and on the "Daily FRI Surveillance/Report Tool" which was submitted to the Infection Lead. Upon review of resident #016's electronic records in PCC, RPN #123 acknowledged that there was no documentation regarding the resident's symptoms on five specific occasions.

Inspector #627 interviewed the Clinical Coordinator, who was the Infection Prevention and Control (IPAC) lead for the home, who stated that when a resident was placed on isolation precautions due to an illness, the RPN documented their assessments for every shift, in the progress notes, as well as on the "Daily FRI Surveillance/Report Tool". The Clinical Coordinator acknowledged that there was no documentation regarding the resident's symptoms on five specified occasions during the time that resident #016 was on isolation precautions. As well, they could not provide the Inspector with the "Daily FRI Surveillance/Report Tool" forms for the period of time resident #016 was on isolation precautions. They further stated that the staff had not completed the "Daily FRI Surveillance/Report Tool". The Clinical Coordinator indicated, "they should have but I guess they didn't". [s. 229. (5) (b)]

2. Resident #014 was identified as having an infection from their most recent MDS assessment.

Inspector #638 reviewed resident #014's health care records and identified resident #014 was placed on isolation for an infection for a specified time period.

Inspector #638 interviewed PSW #115 who indicated that direct care staff monitored residents for signs and symptoms of infection and notified registered staff if there were any changes in the resident's status. The PSW indicated that registered staff monitored and documented resident symptoms.

Inspector #638 interviewed RPN #125 who indicated that when a resident was placed on isolation for an infection, their symptoms were assessed at least every shift by registered staff. The RPN indicated that staff documented these checks in the electronic medication administration records (eMAR) until the resident was symptom free for a set period of time.

The Inspector was provided a "Daily 24-hour Symptom Surveillance" form" record which outlined the resident's symptoms on each shift (day, evening and night) by the Clinical Coordinator. Upon review of the " "Daily 24-hour Symptom Surveillance" form and resident # 014's progress notes, the Inspector identified that the resident's symptoms were not recorded 88 per cent of the time, while on isolation precautions.

Inspector #638 interviewed the Clinical Coordinator who, upon review of the "Daily FRI Surveillance/Report Tools" record, indicated that there were gaps in documentation and stated that staff should have been checking and recording symptoms of infection on each shift.

The licensee has failed to ensure that staff, on every shift, recorded symptoms of infection in residents as the registered staff had not recorded the symptoms of infection for resident #014, 88 per cent of the time that the resident was under isolation precautions. [s. 229. (5) (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 that staff on every shift recorded symptoms of infection in residents and took immediate action as required, to be implemented voluntarily.

WN #6: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Resident #010 was identified as requiring a specific intervention by Inspector #627 during a staff interview with RPN #119.

Inspector #638 reviewed resident #010's personal health records and identified that the resident was to have the specific intervention, which required specified care at regular intervals.The Inspector reviewed the resident's electronic treatment administration record (eTAR) and was unable to identify if the resident had received the specified care at the scheduled intervals on two separate occasions. The Inspector was unable to identify any progress notes regarding the specified care not being provided on the previously identified dates.

Inspector #638 reviewed the home's policy titled "Care Planning – 03-01-02", dated September 2010, which indicated that progress notes were to be completed to demonstrate care was being provided as outlined in the plan of care and to document resident response to the care provided.

Inspector #638 interviewed PSW #115 who indicated that the registered staff completed the specified care to be provided at specific intervals.

Inspector #638 interviewed RPN #118 who indicated that registered staff were in charge of the specified care. The RPN stated that resident #010 required the specified care, at regular intervals, according the physician order, the care was to be documented in the eTAR and a progress note should be created to identify that the care had been provided. The Inspector reviewed resident #010's eTAR and progress notes for two specific dates when the care should have been provided with the RPN #118. The RPN was unable to identify if the care had occurred and indicated that even if the care was not provided, registered staff should have documented the rational so that the next shift could complete the care if necessary.

Inspector #638 interviewed the DOC who indicated that registered staff were in charge of completing the specified care. The DOC indicated that staff should have documented the care on the eTAR and created a progress note to identify that care had been provided. They indicated that if the care was not provided, there should be a notation identifying why the care was not completed. The Inspector reviewed resident #010's eTAR record for two specific dates, with the DOC who indicated that there should have been documentation related to the scheduled care.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented as staff had not documented whether or not resident #010's had received the specified care on two separate occasions. [s. 6. (9) 1.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized food production system in the home, which communicated to residents and staff any menu substitutions.

Inspector #638 conducted a dining observation during a meal service on a specified home area. The planned weekly and daily menu on that day included cherry tart and mangoes, for dessert. The Inspector observed that apple pie, strawberries and mangoes were the offered dessert options; cherry tart was not provided as a dessert option as per the menu.

Inspector #638 reviewed the home's policy titled "Menu Substitutions – NC-05-01-07" last updated December 2017, which indicated that the Dietary department will communicate all temporary menu substitutions to residents and staff and document the substitutions on the production sheet and applicable form, as needed.

Inspector #638 interviewed RPN #118 who indicated that the kitchen provided apple pie instead of cherry tart for the dessert options. The RPN was not sure why they were provided with an alternate dessert instead of the planned menu item and indicated that dietary staff would be able to provide a rational.

Inspector #638 interviewed the Dietary Manager (DM) who indicated that when there was a menu substitution, the menu was revised and the updated menu was to be placed on each home areas to notify residents of the changes. The DM indicated that they had to substitute menu items and had updated the menu to identify the changes, but indicated that the menus on the unit may not have been corrected. [s. 72. (2) (f)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee has failed to comply with this Act, the regulations, and every order made or agreement entered into under this Act.

The licensee was issued compliance order (CO) #002 during inspection #2017_615638_0010 related to Continence Care and Bowel Management. The compliance order instructed the licensee to develop and implement:
1. A process to ensure that each resident requiring assistance to maintain their continence or be continent some of the time received the assistance required as per their assessed needs.
2. An auditing process that identified when staff were not able to provide care as per the resident's assessed continence needs so that corrective actions could be taken.
3. A multidisciplinary process which ensured clear communication between front line staff (PSWs, RPNs and RNs) and management when continence care needs were not being met.

Inspector #627 interviewed the DOC who indicated that when they received the compliance order, a three day bowel and bladder assessment was completed for all residents with continence issues and that their written plan of care was updated accordingly. The staff were re-educated regarding the multidisciplinary approach to be followed regarding continence care. The auditing process was completed by having the registered staff ensure that continence care was completed and the DOC auditing Point of Care (POC) documentation to ensure that all toileting had been completed. As well, the DOC stated that they had implemented a "Daily Toileting Routine Communication Sheet and Audit for PSW/RPN/RN and Management" form which was to be completed for every shift from every home unit, indicating if "all of the residents were toileted as per their toileting routines as identified in the care plan and tasks". This sheet was to be submitted daily to the DOC. The DOC further stated that this form remained in effect.

Inspector #627 reviewed the "Daily Toileting Routine Communication Sheet and Audit for PSW/RPN/RN and Management" forms for a one week period from all the home areas and noted that on 15 occasions, the form had been incomplete. As well, the Inspector was not provided with 17 forms which should have been completed.

Inspector #627 interviewed RPN #127 who indicated that they approached the PSWs at various times during their shift to ensure that all continence care was completed and assisted the PSWs with continence care when needed. RPN #127 stated that they no longer completed the "Daily Toileting Routine Communication Sheet and Audit for PSW/RPN/RN and Management" form as this was no longer enforced.

Inspector #627 interviewed RN #128 who stated that the continence form was implemented after the last inspection. This form "fell by the way side" since the form was their (management) answer to our concerns regarding being unable to toilet the residents due to time constraints. They further stated that they were not sure what occurred to the forms as no feedback was received from management.

Inspector #627 had an additional interview with the DOC, where they identified that the forms had not been completed consistently.

The licensee failed to comply with every order made or agreement entered into under this Act by not ensuring that the Daily Toileting Routine Communication Sheet and Audit for PSW/RPN/RN and Management" were completed daily, as the DOC indicated that the form was part of the auditing process to identify when staff were not able to provide care as per the residents' assessed continence needs so that corrective actions could be taken, and that the forms remained in effect; however, they were not completed daily. [s. 101. (3)]

Issued on this 29th day of March, 2018

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

Original report signed by the inspector.