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

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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
Dec 21, 2014	2014_248214_0029	H-001483-14	Resident Quality Inspection

Licensee/Titulaire de permis

FOYER RICHELIEU WELLAND
655 Tanguay Ave WELLAND ON L3B 6A1

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

FOYER RICHELIEU WELLAND
655 TANGUAY AVENUE WELLAND ON L3B 6A1

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

CATHY FEDIASH (214), GILLIAN TRACEY (130), HUMPHREY JACQUES (599), KELLY HAYES (583)

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

This Inspection Report contains findings of non-compliance identified during inspections conducted concurrently with the Resident Quality Inspection. Concurrent Complaint Inspections include: H-001001-14, H-001146-14 and H-001498-14.

During the course of the inspection, the inspector(s) spoke with the Chief Administrator Officer, Director of Care(DOC), Resident Assessment Instrument (RAI)Coordinator, Maintenance Supervisor, Kitchen and Laundry Supervisor, Registered Dietitian, registered staff, Health Care Aides(HCA)/Personal Support Workers(PSW), residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

15 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the

resident.

A review of resident #103's written plan of care dated October 30, 2014, indicated under Risk for Falls that the resident was to be checked every one hour to ensure their safety. A review of the resident's kardex and the Point of Care (POC) system indicated that the resident was to be checked every two hours to ensure their safety. An interview with the DOC and RAI Coordinator confirmed that the plan of care did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of resident #103's Minimum Data Set (MDS) for section H. Continence in the last 14 days and completed with an identified date in May 2014, indicated that the resident was coded as being frequently incontinent of bladder. A review of this resident's written plan of care with an identified date in May 2014, indicated that the resident was occasionally incontinent of urine. An interview with the RAI Coordinator confirmed that the care set out in the resident's plan of care was not based on an assessment of the resident. [s. 6. (2)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The Quarterly Minimum Data Set (MDS) Assessment completed on an identified date in March 2014, for resident #102, indicated the resident had moderate pain daily. The Quarterly Pain Assessment completed in Point Click Care (PCC) the same day indicated the resident had moderate pain less than daily. The Annual MDS assessment completed on an identified date in June 2014, indicated the resident had mild pain less than daily. The Quarterly Pain Assessment completed in PCC the same day indicated the resident had moderate pain; however, there was no frequency identified. Registered staff confirmed the assessments were not integrated, consistent with and did not complement each other. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A review of resident #106's clinical record indicated that they sustained a fall on an identified date in November 2014. The Physiotherapist completed a post fall follow up for the resident two days later and had made a recommendation that the resident may benefit from the use of hip protectors. A review of the resident's clinical record for an identified period of seven days in November 2014, indicated that no follow up to the recommendation of the hip protectors had occurred. An interview with registered staff confirmed that the resident had not been offered hip protectors and that staff had not collaborated with each other in the development and implementation of the residents plan of care. [s. 6. (4) (b)]

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

A) The plan of care for resident #101 indicated the resident required total assistance from staff to provide oral hygiene. Staff were to brush their teeth after meals and at bedtime. The Point of Care (POC) records indicated the resident was receiving oral hygiene twice daily and not four times daily as per the plan of care. Staff interviewed confirmed the resident does not receive oral hygiene four times daily as per the plan. (130)

B) A review of the plan of care for resident #800 indicated that for bathing, the resident was total dependence and required 2 staff members for the entire bathing process. A review of the progress notes for this resident indicated that on an identified date in August 2014, the resident had experienced a sudden decline in condition while in the bath tub. During an interview with registered and front line nursing staff it was identified and confirmed that at the time of the incident, resident #800 had been left unattended in the bath tub as staff were transferring another resident in the adjoining tub room with a mechanical lift and were approximately five meters away from resident #800.

In an interview with front line nursing staff on an identified date in November 2014, it was identified and confirmed that only one staff member completed bathing with resident #800 when in tub. The inspector also observed transfers being completed in the tub room and identified that staff would not be able to visually monitor another resident in the adjacent tub due to the room layout, curtain placement and need to visually monitor the resident being transferred.

In an interview with registered staff and front line nursing staff on three identified dates in November 2014, it was identified that some residents were routinely left unattended in

the bath tub when staff were transferring another resident in the adjoining tub room with a mechanical lift, approximately five meters away.

In a written document titled, Directions Regarding Baths/Showers and dated August 29, 2014 and signed by the Director of Care, it stated, "during transfers, you will assist your partner, leave both drapes open while you look and listen to ensure your resident is safe". In an interview with the Director of Care on an identified date in November 2014, it was confirmed that the care set out in the plan of care for resident #800 was not provided as specified in the plan.(583) [s. 6. (7)]

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

A review of resident #106's current paper care plan under interventions for toileting completed on an identified date in April 2014, indicated that the resident was on an assisted daily living (ADL) program for toileting at 1030 hour. An interview with front line nursing staff confirmed that the resident was incontinent of urine; however, they were no longer on an assisted daily living program for toileting and were not routinely toileted at 1030 hours. [s.6.(10)(b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complemented each other; that care set out in the plan of care is provided to the resident as specified in the plan; that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

i) The home's "Skin and WoundCare Management" policy revised June 2012, indicated: treatment interventions for stage 1 were to complete a referral to Registered Dietitian (RD).

Resident #101 was identified with a stage I pressure area on an identified date in September 2014. Registered staff confirmed a referral was not completed for the RD to assess.(130)

ii) A review of the home's policy, Falls Prevention & Restraint Reduction (05-02-01 and dated October 2014), indicated: If the RN decides the resident can be moved, transfer the resident using a ceiling lift or portable mechanical lift.

A) A review of resident #103's clinical record indicated that they sustained a fall on two identified dates in November 2014. A review of the resident's progress notes following their first fall, indicated that assistance was given by two staff to assist the resident to a standing position and back to bed. A review of the progress notes for the resident's second fall indicated that the resident was assisted back to their feet by registered staff. The DOC confirmed that for both falls that the resident sustained, once assessed by the Registered Nurse(RN)that they could be moved, the resident was to be transferred using the ceiling lift or portable mechanical lift and that the home had not complied with their policy.(214)

B) Resident #104 sustained a fall on an identified date in October 2014. The clinical record indicated that three staff assisted the resident to stand. Staff confirmed that the resident was not lifted using a mechanical lift as per the policy. (130)

C) Resident #102 sustained a fall with injury on an identified date in January 2014. According to the clinical record, the resident was assisted to a standing position by staff. Registered staff confirmed a mechanical lift was not used as required by the home's policy. (130)

iii) The home's policy "Cytotoxic/Teratogenic Medications" revised March 2009 indicated: gloves should be worn when handling these medications.

Resident #702 had an order for a cytotoxic medication to be taken once daily at lunch. Directions provided from pharmacy on the medication administration record (MAR) indicated that cytotoxic hazardous precautions were required and that two pairs of gloves

should be worn when handling this medication. On an identified date in November 2014, the Inspector observed Registered staff administer the medication without gloves. The Registered staff confirmed they do not wear gloves when they administer the medication. (130) [s.8.(1)(a),s.8.(1)(b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone by the licensee or staff in the home.

A review of the clinical records for resident #888 and #999 during an identified time period from October to November, 2014, was completed. Documentation in the progress notes completed by the registered nursing staff indicated that on an identified date in October 2014, resident #999 with responsive behaviors initiated a physical altercation with resident #888 with responsive behaviors. Resident #888 sustained an injury that required treatment. On an identified date in November 2014, registered nursing staff confirmed the documentation of the incident between resident #999 and #888 was accurate. In an interview with the Director of Care it was confirmed that resident #888 was not protected from abuse by anyone by the licensee or staff of the home. [s. 19. (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 residents are protected from abuse by anyone by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the home's continence care and bowel management program indicated that there was no written description of the program that included its goals and objectives and relevant policies, procedures and protocols and had not provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. The review of this program also indicated that the program had not been evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. An interview with the DOC confirmed that the home's continence care and bowel management program did not include the areas identified above and had not been evaluated and updated at least annually. [s. 30. (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 the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, specifically the continence care and bowel management program: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following legislation was complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the initial tour of the home on an identified date in November 2014, it was observed that the home had a service hallway that contained the staff room, maintenance office/workshop and the laundry room. It was observed that this service hallway could be accessed by three different doors; one from the West unit, one from the North unit and a door located next to the hairdresser salon. All three doors were not equipped with locks. A resident was noted to have gained access to the service hallway through the door next to the hairdresser salon and was observed recycling a soft drink can. Staff were not present to supervise this area. An interview with the Chief Administrator Officer, Maintenance Supervisor and a registered staff member, confirmed that the service hallway was a non-residential area and that all three doors giving access to this hallway were not supervised or equipped with locks and were accessible by residents. [s. 9. (2)]

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

Findings/Faits saillants :

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

On and identified date in November 2014, during the initial tour of the home, it was noted that the windows in resident room numbers 15, 27-2 and 43, could be opened greater than 15 centimetres. The Maintenance Supervisor confirmed that the window stoppers were in disrepair and were not effective in ensuring that the widows did not open more than 15 centimetres. [s. 16.]

WN #7: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents:

a) clearly set out what constitutes abuse and neglect
d) contained an explanation of the duty under section 24 of the Act to make mandatory reports

A review of Resident Negligence and Abuse Policy's i) Resident Abuse: Witnessing and Reporting (#05-04-04), ii) Resident Abuse: Rights and Responsibilities (#05-04-05), iii) Resident to Resident Abuse (#05-04-03), iv) Resident Abuse: General (#05-04-01), v) Determining Resident abuse (#05-04-02), with a revision date of October, 2014, indicated that the home's policies did not clearly set out what constitutes abuse and neglect and did not contain an explanation of the duty under section 24 of the Act to make mandatory reports. An interview with the Chief Administrator Officer and DOC confirmed this. [s. 20. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

The Quarterly Minimum Data Set (MDS) assessment completed on an identified date in September 2014, for resident #101, indicated the resident had a stage I pressure ulcer to their lower extremity. Registered staff interviewed on an identified date in November 2014, confirmed the stage I area was a recurring problem caused by the resident's footwear but this information was not captured on the written plan of care. (130) [s. 26. (3) 15.]

WN #9: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of resident #103's progress notes indicated that they had a stage I pressure ulcer to an identified are on their backside, with an identified start date in April 2014 and a stage II pressure ulcer to an identified area with an identified start date in October 2014. A review of the resident's clinical record indicated that a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, was not completed for either of the identified pressure ulcers. The RAI Coordinator confirmed that this assessment had not been completed.(214)

B) A review of resident #106's Resident Assessment Protocol (RAP) for pressure ulcers completed on an identified date in October 2014, indicated that the resident had two stage I area's to their lower extremities. A review of the resident's clinical record indicated that a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, was not completed for the area identified above. The RAI Coordinator confirmed that this assessment had not been completed.(130) [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

A) The Quarterly MDS assessment completed on an identified date in September 2014, for resident #101, identified a stage I pressure ulcer to their lower extremity. Registered staff verified this was a chronic area that required routine monitoring and they confirmed that weekly skin assessments were not completed. (130)

B) A review of resident #106's Resident Assessment Protocol (RAP) for pressure ulcers and dated with an identified date in October 2014, indicated that the resident had two stage I pressure ulcers to their lower extremities. A review of the resident's clinical record indicated that no weekly re-assessments of the identified areas had been completed by a member of the registered nursing staff. The RAI Coordinator confirmed that weekly re-assessments had not been completed.(214) [s. 50. (2) (b) (iv)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The annual minimum data set (MDS) completed for resident #106 on an identified date in August 2014, indicated that the resident was frequently incontinent of bladder. The quarterly MDS completed for this resident on an identified date in October 2014, indicated that the resident was incontinent of bladder. A review of the resident's assessments indicated that no continence assessment had been completed when the resident's continence status had changed. The RAI Coordinator confirmed that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for continence, when the resident's continence status had changed. [s. 51. (2) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

An interview with the Family Council President on an identified date in November 2014, indicated that concerns or recommendations of the Family Council are not responded to by the licensee within 10 days, in writing. An interview conducted with the Chief Administrator Officer confirmed that concerns or recommendations of the Family Council are not responded to within 10 days in writing. [s. 60. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

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

An interview conducted with a member of the Residents' Council on an identified date in November 2014, indicated that the Satisfaction Survey was distributed in the summer of 2013 and that the Residents' Council were not sought out for their advice in developing and carrying out the Satisfaction Survey. The Chief Administrator Officer confirmed that the advice of the Residents' Council was not obtained in developing and carrying out the Satisfaction Survey and in acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the survey were documented and made available to the Residents' Council and the Family Council, if any, to seek their advice about the survey.

An interview conducted with a member of the Residents' Council on an identified date in November 2014 and with the Family Council President on the following day indicated that the Satisfaction Survey was distributed in the summer of 2013 and that the Family Council and the Residents' Council had not reviewed the results of the Satisfaction Survey, to seek their advice. An interview with the Chief Administrator Officer confirmed that the results of the survey had not been documented and made available to the Family Council or the Residents' Council. [s.85.(4)(a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

A) An interview conducted with resident #103 indicated that they had been missing their comforter for approximately three weeks and had reported this to staff. An interview conducted with the Laundry Manager confirmed that the home does have a policy and procedure to locate residents' lost clothing and personal items; however, the policy and procedure had not been implemented and as a result, the Laundry Manager was not aware of this resident's missing comforter.(214)

B) Resident #102 reported they lost a pair of pants and jacket approximately six months ago and resident #104 stated they reported a lost sweater, which was never found. The Laundry Manager confirmed that the home does have a policy and procedure to locate residents' lost clothing and personal items; however, the policy and procedure has not been implemented and as a result, the Laundry Manager was not aware of these resident's missing items. (130) [s.89.(1)(a)(iv)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident`s SDM and any other person specified by the resident was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse that resulted in a physical injury or pain to a resident.

A review of the clinical records for resident #888 and #999 during an identified time period from October to November, 2014, was completed. Documentation in the progress notes completed by the registered nursing staff indicated that on an identified date in October 2014, at approximately 0554 hours, resident #999 initiated a physical altercation with resident #888. Resident #888 sustained an injury that required treatment. Progress notes indicated that the following day at 1134 hours, resident #888`s family called the home to get details about the incident and express concern about the home not reporting the information to the family. Family shared that resident #888 was expressing fear about being in a room with the resident whom the incident occurred with. On an identified date in November 2014, registered nursing staff confirmed the documented progress notes completed on identified dates in October 2014, were accurate. In an interview with the Director of Care it was confirmed that resident #888`s substitute decision maker (SDM) and any other person specified by the resident were not immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse of resident #888 that resulted in a physical injury and pain.(583) [s. 97. (1) (a)]

WN #15: 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 has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On an identified date in November 2014, it was observed that surplus narcotics were stored in a single locked stationary cupboard in the medication room and not in a double locked cupboard, as required. An interview with the DOC confirmed that surplus narcotics were not stored in a double locked cupboard, as required. [s. 129. (1) (b)]

Issued on this 31st day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), GILLIAN TRACEY (130), HUMPHREY JACQUES (599), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2014_248214_0029
Log No. / Registre no:	H-001483-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 21, 2014
Licensee / Titulaire de permis :	FOYER RICHELIEU WELLAND 655 Tanguay Ave, WELLAND, ON, L3B-6A1
LTC Home / Foyer de SLD :	FOYER RICHELIEU WELLAND 655 TANGUAY AVENUE, WELLAND, ON, L3B-6A1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SEAN KEAYS

To FOYER RICHELIEU WELLAND, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care, including but not limited to the resident's bathing requirements, is provided to all residents, including resident #800, as specified in the plan. The plan is to be submitted electronically to Long Term Care Homes Inspector cathy.fediash@ontario.ca by December 31, 2014.

Grounds / Motifs :

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

A review of the plan of care for resident #800 indicated that for bathing the resident was total dependence and required 2 staff members for the entire bathing process. A review of the progress notes for this resident indicated that on a identified date in August 2014, the resident had experienced a sudden decline in condition while in the bath tub. During an interview with registered and front line nursing staff it was identified and confirmed that at the time of the incident, resident #800 had been left unattended in the bath tub as staff were transferring another resident in the adjoining tub room with a mechanical lift and were approximately five meters away from resident #800. In an interview with front line nursing staff on an identified date in November 2014, it was identified and confirmed that only one staff member completed bathing with resident #800 when in tub. The inspector also observed transfers being completed in the tub room and identified that staff would not be able to visually monitor another resident in the adjacent tub due to the room layout, curtain placement and need to visually monitor the resident being transferred.

In an interview with registered staff and front line nursing staff on three identified dates in November 2014, it was identified that multiple residents were routinely left unattended in the bath tub when staff were transferring another resident in the adjoining tub room with a mechanical lift, approximately five meters away.

In a written document titled, Directions Regarding Baths/Showers and dated August 29, 2014 and signed by the Director of Care, it stated, "during transfers, you will assist your partner, leave both drapes open while you look and listen to ensure your resident is safe". In an interview with the Director of Care on an identified date in November 2014, it was confirmed that the care set out in the plan of care for resident #800 was not provided as specified in the plan.(583)

(583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 21st day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

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