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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2013	2013_205129_0010	H-000201-13	Complaint

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4

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

HARDY TERRACE
612 Mount Pleasant Road, R. R. #2, BRANTFORD, ON, N3T-5L5

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 14, 15, 16, September 12, 13, 16, 17 & 18, 2013

This inspection was conducted concurrently with a Critical Incident Inspection (Inspection # 2013_205129_0011/H-000091-13). Non-compliance identified during that inspection has been included on this Compliant Inspection Report.

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, registered and unregulated nursing staff, Wound Care Coordinator, RAI-MDS Coordinator, Food Services Manager, Assistant Director of Care, Director of Care and the Administrator in relation to Log #H-000201-13, H-000462-13 and H-000521-13.

During the course of the inspection, the inspector(s) reviewed clinical records, reviewed home documents, reviewed documents detailing training provided to staff, staff schedules and reviewed the following home policies:Standard Fluid Provision/Hydration, Nutritional Care Goals of Menu, Nourishment, Nutritional Supplements,Restraint (Physical, Chemical and environmental, Resident Repositioning, Pain Management, Coumandin Therapy, Tuberculin Surveillance and Testing, Food and Fluid Monitoring-Resident Food Intake Evaluation and Responsive Behaviours

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Responsive Behaviours

Skin and Wound Care

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. 6. Plan of care

Specifically failed to comply with the following:

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. (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).

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 did not ensure that the care set out in the plan of care was provided to residents as specified in the plan, in relation to the following: [6(7)]
a) Care set out in the plan of care for resident #001 was not provided as specified in the plan of care in relation to the following:
-The plan of care directed staff to complete weekly skin assessments. Staff and clinical documentation provided by the home confirmed that weekly skin assessments did not occur in May 2013, despite the resident having identified wounds at this time. At the time of this inspection the resident continued to experience skin breakdown, however, no records were available to demonstrate weekly skin monitoring had been completed after August 17, 2013.
-The plan of care directed staff to monitor the food and fluid intake sheets. Registered staff confirmed that these records were not monitored and as a result staff were not aware that the documentation on these sheets was not complete. The documentation records indicated that for July, August and September 2013 the resident did not consume the daily amount of fluid identified as required and the resident consumed less than 50% of food provided on several days over this three month period. The resident was identified at high nutritional risk and received treatment for fluid imbalance on two occasions in 2013.
-The plan of care directed staff to assist the resident to turn and reposition every two hours while in bed. Observations of care provided on September 12 and 16, 2013 confirmed that this care was not provided when the resident was not assisted to turn and reposition for periods of time in excess of two hours.

b) Care set out in the plan of care for resident #002 was not provided as specified in the plan of care in relation to the following:
-The plan of care directed staff to monitor and document the resident's response to the restraint every hour, registered staff were to evaluate the ongoing need for the restraint every shift and direct care staff were to remove the restraint every two hours and reposition the resident. Observation of care provided on September 16, 2013 confirmed that the restraint was not released and the resident was not repositioned for a period of time in excess of two hours. Clinical documentation provided by the home confirmed that staff did not document the resident's response to the restraint for five shifts over the first 16 days of September. Clinical documentation also confirmed that registered staff did not document that they evaluated the ongoing need for the restraint for nine shift over the same period noted above.
-The plan of care directed staff to dress the resident in adaptive clothing to protect the resident from injury. Observation of care provided on September 12 and 16, 2013

confirmed that this care was not provided and the resident was not wearing the adapted garment.

c) Care set out in the plan of care for resident #004 was not provided as specified in the plan of care in relation to the following:
-The plan of care directed the resident to have a restraint applied whenever in the wheelchair for safety. Observation of care provided on September 16, 2013 confirmed that this care was not provided when the resident was noted to be sitting in the wheelchair and did not have the restraining device applied.

d) Care set out in the plan of care for resident #008 was not provided as specified in the plan of care in relation to the following:
-The plan of care directed staff to reposition the resident every two hours while in bed and in the wheelchair in order to prevent skin breakdown. Observations of care provided on September 23, 2013 confirmed that this care was not provided when the resident was not repositioned in the wheelchair for a period of time in excess of two hours. [s. 6. (7)]

2. The licensee did not ensure that the provision of care as set out in the plan of care was documented, related to the following: [6(9)1]
a) Bathing records for 24 residents were reviewed and documentation indicated that 11 of those 24 residents where not provided with two baths a week in the first 17 days of September 2013.
b) Food and fluid consumption records reviewed indicated:
-Documentation on food and fluid consumption records for resident #001 indicated that there was an absence of documentation for 14 meal periods over the last 23 days in July 2013, an absence of documentation for 22 meal periods in August 2013 and an absence of documentation for eight meal period in the first 13 days of September 2013.
-Documentation on food and fluid consumption records for resident #002 indicated that there was an absence of documentation for 6 meal periods over 15 days in July 2013, an absence of documentation for 2 meal periods in August 2013 and an absence of documentation for 5 meal period in the first 23 days of September 2013
-Documentation on food and fluid consumption records for resident #004 indicated that there was an absence of documentation for the last 23 days in July 2013, an absence of documentation for 25 meal periods in August 2013 and an absence of documentation for 16 days in the first 23 days of September 2013

c) Restraint Monitoring Records were reviewed and indicated:
-Documentation of care provided to resident #005 while being restrained was noted to be incomplete for seven shifts over the first 15 days of September 2013. Documentation that a registered staff had approved the ongoing use of the restraint was not completed for three of the 15 days.
-Documentation of care provided to resident #002 while being restrained was noted to be incomplete for four of the first 15 days of September 2013. Documentation that a registered staff had approved the ongoing use of the restrain was not completed for three of the 15 days.
d) Resident Turning and Positioning Monitoring Records were reviewed and indicated care provided to resident #001 related to the requirement to turn and position the resident were incomplete for 30 days in July 2013, 26 days in August 2013 and 10 days in the first 12 days of September 2013. [s. 6. (9) 1.]

3. The licensee did not ensure that residents were reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change, in relation to the following: [6(10)(b)]
a) Resident #001's care needs change, however the resident was not reassessed and the plan of care was not reviewed and revised, in relation to the following:
-Data collected on the Minimum Data Set (MDS) tool completed in July 2013 indicated the resident's pain had worsened over the previous data period and that the resident now experienced pain at a moderate level daily. The Resident Assessment Protocol (RAP) portion of the tool was not completed and staff confirmed that the resident was not reassessed when pain being experienced by the resident worsened and the resident's plan of care was not reviewed or revised at this time.
b) Resident #003's care needs changed, however the resident was not reassessed and the plan of care was not reviewed or revised, in relation to the following:
-The resident's care needs changed when this resident experienced side effects while being treated with anticoagulant medication. Clinical documentation indicated that the resident experienced these side effects on an identified date in 2012 which was unable to be managed in the home and as a result the resident was transferred to hospital for treatment and again experienced this side effect 13 days later. Staff confirmed that the resident was not reassessed in relation to the risk of injury and the resident's plan of care was not reviewed or revised to include action staff should take to reduce the risk of injury that could result from the side effects of this medication. The resident fell on an identified date at the beginning of 2013 and as a result of this injury experienced significant side effects from this medication.

- The resident's care needs changed when this resident experienced two seizures on an identified date in 2013, in the absence of a medical history of seizures. Staff confirmed that the resident's plan of care was not reviewed or revised with respect to the noted seizure activity and did not include directions for care designed to reduce the risk of injury related to seizure activity.

-The resident was identified on admission to the home as being a moderate risk for falling. Clinical documentation indicated that the resident had an unwitnessed fall on an identified date in 2013. Staff and clinical documentation confirmed that the resident was assessed for injuries at the time of the fall, but the plan of care was not reviewed or revised to include care to be provided to the resident that would prevent falling or minimize the risk of injury from falling.
(PLEASE NOTE: This evidence of non-compliance was found during Inspection # 2013_205129_0011) [s. 6. (10) (b)]

4. The licensee did not ensure that residents were reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective, in relation to the following: [6(10)(c)]
a)Resident #001's plan of care identified a goal of adequate fluid intake with an estimated fluid requirement of 1925 millilitres of fluid a day in order to prevent fluid imbalance. Clinical documentation indicated that the resident was treated twice in 2013 for imbalance, once in the hospital and once in the home. Documentation on food and fluid consumption record indicated that over 23 days in July 2013 the resident did not consume the required amount of fluid on 22 days, over 31 days in August 2013 the resident did not consume the amount of fluid required on 31 days and over the first 13 days of September the resident did not consume the required amount of fluid on 12 days. Staff confirmed that the plan of care was not reviewed or revised when the goal of care for this resident was not met and the resident continued to be at risk for imbalance.
b) Resident #002's plan of care identified a goal to meet daily fluid requirements of 1840 millilitres related to the prevention of fluid imbalance. Clinical records indicated the resident received treatment in the home for fluid imbalance in 2013.
Documentation on food and fluid consumption records in July 2013 indicated that over a 17 day documentation period the resident did not consume the required amount of fluid on 17 days, in August 2013 the resident did not consume the required amount of fluid on 21 days and in September 2013 over a 22 day documentation period did not consume the required amount of fluid on 21 days. Staff confirmed that the plan of care was not reviewed or revised when the goal of care for this resident was not met

- The resident's care needs changed when this resident experienced two seizures on

Additional Required Actions:

CO # - 001, 002, 009 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 and ensuring that the provision of care as set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the requirement that a significant risk of harm be identified prior to restraining resident #004 was in place, in relation to the following: [31)2)1]
Resident #004 was noted to be restrained in a wheelchair on an identified date during this inspection. Staff and the clinical record confirmed that an assessment had not been completed identifying a risk to the resident prior to the application of this front fastening seat belt. [s. 31. (2) 1.]

2. The licensee did not ensure that the requirement to ensure that alternatives to retraining resident #002 and #004 were considered prior to the application of restraining devices. [31(2) 2]
Resident #002 was noted to be restrained in a wheelchair by the use of a front closing seat belt at 0915hrs. on an identified date during this inspection. The home requires staff to complete the form [Methods to Manage Safety Risks] which includes the identification and documentation of alternatives to restraints that were considered. Staff and clinical records confirmed that this form was not completed for resident #002 and staff were unable to provide other assessments or documents to confirm that alternatives to the use of this restraining device were considered prior to restraining resident #002.
Resident #004 was noted to be restrained in a wheelchair by the use of a front closing seat belt at 1010hrs on an identified date during this inspection. The home requires staff to complete the form [Methods to Manage Safety Risks] which includes the identification and documentation of alternatives to restraints that were considered. Staff and clinical records confirmed that this form was not completed for resident #004 and staff were unable to provide any other assessments or documents to confirm that alternatives to the use of this restraining device were considered prior to restraining resident #004. [s. 31. (2) 2.]

3. The licensee did not ensure that when a resident is restrained the resident is released from the restraint and repositioned at least every two hours in accordance with O. Reg. 79/10, s. 102(2), in relation to the following: [31(3)c]
a) Resident #002 was noted to be sitting in a wheelchair in the resident lounge and was noted to be restrained in the wheelchair using a front fastening seat belt at 1025hrs on an identified date during this inspection. The resident was monitored for a period of time in excess of two hours and although the resident was moved into the dining room for lunch at 1150hrs the resident was not released from the restraint or repositioned throughout the meal service. At the conclusion of the meal service the

resident was moved back into the resident lounge at 1247hrs and during the entire monitoring period the restraint was not released nor was the resident repositioned.
b) Resident #008 was noted to be sitting in a wheelchair in the resident lounge and was also noted to be restrained in the wheelchair using a front fastening seat belt at 1035hrs on an identified date during this inspection. The resident was monitored for a period of time in excess of two hours and although the resident was moved into the dining room for lunch at 1200hrs the resident was not released from the restraint or repositioned throughout the meal service. At the conclusion of the meal service the resident was moved back into the resident lounge at 1255hrs and during the entire monitoring period the restraint was not released nor was the resident repositioned. [s. 31. (3) (c)]

Additional Required Actions:

CO # - 003, 004 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 and ensuring that if restraining is included in a resident's plan of care there be a significant risk identified to the resident or a risk that another person would suffer serious bodily harm, to be implemented voluntarily.

WN #3: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were reassessed at least weekly by a member of the registered nursing staff, in relation to the following: [50(2)(b)(iv)
a) Resident #001 was identified as having a staged wound and did not have weekly skin assessments completed by the registered staff. Staff and clinical records confirmed that the resident's wound was not assessed weekly.
b) Resident #008 was identified as having two staged wounds and also had a skin tear. Staff and clinical documentation confirmed that these wounds were not assessed weekly.
c) Resident #009 was identified as having altered skin integrity when it was identified that the resident had an infection and also developed cellulitis of the skin around the open area. Staff and clinical documentation confirmed that this resident's skin was not assessed weekly. [s. 50. (2) (b) (iv)]

2. The licensee did not ensure that residents exhibiting altered skin integrity and who are dependent on staff for repositioning were repositioned every two hours, in relation to the following: [50(2)d)
Resident #001 was not turned or repositioned during monitoring periods on two identified dates during this inspection. This resident was identified as having a staged wound and the plan of care for the resident indicated that extensive assistance of two staff was required for bed mobility and that the resident was to be assisted to turn and reposition every two hours while in bed. The resident was monitored on an identified date during this inspection from 0915hrs to 1200hrs and during this period of time the resident remained in the back lying position. The resident was also monitored on a second identified date during this inspection from 1030hrs to 1250hrs and during this period of time the resident remained in the back lying position.
Resident #008 was not repositioned in the chair during a monitoring period on an identified date during this inspection. This resident was identified as having two staged wounds and a skin tear. The resident's plan of care directed staff to reposition the resident every two hours while in bed and while sitting in the wheelchair. During the monitored period between 1015hrs. and 1248hr. staff moved the wheelchair, but did not assist the resident to change position or re-balance weight while in the chair over the monitoring period. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

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:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when restraining a resident with a physical device that staff apply the device in accordance with the manufactures directions, with respect to the following: [110(1)1]
1. Staff did not apply the seat belt restraint being used for resident #002 in accordance with directions from the manufacturer, when the seat belt was noted to be applied loosely. The resident was monitored on an identified date during this inspection at 1125hrs and was noted to be sitting in the lounge area with a seat belt restraint applied. At this time it was noted that there was a six inch gap between the resident's body and the seat belt. The resident was also monitored on a second dated during this inspection and it was noted that the seat belt had not been applied according to directions from the manufacturer, when a six inch gap was noted between the resident's body and the seat belt and the straps of the seat belt were twisted many times. Staff identified that this resident slides forward when sitting in the wheelchair increasing the risk for injury when the seat belt is not applied properly.
2. Staff did not apply the seat belt restraint for resident #005 in accordance with directions from the manufacturer, when the seat belt was noted to have been applied loosely. The resident was monitored on an identified date at 0945hrs. and it was noted that there was a five to six inch gap between the resident's body and the seat belt.
3. Staff did not apply the seat belt restraint for resident #004 in accordance with directions from the manufacturer, when the seat belt was noted to have been applied loosely. The resident was monitored on an identified date at 1010hrs. and it was noted that there was a five to six inch gap between the resident and the seat belt. [s. 110. (1) 1.]

2. The licensee did not ensure that when a resident is restrained by a physical device that the device was applied in accordance with any instructions specified by the physician, in relation to the following: [110(2)2]
Resident #004's physician had ordered the application of a front fastening seat belt for safety and to reduce the risk of falling whenever the resident was in the wheelchair. The resident was monitored on September 16, 2013 at 1040hrs and it was noted that the resident was sitting in the wheelchair and the front fastening seat belt was not applied. [s. 110. (2) 2.]

Additional Required Actions:

CO # - 007 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 and ensuring that when a resident is restrained that staff apply the physical device in accordance with directions specified by the physician or registered nurse in the extended class, 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, in relation to the following: [229(10)1]
Information provided by the home and also contained in the clinical records of resident #003, #004 and #006 indicated these residents were not screened for tuberculosis within 14 days of admission to the home.
a)Resident #003 was admitted to the home on an identified date in 2012. Staff and clinical documentation confirmed that staff administered step one of the tuberculosis screen to this resident two months later. There was no further documentation in the clinical record that this resident had a completed screen for tuberculosis by any other means.
(PLEASE NOTE: This evidence of non-compliance was found during inspection # 2013_205129_0011)
b)Resident #004 was admitted to the home on an identified date in 2013. Staff and clinical documentation confirmed that staff administered step one of the tuberculosis screen four months later. There was no further documentation in the clinical record that this resident had a completed screen for tuberculosis by any other means.
c)Resident #006 was admitted to the home on an identified date in 2013. Staff and clinical documentation confirmed that staff administered step one of the tuberculosis screen a month later. There was no further documentation in the clinical record that this resident had a completed screen for tuberculosis by any other means.
(PLEASE NOTE: This evidence of non-compliance was found during inspection # 2013_205129_0011) [s. 229. (10) 1.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

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 did not ensure that the plan of care was based on, at a minimum an interdisciplinary assessment of mood and behaviour patterns, in relation to the following: [26(3) 5]
a) The plan of care for resident #002 was not based on an interdisciplinary assessment of behaviour patterns including the identification of responsive behaviours and potential behaviour triggers. This resident demonstrated a responsive behaviour that resulted in self injury. Although an intervention was put in place to protect the resident from injury, staff and clinical documentation confirmed that an interdisciplinary assessment of behaviour was not completed. Staff and clinical documentation confirmed that although there were other responsive behaviours identified in the care plan, the care plan developed for this resident did not identify this specific behaviour that resulted injury and did not identify possible triggers for this behaviour.
b) The plan of care for resident #003 was not based on an interdisciplinary assessment of identified behavioural changes. Clinical documentation indicated that behaviour being demonstrated began to change at the end of December 2012 related to two identified behaviours. Clinical documentation also indicated that the resident continued to demonstrate behaviours through the end of January 2013 and two additional behaviours were identified. Staff and clinical documentation confirmed that an interdisciplinary assessment of these behavioural changes was not completed and the care plan developed for this resident did not identify three identified behaviours as care need areas for this resident.
PLEASE NOTE: This evidence of non-compliance was found during Inspection #2013_205129_0011. [s. 26. (3) 5.]

2. The licensee did not ensure that the plan of care was based on, at a minimum an interdisciplinary assessment of health conditions including pain, risk of falls and other special needs, with respect to the following: [26(3)10]
a) The plan of care for resident #003 was not based on an interdisciplinary assessment related to four identified need area, in relation to the following:
- Nursing staff identified the resident at risk for falling however did not discuss this risk with the resident's physician or develop strategies to prevent the risk of injury related to falling and an interdisciplinary assessment was not completed. Clinical record information confirmed that the resident began demonstrating unsteadiness when walking in 2013, the resident had an unwitnessed fall eight days following this which resulted in a large hematoma. The resident was again described as experiencing unsteady gait a day later and the family expressing concern related to the risk of falling and unsteady gait. The resident fell again a day later resulting in significant

injuries for which the resident was transferred to hospital and later died from a complication of this injury. Staff and clinical documentation confirmed the care plan developed for this resident did not provide directions to staff related to falls unsteady gait or the management of the risk of injury from falling.
-The resident's medical history indicated previous cerebral incidents and although the resident complained of headaches, had noted facial drooping and was note to be unable to self feed, an interdisciplinary assessment was not completed in relation to the risk of further cerebral incidents. Clinical records indicated the resident complained of headaches and received medication to manage this pain twice during an identified period in 2012 and four times during an identified period in 2013. Staff and clinical documentation confirmed that the care plan developed for this resident did not provide directions for staff to monitor and report signs and symptoms that may indicate the possibility of cerebral incidents.
- Clinical documentation indicated the resident experienced two episodes of seizure activity on an identified date in 2013 and although the resident's physician ordered medication for this condition an interdisciplinary assessment was not completed. Staff and clinical documentation confirmed that the care plan for this resident did not provide information to staff that this resident experienced seizures or directions about the care for this resident related to seizures.
PLEASE NOTE: This evidence of non-compliance was found during Inspection #2013_205129_0011/H-000091-13

b) The plan of care for resident #004 was not based on an interdisciplinary assessment related to risk of falls, in relation to the following:
-Resident #004's physician had ordered the application of a seat belt restraint whenever the resident was in the wheelchair. Staff and clinical documentation confirmed that an interdisciplinary assessment of the risk for falling and the need for the restraint was not completed. Staff and clinical documentation also confirmed that even though the resident was noted to have a seat belt restraint applied, the care plan developed for this resident did not contain directions for staff to apply a seat belt restraint or the care required for a resident while being restrained. [s. 26. (3) 10.]

3. The licensee did not ensure that the plan of care was based on, at a minimum an interdisciplinary assessment of skin conditions, including altered skin integrity and foot conditions in relation to the following:[26(3) 15]
The plan of care for resident #009 was not based on an interdisciplinary assessment of the skin integrity issues. The resident was noted to have a dressing applied to the

foot and indicated that there was a sore on the foot and also indicated the area was painful. Clinical record information confirmed that the resident was treated for an infection at the site and then subsequently treated for a generalized cellular infection around the site. Staff and clinical documentation confirmed that an interdisciplinary assessment of skin integrity and skin infection issues demonstrated by the resident was not completed and also confirmed that the plan of care developed for this resident did not contain directions for staff with respect to the provision of basic foot care needs or an indication that the resident was experiencing skin integrity issues. [s. 26. (3) 15.]

Additional Required Actions:

CO # - 010, 011 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 and ensuring that the plan of care is based on an assessment of the skin conditions, including altered skin integrity and foot conditions, to be implemented voluntarily.

WN #7: 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 did not ensure that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that directions contained in those directive documents where complied with, in relation to the following: [8(1)(b)]
1. Staff in the home did not comply with directions contained in the home's policy [Tuberculin Surveillance and Testing (Residents) identified as #ICM-040 and dated March 30, 2013 when they did not screen resident #003, #004 and #006 within 14 days of admission to the home. Staff in the home also did not comply with directions contained in this policy when they did not complete step two of tuberculin screening protocol for resident #004 and resident #006 within 21 days of admission to the home.
2. Staff in the home did not comply with directions contained in the home's policy [Pain Management] identified as #NM-II-P010 and dated February 2009 when they did not complete weekly pain assessments for residents receiving medication/treatment for pain.
-Resident #001 was ordered to receive a regularly scheduled narcotic analgesic to manage pain the resident was experiencing. Staff and clinical documentation confirmed that weekly pain assessments were not completed for this resident.
3. Staff in the home did not comply with directions contained in the home's policy [Restraint: Physical, Chemical and Environmental] identified as #NM-II-R008 and dated February 2012, in relation to the following:
-Staff did not comply with the directions that a resident is not to be restrained without informed consent of the resident or family member/substitute decision-maker when staff in the home were unable to provide documentation to confirm that consent for resident #002 and resident #004 was obtained prior to the use of front fastening seat belt restraints for both of these residents.
-Staff did not comply with the directions that a restraint may only be used if the details relating to the restraining are included in the plan of care when the plan of care for resident #004 was noted to contain no reference to the use of a front fastening seat belt nor did the resident's care plan contain directions for staff related to the care to be provided to the resident while in restraints.
-Staff did not comply with the directions that the device is applied in accordance with directions from the manufacturer, when the front fastening seat belts for resident #002, #004 and #005 were noted to be applied with a six inch gap between the residents body and the seat belts on September 13 and 16, 2013.
-Staff did not comply with the directions that the resident is to be released from the device and repositioned at least every two hours when it was noted that resident #002 and resident #008 did not have the front fastening seat belts released nor were the

residents repositioned for a period of time in excess of two hours on September 16, 2013
4. Staff in the home did not comply with the home's policy [Food and Fluid Monitoring and Resident Food Intake Evaluation], identified as #DTY-III-027 and dated February 2013, in relation to the following:
Staff did not comply with the directions that food and fluid is monitored and recorded for all residents on a daily basis by nursing staff when:
- Food and fluid consumption was not recorded for resident #001 during 14 meal periods over 23 days in July 2013, 22 meal periods in August 2013 and 8 meal periods over 13 days in September 2013.
-Food and fluid consumption was not recorded for resident #004 during 25 meal periods over 23 days in July 2013, 25 meal periods in August 2013 and 16 meal periods over 23 days in September 2013. [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 and ensuring that where the Act or the Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the directions contained in those documents are complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee did not ensure that a quality improvement and utilization review system that monitors, evaluates and improves the quality of care provided to residents was developed and implemented, in relation to the following: [84]
Staff confirmed that there were not systems or practises in the home to monitor and improve the care residents received related to the required programs identified in the LTCHA and Regulations, specifically the following:
a) During this inspection non-compliance was identified in the organized program of Nursing and Personal Care, specifically related to reassessing the resident and reviewing and revising the plan of care. Non-compliance was identified when it was determined that residents reviewed during this inspection were not reassessed nor were the associated plans of care reviewed and revised when the residents care needs changed and when the care set out in the plan of care was not effective in meeting the needs of the resident. Staff confirmed that there were not mechanisms in place for identifying or communicating to members of the interdisciplinary team when residents needs change nor was there a process where the plans of care for residents were monitored to ensure those plans are reviewed and updated based on the changing needs of the residents. Previous non-compliance in these areas was identified in October 2010, January 2011, February 2011, June 2011 and September 2011.
b) During this inspection non-compliance was identified in relation to staff not complying with directions contained in the home's established policies within the care programs, specifically the Pain Management Policy, the Tuberculin Surveillance and Testing policy, the Restraint policy and the Food and Fluid Monitoring policy. Staff confirmed that there was not an auditing process in place in the home to ensure staff comply with the homes policies contained within the care programs. Previous no-compliance in this area was identified in April 2011, June 2011 and August 2011.

c) During this inspection non-compliance was identified in the organized program of Nursing and Personal Care, specifically related to the restraining of residents. Non-compliance was identified related to the completing an assessment of the resident requiring restraints, the appropriate application of the restraining device, care provided to residents who were being restrained and the documentation of the care provided to residents who were being restrained. Staff confirmed that there is not a mechanism in place where staff in the home monitor the completion of assessments for all residents restrained, that residents in restraints are monitored to ensure the restraining device is applied safely, that resident in restraints have the restraint released and are repositioned at least every two hours or that staff document the care provided to

residents in restraints.
d) During this inspection non-compliance was identified related to the legislative requirements contained in the required Skin and Wound Care program. Non-compliance was identified when residents reviewed who had skin and wound care needs were not repositioned at minimum every two hours in order to relieve pressure to areas of compromised skin and did not have weekly skin assessment completed in order to determine if treatment being provided to manage skin breakdown was effective. Staff in the home confirmed that there is not a process in place where weekly assessments for residents are monitored for completeness and to determine if care being provided has been effective or monitoring residents to ensure that care identified as being required is provided to the residents. [s. 84.]

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 and ensuring that the quality improvement and utilization review system monitors, evaluates and improves the quality of care provided to residents is developed and implemented, to be implemented voluntarily.

WN #9: 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. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the licence is subject, in accordance with LTCHA 2007, c. 8, s. 101(3), in relation to the following: [101(4)] The licensee failed to comply with the RAI-MDS 2.0 LTC Homes-Practise Requirement #10, dated October, 31, 2007 when the home failed to generate and complete RAPs within seven days of the Assessment Reference Date (ARD). Staff and computerized documentation confirmed that RAPs were not generated or completed within seven days of a July 8, 2013 ARD for resident #001. [s. 101. (4)]

WN #10: 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 were stored in an area or medication cart that is secured and locked, in relation to the following: [129(1)(a)(ii)
Staff did not ensure the medication room was secured and locked on September 23, 2013 at 1115hrs when a registered staff person was noted to leave the medication room door open and asked a Personal Support Worker who was using the Point of Care documentation station located just outside the medication room to watch the medication room. This staff person was then observed to enter the dining room to administer medications. The registered staff person did not maintain visual contact with the medication room and the medication room was noted to be in a high resident traffic area adjacent to the resident lounge where many residents were congregated awaiting the lunch meal service. [s. 129. (1) (a) (ii)]

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 30th day of December, 2013

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

Phyllis Hiltz-Bontje.

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) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2013_205129_0010
Log No. / Registre no:	H-000201-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 19, 2013
Licensee / Titulaire de permis :	DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC 2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	HARDY TERRACE 612 Mount Pleasant Road, R. R. #2, BRANTFORD, ON, N3T-5L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PAUL ROOYAKKERS

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

To DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 specified in the plan of care is provided to all residents including residents #001, #002, #004 and #008. The plan is to include but not limited to: the development of a mechanism where residents at risk related to pain, food and fluid consumption, skin breakdown, poor positioning, being restrained and falling are identified in a format that can be easily monitored by all staff; a schedule of monitoring the care plans of those residents with identified risk factors to ensure care to be provided to those residents is clearly identified; and a method and schedule of monitoring the care of residents identified at risk to ensure that the care related to those risk factors is being provided. The plan is to be submitted on or before January 31, 2014 to Phyllis Hiltz-Bontje by mail at 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified as non compliant on February 10, 2011 (VPC) and September 21, 2011(WN).
2. Four of four residents reviewed were not provided with care as specified in the plan of care.
3.Care specified in the plan of care for Resident #001 was not provided in relation to the following:
-The plan of care directed staff to monitor pain symptoms weekly. Staff and clinical documentation provided by the home confirmed that weekly monitoring of pain symptoms did not occur in May 2013 and no records were available at the time of this inspection for weekly monitoring after August 17, 2013. At the time of this inspection the resident was receiving regularly scheduled narcotic

analgesics and staff confirmed that the resident was experiencing an increase in pain.
-The plan of care directed staff to monitor the food and fluid intake sheets. Registered staff confirmed that these records were not monitored and as a result staff were not aware that the documentation on these sheets was not complete. The documentation indicated that for July, August and September 2013 the resident did not consume the daily amount of fluid identified as required and the resident consumed less than 50% of food provided on several days over this three month period.
-The plan of care directed staff to assist the resident to turn and reposition every two hours while in bed. Observations of care provided on September 12 and 16, 2013 confirmed that this care was not provided when the resident was not assisted to turn and reposition for periods of time in excess of two hours.
4. Care specified in the plan of care was not provided to resident #002 in relation to the following:
-The plan of care directed staff to monitor and document the resident's response to being restrained every hour, registered staff were to evaluate the ongoing need for the restraint every shift and direct care staff were to remove the restraint every two hours and reposition the resident. Observation of care provided on September 16, 2013 confirmed that the restraint was not released and the resident was not repositioned for a period of time in excess of two hours. Clinical documentation provided by the home confirmed that staff did not document the resident's response to the restraint for five shifts over the first 16 days of September. Clinical documentation also confirmed that registered staff did not document that they had evaluated the ongoing need for the restraint for nine shifts over the same period noted above.
-The plan of care directed staff to apply adaptive clothing in the morning. Observation of care provided on September 12 and 16, 2013 confirmed that this care was not provided and the resident was not wearing the adaptive garment.
5. Care specified in the plan of care was not provided to resident #004 in relation to the following:
-The plan of care directed the resident to have a front fastening seat belt applied whenever in the wheelchair for safety. Observation of care provided on September 16, 2013 confirmed that this care was not provided when the resident was noted to be sitting in the wheelchair and did not have a front fastening seat belt applied.
Staff identified the resident as a risk for falling and the resident had experienced two falls.

6. Care as specified in the plan of care was not provided to resident #008 in relation to the following:
-The plan of care directed staff to reposition the resident every two hours while in bed and in the wheelchair in order to prevent further skin breakdown. Observations of care provided on September 23, 2013 confirmed that this care was not provided when the resident was not repositioned in the wheelchair for a period of time in excess of two hours. At the time of this review the resident was experiencing skin breakdown. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that when residents care needs change, including resident #001, that the resident is reassessed and the plan of care is reviewed and revised. The plan is to include but is not limited to: training for staff in relation to those conditions or circumstances that indicate a resident's care needs have changed; the development of specific protocols that staff must follow when it is identified that the care need(s) of a resident have changed; and a method and schedule for monitoring staffs performance in both the identification of changing care needs and the adherence to the established protocols identified above. The plan is to be submitted on or before January 31, 2014 to Phyllis Hiltz-Bontje by mail at 119 King Street West, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified as non compliance on February 10, 2011 (VPC), October 12, 2010 (WN), January 12, 2011 (VPC), June 9, 2011 (VPC) and September 21, 2011 (VPC).
2. Two of three residents reviewed who experienced changes in their care needs were not reassessed nor were their plans of care reviewed or revised in accordance with s. 6(10)(b).
3. Resident #003's care needs changed, however the resident was not reassessed and the plan of care was not reviewed and revised in relation to the

following:

-The resident's care needs changed when this resident experienced side effects from a medication being administered. Clinical documentation indicated that the resident experienced this side effect on an identified date in 2012 and required treatment in hospital. The resident again experienced this side effect 13 days later. Staff confirmed that the resident was not reassessed in relation to the risk of injury and the resident's plan of care was not reviewed or revised to include action staff should take to reduce risk of further injury as a result of this side effect. The resident experienced this side effect a third time on an identified date in 2013.

- The resident's care needs changed when this resident experienced two seizures on an identified date in 2013, in the absence of a medical history of seizures. Staff confirmed that the resident's plan of care was not reviewed or revised with respect to the noted seizure activity and did not include directions for care designed to reduce the risk of injury related to seizure activity.

-The resident was identified on admission to the home as being a moderate risk for falling. Clinical documentation indicated that the resident had an un-witness fall on an identified date in 2013. Staff and clinical documentation confirmed that the resident was assessed for injuries at the time of the fall, but the plan of care was not reviewed or revised to include care to be provided to the resident that would prevent falling or minimize the risk of injury from falling. The resident experienced a subsequent fall three days later that resulted in the resident being transferred to hospital.

4. Resident #001 's care needs change, however the resident was not reassessed and the plan of care was not reviewed and revised, in relation to the following:

-Data collected on the Minimum Data Set (MDS) tool completed on July 2013 indicated the resident's pain had worsened over the previous data period and that the resident now experienced pain daily at a moderate level. The Resident Assessment Protocol (RAP) portion of the tool was not completed and staff confirmed that the resident was not reassessed when pain being experienced by the resident worsened and the resident's plan of care was not reviewed or revised at this time. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure that all residents being considered for restraining and all current residents being restrained, including resident #002 and #004 are assessed to determine what alternatives to restraints have been considered and tried, but would not or have not been successful in addressing the identified risk to those residents and that the assessment noted above is documented in the resident's clinical record.

Grounds / Motifs :

1. Two of three residents noted to be in physical restraints were not assessed for alternatives to the restraining device.
2. Resident #002 was noted to be restrained in a wheelchair by the use of a front closing seat belt at 0915hrs. on an identified date during this inspection. The home requires staff to complete the form [Methods to Manage Safety Risks] which included the requirement to identify and document the alternatives to restraints that were considered. Staff and clinical records confirmed that this form was not completed for resident #002 and staff were unable to provide other assessments or documents to confirm that alternatives to the use of this restraining device were considered prior to the application of the device.
3. Resident #004 was noted to be restrained in a wheelchair by the use of a front closing seat belt at 1010hrs on an identified date during this inspection. The home requires staff to complete the form [Methods to Manage Safety Risks] which included a requirement to identify and document the alternatives to restraints that were considered. Staff and clinical records confirmed that this form was not completed for resident #004 and staff were unable to provide any other assessments or documents to confirm that alternatives to the use of this device were considered prior to the application of the device. (129)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations;
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations;
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;
(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2);
(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):
(i) an alternative to restraining, or
(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; and
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Order / Ordre :

The licensee shall ensure that all residents being restrained by a physical device, including resident #002 and #005 are released from the restraints and are repositioned at minimum every two hours.

Grounds / Motifs :

1. Two of two resident who were being restrained with the use of a physical device did not have the restraint released and were not repositioned at minimum every two hours.
2. Resident #002 was noted to be sitting in a wheelchair in the resident lounge and was restrained in the wheelchair using a front fastening seat belt at 1025hrs on an identified date during this inspection. The resident was monitored for a period of time in excess of two hours and during this monitoring period the restraint was not released nor was the resident repositioned in the wheelchair.
3. Resident #005 was noted to be sitting in a wheelchair in the resident lounge and was also noted to be restrained in the wheelchair using a front fastening seat belt at 1035hrs on an identified date during this inspection. The resident was monitored for a period of time in excess of two hours and during this monitoring period the restraint was not released and the resident was not repositioned in the wheelchair. (129)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents exhibiting altered skin integrity, including residents #001, #008 and #009 are reassessed at least weekly by a member of the registered nursing staff. The plan is to include but is not limited to: a schedule for staff training in the collection of data related to the specific areas of altered skin integrity; a process of analyzing the data collected to determine if care being provided is effective; and a schedule of monitoring staffs performance in the above noted processes. The plan is to be submitted on or before January 31, 2014 to Phyllis Hiltz-Bontje by mail at 119 King Street, West, 11th Floor, Hamilton, Ontario L8P 3Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Three of three residents who demonstrated altered skin integrity did not have weekly assessments completed in accordance with s. 50(2)(b)(iv).
2. Resident #001 was identified as having a wound and did not have weekly skin assessments completed by the registered staff. Staff and clinical records confirmed that the resident's wound was not assessed weekly.
3. Resident #008 was identified as having two wounds and also had a skin tear. Staff and clinical documentation confirmed that these wounds were not assessed weekly.
4. Resident #009 was identified as having altered skin integrity on a lower limb. Staff and clinical documentation confirmed that this resident's skin was not assessed weekly. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents who are dependent on staff for repositioning, including resident #001and #008, are repositioned every two hours or more frequently as required. The plan is to include, but is not limited to: training for staff to identify those residents who are unable to effectively reposition themselves; and a schedule for monitoring those residents to ensure that repositioning occurs. The plan is to be submitted on or before January 31, 2014 to Phyllis Hiltz-Bontje by mail at 119 King Street, West, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Two of two residents monitored who were dependent on staff for repositioning did not have their positions changed for periods of time in excess of two hours in accordance with s. 50(2)(d).
2. Resident #001 was not assisted or reposition during monitoring periods on September 13 and 15, 2013. This resident was identified as having a wound and the plan of care for this resident indicated that extensive assistance of two staff was required for bed mobility and that the resident was to be assisted to turn and reposition every two hours while in bed. The resident was monitored on September 13, 2013 from 0915hrs to 1200hrs and during this period of time the resident remained in the back lying position. The resident was also monitored on September 15, 2013 from 1030hrs to 1250hrs and during this period of time the resident was not assisted to turn and reposition and remained in the back lying position during this period of time.
3. Resident #008 was not assisted to reposition in the chair during a monitoring period on September 23, 2013. This resident was identified as having two wounds and a skin tear. The resident's plan of care directed staff to reposition the resident every two hours while in bed and while in the wheelchair. The resident was monitored on September 23, 2013 from 1015hrs until 1248hrs and during this period of time staff moved the wheelchair, but did not assist the resident to change position or redistribute weight while in the chair over the monitoring period. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall ensure that all residents, including resident #002, #004 and #005, who are in physical restraints have those devices applied in accordance with the instructions from the manufacturer.

Grounds / Motifs :

1. Three of three residents who were restrained by the use of a physical device did not have those devices applied in accordance with the manufacturer's directions.
2. Staff did not apply the seat belt restraint for resident #002 in accordance with the manufacturer's directions when the seat belt was noted to be applied loosely. The resident was monitored at 1125hrs. on an identified date during this inspection and was noted to be sitting in the lounge area with a seat belt restraint applied. At this time it was noted that there was a six inch gap between the resident's body and the seat belt. The resident was again monitored on a second date during this inspection and it was noted that the seat belt had not been applied according to manufactures direction. A six inch gap was noted between the resident's body and the seat belt, and it was also noted that the straps of the seat belt were twisted many times.
3. Staff did not apply the seat belt restraint for resident #005 in accordance with the manufacturer's directions when the seat belt was noted to have been applied loosely. The resident was monitored at 0945hrs on an identified date during this inspection and at this time it was noted that there was a five to six inch gap between the resident's body and the seat belt.
4. Staff did not apply the seat belt restraint for resident #004 in accordance with manufacturer's directions when the seat belt was noted to have been applied loosely. The resident was monitored at 1010hrs on an identified date during this inspection and it was noted that there was a five to six inch gap between the resident and the seat belt. (129)

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Order / Ordre :

The licensee shall ensure that each resident admitted to the home, including resident #004 and #006 is screened for tuberculosis within 14 days of admission unless the resident was screened at some time within 90 days prior to admission.

Grounds / Motifs :

1. Three of three residents admitted to the home where not screened for tuberculosis within 14 days of admission to the home.
2. Resident #003 was admitted to the home on an identified date in 2012. Staff and clinical documentation confirmed that staff administered step one of the tuberculosis screen to this resident two months after the date of admission.
3. Resident #004 was admitted to the home on an identified date in 2013. Staff and clinical documentation confirmed that staff administered step one of the tuberculosis screen to this resident four months after the date of admission.
4. Resident #006 was admitted to the home on an identified date in 2013. Staff and clinical documentation confirmed that staff administered step one of the tuberculosis screen a month following the date of admission.
(129)

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

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

Ministère de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 009

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that when the care set out in the plan of care has not been effective the resident is reassessed and the plan of care is reviewed and revised. The plan is to include but is not limited to: training for staff related to how to determine if the care being provided to the resident has not been effective; a specific protocol that staff must follow when it is determined that the care has not been effective; and a mechanism and schedule for monitoring staff to ensure the processes established are being followed. The plan is to be submitted on or before January 31, 2014, by mail to Phyllis Hiltz-Bontje at 119 King Street, West, 11th Floor, Hamilton, L8P 4Y7 or by email at Phyllis.Hiltzbontje@Ontario.ca

Grounds / Motifs :

1. Two of three residents were not reassessed nor was the plan of care reviewed and revised when clinical documentation indicated that the care being provided to these residents was not effective in meeting the goals of care in accordance with s. 6(10)(c).
a)Resident #001's plan of care identified a goal of adequate fluid intake with an estimated fluid requirement of 1925 millilitres of fluid a day in order to prevent dehydration. Clinical documentation indicated that the resident was treated twice in 2013 for dehydration. Documentation on food and fluid consumption record indicated that over 23 days in July 2013 the resident did not consume the required amount of fluid on 22 days, over 31 days in August 2013 the resident did not consume the amount of fluid required on 31 days and over the first 13 days of September the resident did not consume the required amount of fluid on 12 days. Staff confirmed that the plan of care was not reviewed or revised when the goal of care for this resident was not met and the resident continued to be at risk for dehydration.
b) Resident #002's plan of care identified a goal to meet daily fluid requirements of 1840 millilitres of fluid a day related to the prevention of dehydration. Clinical records indicated the resident received treatment in the home for dehydration in 2013. Documentation on food and fluid consumption records in July 2013 indicated that over a 17 day documentation period the resident did not consume the required amount of fluid on 17 days, in August 2013 the resident did not consume the required amount of fluid on 21 days and in September 2013 over a 22 day documentation period did not consume the required amount of fluid on 21 days. Staff confirmed that the plan of care was not reviewed or revised when the goal of care for this resident was not met and the resident continued to be at risk for dehydration. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2014

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* longué durée, L.O. 2007, chap. 8

Order # / Ordre no : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the plans of care for all residents demonstrating mood and behaviour patterns, including resident #002, are based on an interdisciplinary assessment of these issues. The plan is to include but not limited to: a schedule of training to ensure staff recognize mood and behaviour patterns; a mechanism to ensure that a documented interdisciplinary assessment of the identified mood and behaviour patterns is completed; and a mechanism and schedule for monitoring the plans of care for those residents who demonstrate mood and behaviour patterns. The plan is to be submitted on or before January 31, 2014 to Phyllis Hiltz-Bontje by mail at 119 King Street, West, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. The plan of care for two of two residents reviewed who demonstrated behaviour patterns was not based on an interdisciplinary assessment of those behaviour patterns in accordance with s. 26(3)5.
a) Resident #002 demonstrated a responsive behaviour. Although an intervention was put in place to protect the resident, staff and clinical documentation confirmed that an interdisciplinary assessment of behaviour was not completed. Staff and clinical documentation confirmed that the care plan developed for this resident did identify this behaviour as a problem; however the plan of care did not identify possible triggers for this behaviour.
b) Clinical documentation indicated that behaviour being demonstrated by resident #003 began to change at the end of December 2012, with two new behaviours. Clinical documentation also indicated that the resident continued to demonstrate these behaviours through the end of January 2013 and an additional behaviour was also identified. Staff and clinical documentation confirmed that an interdisciplinary assessment of these behavioural changes was not completed and the care plan developed for this resident did not identify the behaviours being demonstrated.
PLEASE NOTE: This evidence of non-compliance was found during Inspection #2013_205129_0011/H-000091-13 (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 011

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions; including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the plans of care for residents, including resident #004, with health conditions including pain, risk of falls and other special needs are based on an interdisciplinary assessment of those conditions. The plan is to include, but is not limited to: a mechanism for organizing and documenting interdisciplinary assessments of resident health conditions; and a method and schedule for monitoring the coordination and completion of the interdisciplinary assessments as well as ensuring that the plans of care for those residents reflect decisions made during the assessments The plan is to be submitted on or before January 31, 2014 to Phyllis Hiltz-Bontje, by mail at 119 King Street, West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. The plans of care for two of four residents reviewed who demonstrated health conditions were not based on an interdisciplinary assessment of those conditions in accordance with s. 26(3)10.
2. The plan of care for resident #003 was not based on an interdisciplinary assessment related to four identified need areas, in relation to the following:
- Nursing staff identified the resident at risk for falling however did not discuss this risk with the resident's physician or develop strategies to prevent the risk of injury related to falling and an interdisciplinary assessment was not completed. Clinical record information confirmed that the resident began demonstrating unsteadiness when walking in 2013, the resident had an un-witnessed fall eight days later resulting in a large hematoma. The resident was again described as experiencing unsteady gait a day later and the family expressed concern related to the risk of falling and unsteady gait. The resident fell a day later resulting in significant injuries for which the resident was transferred to hospital. Staff and clinical documentation confirmed the care plan developed for this resident did not provide directions to staff related to falls unsteady gait or the management of injury from falling.
-The resident's medical history indicated previous cerebral vascular incidents and although the resident complained of headaches,had noted facial drooping was noted to be unable to self feed, nursing staff did not participate in an interdisciplinary assessment related to the risk of further cerebral vascular incidents. Clinical records indicated the resident complained of headaches and received medication to manage this pain twice during an identified period in 2012 and four times during an identified period in 2013. Staff and clinical documentation confirmed that the care plan developed for this resident did not

provide directions for staff to monitor and report signs and symptoms that may indicate the possibility of cerebral vascular events.
- Clinical documentation indicated the resident experienced two episodes of seizure activity on an identified date in 2013 and although the resident's physician ordered medication for this condition nursing staff did not participate in an interdisciplinary assessment of this health condition. Staff and clinical documentation confirmed that the care plan for this resident did not provide information to staff that this resident experienced seizures or directions about the care for this resident related to seizures.
PLEASE NOTE: This evidence of non-compliance was found during Inspection #2013_205129_0011/H-000091-13

3. Resident #4's physician had ordered the application of a seat belt restraint whenever the resident was in the wheelchair. Staff and clinical documentation confirmed that an interdisciplinary assessment of the risk for falling and the need for the restraint was not completed. Staff and clinical documentation also confirmed that even though the resident was noted to have a seat belt restraint applied, the care plan developed for this resident did not contain directions for staff to apply a seat belt restraint or the care required for the resident while being restrained. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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.

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

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

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

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

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

Issued on this 19th day of December, 2013

Signature of Inspector / Signature de l'inspecteur : Phyllis Hiltz-Bontje

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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