Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 21, 2017	2017_553536_0010	010819-17	Resident Quality Inspection

Licensee/Titulaire de permis

PLEASANT MANOR RETIREMENT VILLAGE
15 Elden Street Box 500 Virgil ON L0S 1T0

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

PLEASANT MANOR RETIREMENT VILLAGE
15 Elden Street Box 500 Virgil ON L0S 1T0

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

CATHIE ROBITAILLE (536), KELLY CHUCKRY (611), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 15, 16, 19, 20, 21, 22, 23 and 26, 2017.

The following inspections were completed concurrently with the Resident Quality Inspection (RQI).

Critical Incident System Reports:

003102-17: pertaining to: Prevention of Abuse
011943-17: pertaining to: Prevention of Abuse
007897-16: pertaining to: Elopement

Follow Up:

004504-17: Order #001-pertaining to: Policy not complied

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSWs), registered staff, Nutrition Manager, Therapeutic Recreation Supervisor, Maintenance Supervisor, Human Resource Manager, Clinical Quality Co-Ordinator, Director of Clinical Services (DOC) and the Director.

During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms, common areas and kitchen, reviewed documentation related to bed safety, bed evaluations and assessments, reviewed policies and procedures, clinical health records, meeting minutes, investigation notes, staff files, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **10 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

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,
(b) is complied with. O. Reg. 79/10, s. 8 (1).

A review of the home's policy titled: Falls Prevention and Management Program, last revised: May 2016, directed staff to complete the following:

i) Registered nursing staff shall: Initiate Head Injury Routine for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy.

ii) Training-annual evaluation/training with team.

A review was completed of all unwitnessed falls that occurred since the identified compliance date. The following data was obtained:

A) resident #038 had an unwitnessed fall on an identified date, and Head Injury Routine (HIR) was not completed. Resident had a specified CPS, so staff did not completed HIR as resident stated they did not hit their head.

B) resident #039 had an unwitnessed fall on an identified date, and HIR was not completed. Resident had a specified (cognitive performance scale (CPS), so staff did not completed HIR as resident stated they did not hit their head.

C) resident #036 had an unwitnessed fall on an identified date, and HIR was not completed. Resident had a specified CPS, so staff did not completed HIR as resident stated they did not hit their head.

D) resident #033 had an unwitnessed fall on an identified date, and HIR was not completed. Resident had a specified CPS, so staff did not completed HIR as resident stated they did not hit their head.

E) resident #017 had an unwitnessed fall on an identified date, and HIR was not completed. Resident had a specified CPS, so staff did not completed HIR as resident stated they did not hit their head.

F) resident #011 had a fall on an identified date, and HIR was not completed. Resident had a specified CPS.

G) resident #008 had a fall on an identified date, and HIR was not completed. Resident has a specified CPS.

When interviewed, registered staff #101 and #112 both revealed that HIR was not completed.

When interviewed the DOC also acknowledged that 100 percent (%) of all direct care staff had not been educated as per previous compliance order issued. The DOC acknowledged that an identified number of direct care staff had training on mandatory programs Skin and Wound and Falls Prevention, in regards to previous compliance order requiring all direct care staff to be educated.

Please note: This non compliance was issued as a result of a Follow Up, which was conducted concurrently with the RQI. (Inspector #536). [s. 8. (1) (a),s. 8. (1) (b)]

2. A) The home's policy titled: Bed Rails, last revised: January 2016, indicated that registered staff were to update care plan to include type and number of rails(s) that were in use. On an identified date, resident #029's bed was observed with bed rails in a specified position. Interview with staff #116 reported the resident used bed rails for safety. On June 20, 2017, RAI Co-ordinator indicated that bed rails were to be included in resident's plan of care. A review of the resident's plan of care did not include the use of bed rails by the resident, which was confirmed by staff #103 and acknowledged by DOC. The home did not ensure that the Bed Rail policy was complied with. (632)

B) The home's policy titled Bed Rails, revised in January 2016, indicated that registered staff were to update care plan to include type and number of rails(s) that were in use. Interview with staff #116 reported that the resident used bed rails for safety. On June 20, 2017, RAI Co-ordinator indicated that bed rails were to be in resident's plan of care. A review of the resident's plan of care did not include the use of bed rails by the resident, which was confirmed by staff #103 and acknowledged by DOC. The home did not ensure

that Bed Rails Policy was complied with. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

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

On an identified date and time, resident #026 accessed an unlocked door to the outside. The home's expectation is when staff are not in the specified area that all doors were to be locked. The home failed to ensure that the specified doors were locked when resident #026 was not being supervised by staff.

Please note: This non compliance was issued as a result of a Critical Incident System (CIS), which was conducted concurrently with the RQI. (Inspector #536). [s. 9. (1) 2.]

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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) On an identified date, resident #029's bed was observed with bed rails in a specified position. A review of the resident's clinical health records revealed, that a bed rail assessment had not been completed. During interview with staff #116 they reported that the resident used bed rails for safety. On June 20, 2017, during interview with staff #103 they indicated that the bed rails assessment had not been completed, which the DOC also acknowledged. Staff did not ensure that the resident was assessed and their bed system was evaluated in accordance with evidence-based practices. (632)

B) On an identified date, resident #010's bed was observed with bed rails in a specified position. A review of the resident's clinical health records revealed, that a bed rail assessment had not been completed. During interview with staff #116 they reported that the resident used bed rails for safety. On June 20, 2017, during interview with staff #103 they indicated that the bed rails assessment had not been completed, which the DOC also acknowledged. Staff did not ensure that the resident was assessed and their bed system was evaluated in accordance with evidence-based practices. (632)

C) On an identified date, resident #023's bed was observed with bed rails in a specified position. A review of the resident's clinical health record revealed, that a bed rail assessment had not been completed. During interview with staff # 136 they reported that the resident used bed rails for repositioning and safety. On June 20, 2017, during interview with staff #103 they indicated, that the bed rails assessment had not been completed, which the DOC also acknowledged. Staff did not ensure that the resident was assessed and their bed system was evaluated in accordance with evidence-based practices. [s. 15. (1) (a)]

2. The licensee has failed to ensure that when bed rails were used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On an identified date, resident #029's bed was observed with bed rails in a specified position. During interview with staff #116 they reported, that the resident used bed rails for safety. A review of the bed entrapment records (no date) contained the information that zone number 4 had failed the resident's bed entrapment assessment and bed system, and the "Measurement Device Test Results Worksheet" was not completed for the bed entrapment assessment. On June 21, 2017, during interview with the Maintenance Supervisor they indicated, that no records were available for the resident's bed entrapment assessment, which was confirmed by the DOC. Staff did not ensure that the steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

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

On an identified date, resident #029's bed was observed with bed rails in a specified position. During interview with staff #116 they reported that the resident used bed rails for safety. A review of the bed entrapment records (no date) contained the information that zone number 4 had failed the resident's bed entrapment assessment and bed system,

and the "Measurement Device Test Results Worksheet" was not completed for the bed entrapment assessment. On June 21, 2017, during interview with the Maintenance Supervisor they indicated that the height and latch reliability were to be addressed during the bed entrapment assessment, and that no records were available for the resident's bed entrapment assessment, which was confirmed by the DOC. Staff did not ensure that the steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that when bed rails are used, resident's are assessed and their bed system evaluated to minimize risk to the resident. This VPC applies to r.15(1)(a) only, r. 15(1)(b) and r.15(1)(c) have been issued as written notifications., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

During the initial tour of the home, the LTC Inspector noted that an activation station connected to the resident-staff communication and response system was not available in specified areas of the home. During interview with the DOC they acknowledged that this activation stations were not installed in the specified areas. [s. 17. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the home is equipped with a resident-staff communication and response system that can easily be accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure to protect residents from abuse by anyone.

A review of a Critical Incident System (CIS) submitted by the home and documentation provided by the home indicated that on an identified date, alleged identified abuse by staff member #130 to resident #014 occurred in the home. A review of the investigation notes and other documentation provided by the home, indicated that staff #130 was disciplined as a result which was ackowledged by the DOC on June 26, 2017.

Please note: This non compliance was issued as a result of a CIS, which was conducted concurrently with the RQI. (Inspector #632). [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Falls Prevention and Skin and Wound Programs were evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The LTC Inspector requested the annual program evaluations for both Falls Prevention, and Skin and Wound Care. On June 26, 2017, both the Director and the DOC acknowledged that the home had not completed these mandatory program evaluations.

Please note: This non compliance was issued as a result of a Follow Up, which was conducted concurrently with the RQI. (Inspector #536). [s. 30. (1) 3.]

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 Falls Prevention and Skin and Wound Care Programs are evaluated and updated at least annually, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

A review of a Critical Incident System (CIS), submitted by the home and the documentation obtained by the home indicated that on an identified date, alleged identified abuse by staff member #130 to the resident #014 occurred in the home. Review of investigation notes and other documentation provided by the home indicated that no evaluation at least once a year was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences, which was confirmed by the DOC on June 26, 2017.

Please note: This non compliance was issued as a result of a CIS, which was conducted concurrently with the RQI. (Inspector #632). [s. 99. (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 at least once in every calendar year, an evaluation is completed to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. . [s. 113. (b)]

2. The licensee has failed to ensure that at least once every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 290 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and Regulation.

A review of the documentation provided by the home to the LTC Inspector indicated that no evaluation of Restraints – Minimizing Restraining Resident and Use of Personal Assistance Devices (PASDs) Policy was made to determine the effectiveness of the licensee's policy under section 290 of the Act, and what changes and improvements were required to minimize restraining. This was confirmed by the Director and the DOC on June 26, 2017. [s. 113. (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 at least once every calendar year, an evaluation is completed related to restraints, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the programs include a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

During stage one review of resident's height & weight summary, LTC Inspector identified that there were nine residents out of randomized sample of 20 (45%), whose heights were not measured and recorded on annual basis by the home's staff. During interview, staff #101 confirmed that residents' heights were measured in a home upon their admission and annually thereafter during annual physical exam. The DOC confirmed that heights for the residents were to be done upon admission, and annually. The home's policy titled: Weight and Height Measurement, last revised: May 2013, contained information that residents' height were to be measured upon admission and annually if necessary, thereafter. The staff did not ensure that the height was measured and recorded for each resident on annual basis. [s. 68. (2) (e) (ii)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the satisfaction survey where documented and made available to the Family Council in order to seek the advice of the Council.

On an identified date, the LTC Inspector completed a review of the Family Council President or Delegate Questionnaire completed by the Family Council representative, which indicated that they did not know about the home's requested advice from the Family Council in acting on the satisfaction survey results. A review of the Family Council minutes indicated that there was no recorded information in the minutes, in relation to the licensee seeking the advice of the Council about the survey results. During interview with the Therapeutic Recreation Supervisor they indicated that there were no records about the licensee documenting and making available to the Family Council the results of the satisfaction survey in order to seek advice of the Council about the survey, This was confirmed by the DOC. [s. 85. (4) (a)]

Issued on this 28th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHIE ROBITAILLE (536), KELLY CHUCKRY (611), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2017_553536_0010
Log No. / Registre no:	010819-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 21, 2017
Licensee / Titulaire de permis :	PLEASANT MANOR RETIREMENT VILLAGE 15 Elden Street, Box 500, Virgil, ON, L0S-1T0
LTC Home / Foyer de SLD :	PLEASANT MANOR RETIREMENT VILLAGE 15 Elden Street, Box 500, Virgil, ON, L0S-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TIM SIEMENS

To PLEASANT MANOR RETIREMENT VILLAGE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_247508_0017, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall:

a) educate all registered staff on the home's Falls Prevention and Management Program and the requirement to initiate Head Injury Routine for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy,

b) educate all the remaining registered staff and direct care staff that were not educated as per the January 2017 compliance order in regards to Falls Prevention Management Program and the Skin and Wound Care Program.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (2), scope (2), and compliance history (4), in keeping with r. 299 of the Regulations. This is in respect to the severity of potential or actual harm, the scope of a pattern, and the licensee's history of non-compliance which included a Written Notification in January 2016, and a Compliance Order in January 2017 issued during the Resident Quality Inspection.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the home's policy titled: Falls Prevention and Management Program, last revised: May 2016, directed staff to complete the following:

i) Registered nursing staff shall: Initiate Head Injury Routine for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy.

ii) Training-annual evaluation/training with team.

A review was completed of all unwitnessed falls that occurred since the identified compliance date. The following data was obtained:

A) resident #038 had an unwitnessed fall on an identified date, and Head Injury Routine (HIR) was not completed. Resident had a specified CPS, so staff did not completed HIR as resident stated they did not hit their head.

B) resident #039 had an unwitnessed fall on an identified date, and HIR was not completed. Resident had a specified (cognitive performance scale (CPS), so staff did not completed HIR as resident stated they did not hit their head.

C) resident #036 had an unwitnessed fall on an identified date, and HIR was not completed. Resident had a specified CPS, so staff did not completed HIR as resident stated they did not hit their head.

D) resident #033 had an unwitnessed fall on an identified date, and HIR was not completed. Resident had a specified CPS, so staff did not completed HIR as resident stated they did not hit their head.

E) resident #017 had an unwitnessed fall on an identified date, and HIR was not completed. Resident had a specified CPS, so staff did not completed HIR as resident stated they did not hit their head.

F) resident #011 had a fall on an identified date, and HIR was not completed. Resident had a specified CPS.

G) resident #008 had a fall on an identified date, and HIR was not completed. Resident has a specified CPS.

When interviewed, registered staff #101 and #112 both revealed that HIR was not completed.

When interviewed the DOC also acknowledged that 100 percent (%) of all direct care staff had not been educated as per previous compliance order issued. The DOC acknowledged that an identified number of direct care staff had training on mandatory programs Skin and Wound and Falls Prevention, in regards to previous compliance order requiring all direct care staff to be educated.

Please note: This non compliance was issued as a result of a Follow Up, which was conducted concurrently with the RQI. (Inspector #536). [s. 8. (1) (a),s. 8. (1) (b)]

(536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 21st day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathie Robitaille

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