Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Oct 6, 2014	2014_267528_0029	H-001189-14	Resident Quality Inspection

Licensee/Titulaire de permis

IDLEWYLD MANOR
449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7

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

IDLEWYLD MANOR
449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7

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

CYNTHIA DITOMASSO (528), CAROL POLCZ (156), IRENE PASEL (510)

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): September 9, 10, 11, 15, 16, 17, 18, 2014

This inspection was done concurrently with Critical Incident Inspections Log#'s: H-000902-13, H-000932-13, H-000133-14, H-000842-14, H-000844-14, H-000883-14, H-000098-14, H-000977-14; and Follow up Inspection Log#'s: H-000755-13, H-000911-13

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DON), Director of Finance, Manager of Recreation and Volunteer Services, Food Service Manager (FSM), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Wound Care Nurse (WCN), registered nurses (RN), registered practical nurses (RPN), health care aides (HCA), housekeeping staff, dietary aides, recreation staff, residents and families

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed documents including but not limited to: menus, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure the resident was treated with courtesy and respect that recognized their individuality and respected their dignity.

A) In July 2014, resident #43 approached registered staff, visibly upset and crying. Resident #43 reported a staff member had come into their room, pulled them out of bed and got them changed.

i. In an interview with the resident two months later, they recalled the incident as described above.
ii. Review of the clinical health record and investigative notes revealed that a HCA assisted the resident with incontinent care that morning, even though the resident refused care. A second staff member came to assist with morning care, after the resident was upset and the second staff member indicated that the resident was "settled down" and assisted back to bed.
iii. In an interview with the DON, they reported that the internal investigation was cut short when the accused staff member resigned.
iv. The police investigation found no evidence that abuse had occurred.
v. On September 18, 2014, the resident indicated that they were not hurt during the incident but did not want to get up at the time; the staff did not listen and that was upsetting.

Resident #43 was not treated with courtesy and respect when a staff member did not listen to the resident's request to stay in bed. [s. 3. (1) 1.]

2. The licensee did not ensure that every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A) On September 11, 2014 at 1330 hours, registered staff was overheard denying assistance to resident #82, indicating that other resident's required assistance and staff would not be available anytime soon. The registered staff was then observed to return to sit at the nursing station with a student.

i. Interview with the resident at 1335 hours, confirmed that the resident was not feeling well, had to use the bedpan, and wanted to go to bed. The resident reported that four staff members were required to complete a transfer and felt remorseful that they required so much assistance.
ii. Review of the plan of care revealed that the resident was a three person assist with use of a lift.
iii. In an interview with three HCAs working on the unit, at 1350 hours, indicated that the resident actually required four staff to assist with transfers. All three HCAs denied being informed that the resident requested the bed pan to go to bed 20 minutes earlier.
iv. At 1400 hours, one health care aide was observed leaving the unit and in an interview on their way off the unit confirmed that there was no staff member to replace

them and when they left there would not be enough staff on the floor to assist resident #82 to bed.
v. A total of four staff members, including one registered staff, one student, and two health care aides were noted on the unit, sitting in the nursing station, at 1420 hours.
vi. At 1440 hours, three staff members were noted to exit resident #82's room; resident was in bed and on bed pan.

Despite Inspector intervention, resident #82 waited one hour and ten minutes for assistance, and therefore was not cared for in a manner consistent with their needs.

B) During stage one of the inspection, the power of attorney (POA) for resident #18 informed the inspector that staff do not always pull up the resident's pants properly or tuck them in leaving their bottom exposed.

i. On September 16, 2014 at approximately 1120 hours, the resident was observed in the lounge with approximately fifteen other residents. The resident's pants were not tucked in and the resident's upper leg skin was visible.
ii. The Inspector notified the staff who immediately covered the resident up.
iii. Interview with registered staff confirmed that the resident should be covered at all times.

The resident's rights were not fully respected on September 16, 2014 when the resident was found to be uncovered. [s. 3. (1) 4.]

3. The licensee did not ensure that every residents right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, was protected.

A) The Home’s medication dispensing system provided resident medications in packages that were labeled with the resident’s name and the medications contained in that package.

i. Throughout the course of the inspection, registered staff were observed to throw medication packages in the general garbage.
ii. On the morning of September 16, 2014, the Inspector found several empty medication packages in the general garbage. The packages contained the resident's name and medication type and medication dosage.
ii. Interview with registered staff confirmed that the medication packages, which

contained residents names and medication regimes, were discarded with the general garbage and not disposed of in a manner which would protect the residents' personal health information. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is treated with courtesy and respect that recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A) On the first day of the inspection, it was noted that the steam tables in the dining rooms were accessible to residents.

i. Glass on the steam tables did not cover the area completely to prevent access by residents to touch the steam table and burn themselves.
ii. Residents were found to be in the dining rooms prior to meal service
iii. Interview with the FSM confirmed that the steam tables were turned on at least 20 minutes prior to the food arriving and dietary staff being present to serve.

The access to the hot steam tables did not ensure a safe environment for the residents in the dining areas. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care for each resident set out the planned care for the resident.

A) The plan of care for resident #27, including both the care plan and resident kardex, indicated that the resident preferred a shower. In interviews with both the resident and registered staff it was confirmed that the resident actually preferred and received a bed bath regularly. The written plan of care for the resident did not include that the

resident was to receive a bed bath.

B) In a recent assessment, resident #23 scored three on the cognitive performance scale (CPS); and during the course of the inspection was observed to be in bed, not participating in programming for residents with cognitive impairment. The care plan directed that staff should encourage the resident to take an active social role within the facility. Interview with program staff confirmed the resident is unable to take an active social role within the facility and is offered one on one interactions. The recreation staff confirmed that the plan of care did not reflect the resident's planned care, related to recreation therapy. [s. 6. (1) (a)]

2. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A) Resident #10 was observed throughout the inspection to be in bed each afternoon.

i. The written plan of care for the resident indicated that they would have all meals in the dining room as requested by family. Notes from an interdiscipinary meeting from March 2014, indicated that family had agreed to the resident being up for lunch and breakfast but could be put to bed for dinner.
ii. In an interview with two HCA's; one reported that the resident was returned to bed after lunch every day, while the other reported the resident was returned to bed after lunch on alternate days. In an interview with the registered staff it was reported that the resident would stay up for all meals if there was no skin breakdown on the coccyx.

All three staff members interviewed provided different version of the resident's daily care routine at meal times; the written plan of care did not set out clear direction to staff and others who provided direct care to the resident.

B) Throughout the course of the inspection, resident #13 was noted to have a contact precaution sign posted on their door and isolation cart in their bathroom.

i. Review of clinical health record indicated that the resident was on isolation precautions for an antibiotic resistant organism identified at two sites; however, the document the home refers to as the care plan did not include the type of organism being isolated, location of infection, or precautions required by staff.

ii. In an interview with two direct care staff members, only one member was able to identify the organism isolated and other than speaking to registered staff did not know where to look in the clinical health record to find information related to isolation precautions. Interview with the DOC confirmed that care plan should have included the type of organism being isolated and location of infection.

The plan of care did not set out clear directions to staff and others who provide direct care to the resident, related to isolation precautions for resident #13. [s. 6. (1) (c)]

3. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) In January 2014, the Quarterly Minimum Data Set (MDS) assessment for resident #18 coded the resident as having an increase in socially inappropriate, disruptive behaviour occurring daily over a seven day observation period. This assessment; however, was not consistent with documentation in the progress notes during the same time period, as there was no evidence that the resident had any socially inappropriate, disruptive behaviours. The RAI coordinator and registered staff interviewed were unable to identify any specific changes occurring over the seven days observation period. [s. 6. (4) (a)]

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

A) On September 11 and 12, 2014, resident #11 was observed to be transferred to bed after breakfast with the assistance of two staff members and use of a lift. The resident then spent the remainder of the day in bed.
i. The plan of care for the resident indicated that two staff were to toilet the resident after breakfast daily and when requested, using a lift.
ii. Interview with HCA's on both days confirmed that the resident was not toileted after breakfast before spending the rest of the day on September 11 and 12, 2014.

The resident was not provided with the care as specified in the plan related to their toileting schedule on September 11 and 12, 2014. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
i. that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident
ii. that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Policy "RC-05-08-07:Pain Assessment and Symptom Management", last revised November 2012, directed registered staff to assess pain on admission, on return of a leave of absence, transfer to hospital and post admission, with a significant change that requires the initiation of a special surface, as directed by individual programs, and quarterly.

i. The plans of care for residents #11, #14, and #23 indicated that all of the residents received analgesics daily to control moderate pain. Review of the electronic documentation system did not include pain assessments quarterly:
ii. from September 2013 to present, only one quarterly pain assessment was completed for resident #11.

iii. in March 2014, the quarterly pain assessment was not completed for resident #14.
iv. pain was not assessed after October 2013 quarterly assessment for resident #23

Interview with the RAI Coordinator confirmed that the quarterly pain assessments were not consistently completed for residents #11, #14, and #23; as outlined in the policy.

B) Policy "RC-05-08-07:Pain Assessment and Symptom Management, last revised November 2012", directed registered staff that when a new regular or PRN medication is ordered the nurse must monitor the effectiveness, with a formal evaluation to occur after one week
-the nurse must be aware of and monitor for possible side effects of the new/changed medication
-in addition to the notes made during/following the administration of medication, the nurse must make a progress/summary note in the resident's chart each month
-the Policy identified the "PQRST" characteristic as a baseline pain assessments tool for the verbal resident; and if the resident was unable to communicate pain, indicators of pain were to be described in the narrative section
-it was also identified that for residents at high risk for respiratory complication receiving opioids, staff are to assess respiratory status and opioid induced sedation

i. In June 2014, resident #83 was noted to have increased agitation and discomfort; as a result, the physician increased routine and PRN narcotic orders to double the original dosage.
ii. In June 2014, the resident was given the first PRN narcotic dosage. Registered staff documented that the medication was administered for comfort measures.
iii. Routine administration of the new narcotic dosages were administered as ordered, for two consecutive doeses.
iv. One day later registered staff documented that the resident was resting more comfortably and then approximately one hour later administered PRN narcotic. Registered staff documented that the resident was "in pain" and was "effective"
vi. Approximately 2.5 hours later the POA of the resident identified to registered staff that the resident was not breathing normally. Upon assessment registered staff noted the resident was non responsive, had shallow respirations, and decreased oxygen saturation. The resident was transferred to the hospital at that time.

Review of the progress notes for the initial 24 hours following an increase in narcotic dosages did not include a formalized pain assessment or respiratory assessment

using tools identified in the Policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. Policy "RC-05-06-01:Policies governing the use of restraints", last revised May 2014 states that "the RPN is expected to reassess the need to continue the restraint use at quarterly intervals (at the time that the RAI-MDS assessment is conducted) documenting the assessment in the individual electronic record PCC-clinical-assessments-restraint assessment”.

A) The plans of care for residents #15, #19 and #21 indicated that all three residents required assist side rail restraints when in bed. Review of the clinical record revealed that the quarterly restraint assessment in the electronic record were not completed quarterly:
i.After June 2012, there was no quarterly restraint assessment completed for resident #015
ii. After October 2013, there was no quarterly restraint assessment for resident #019
iii. After February 2013, there was no quarterly restraint assessment for resident#021

The RAI coordinator confirmed that quarterly restraint assessments for these residents were not completed as directed by Policy # RC-05-06-01. [s. 8. (1) (a),s. 8. (1) (b)]

3. Policy "RC-05-03-17:Repositioning Techniques in Bed", last revised June 2012, outlined that when a resident is unable to change positions in bed independently and required staff to assist, it should always be done using two persons.

A) On a late afternoon in January 2014, resident #81 activated the communication system, requesting incontinent care.

i. Interview with the HCA who assisted the resident that morning, and she confirmed that the resident required incontinent care in bed. The HCA stated that although the resident was resistant to care, she assisted the resident to change positions in bed, and provided the resident's with a clean brief and soaker pad on their own.

Two staff members did not assist the resident as outlined in Policy RC-05-03-17. [s. 8. (1) (b)]

4. Policy "AM-02-01-12 Complaint Resolution Process/Resident/Family", last revised May 2014, indicated for written and verbal complaints of a minor nature that are not

resolved within 24 hours are to be submitted to the Administrative Assistant to the Executive Director and a Concern Complaint Investigation form is initiated.

A) In Sept 2014, resident #22 indicated that a small amount of money went missing from their bedroom a few weeks prior, that staff was notified immediately, and the money remained missing.

i. Review of the plan of care and complaints log did not include resident #22's concern about missing money.
ii. Interview with registered staff confirmed that the resident did express concerns about missing money; however, the staff member could not confirm the exact dates of the incident.
iii. Registered staff also stated that the resident's story did change over time and that the POA was aware. Staff could not confirm that administration was notified of the concern. In an interview with the DON, it was identified that she was unaware of the missing money reports from resident #22.

Registered staff did not notify the administration of resident concerns as outlined in the Policy; and therefore, the formalized concern and complaints process was not initiated for the missing money reported by resident #22. [s. 8. (1) (b)]

5. Review of Policy "RC-11-01-05 Falls Prevention and Management Program: Post Fall Assessment and Management", revised March 2014, identified that after a resident had fallen and there is an apparent injury, the physician was to be notified.

A. In July 2014, resident #85 lost consciousness and had a witnessed fall; hitting their head. The resident was immediately assessed by registered staff and an area of slight redness was noted to the back of their head. The physician was not notified of the fall incident causing injury. Interview with registered staff confirmed that the physician was not notified of the fall; although should have been as advised in Policy. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #5: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the registered dietitian who was a member of the staff of the home assessed the resident's nutritional status, including height, weight and any risks related to nutrition care.

A) Resident #23 was assessed for swallowing by the RD post a possible stroke on November 12, 2013, and put on nectar thickened fluids. Eight days later the resident was assessed and put on honey thickened fluids and on pudding thickened fluids five days after that.
i. In January 6, 2014, the resident's swallowing was assessed by the RD and the consistency was changed to nectar thickened fluids and then changed to regular fluids on January 13, 2014. On March 6, 2014, documentation confirmed that the resident was again having difficulty swallowing and the RD ordered nectar thickened fluids for the resident. On April 7, 2014 the RD assessment reported that the resident was fed in bed and would often not sit up or allow staff to reposition making swallowing liquids difficult resulting in coughing with regular fluids; however, took nectar thick without any cough or swallowing difficulty.
ii. On May 5, 2014, documentation by the RD indicated that the resident would be provided ice cream at dinner, no RD assessment was noted with the addition of ice cream.
iii. The home's "Policy FS-04-01-13 Thickened Fluids", as well as in an interview with the FSM on September 17, 2014, it was confirmed that ice cream was contraindicated on a thickened fluid diet order.

The risk related to nutritional care of the resident receiving ice cream was not assessed by the RD. (156) [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that the registered dietitian assesses the resident's nutritional status, including height, weight and any risks related to nutrition care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

**s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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

A) Since May 2014, resident #18 was noted to have an area of skin breakdown; ongoing treatment included dressing changes and pressure relieving surfaces. Review of the plan of care did not include weekly wound assessment for three weeks in July 2014 and two weeks in August 2014. Interview with the Wound Care Nurse (WCN) confirmed that weekly wound assessments were not completed consistently for resident #18 in July and August 2014. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a cleaning schedule for the food production areas, servery areas, and dishwashing areas and that staff comply with this schedule.

A) The food servery areas on all three floors in the building were found to be in need of cleaning. It was noted that the walls in the servery areas required repair and painting to ensure a smooth surface in which to clean. As confirmed with the FSM on September 18, 2014, the walls, fridges, and flooring in these areas were found to be in need of deep cleaning; and the home had cleaning schedules for these areas, which had not been followed. [s. 72. (7) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a cleaning schedule for the food production areas, servery areas, and dishwashing areas and that staff comply with this schedule, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were monitored during meals, including residents eating in locations other than dining areas.

A) Residents #26 and #27 were noted to routinely eat meals in their rooms; however, were not monitored during this time. On September 16, 2015, both residents were in their rooms during the lunch meal and not found to be monitored. Resident #26 was in their room eating lunch with the door open and resident #27 was in their room eating lunch with the door closed. Staff were not observed monitoring the residents during the meal. Front line staff reported on September 16, 2014 that both of these residents were not routinely monitored during their meals. As confirmed with the Director of Care on September 16, 2014 the expectation would be that staff be in the hallway or in resident rooms to provide supervision to the residents in their rooms during the meal. Two residents were not found to be monitored while eating in their rooms on September 16, 2014. [s. 73. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are monitored during meals, including residents eating in locations other than dining areas, to be implemented voluntarily.

WN #9: 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:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that three residents were not offered immunizations against pneumococcus, tentanus and diptheria.

A) Reviewed of the plans of care for residents #84, #85, #86, admitted from March to July 2013. Immunization records for all three residents did not include screening of pneumococcus, tetanus and diptheria; or documentation that the vaccines were offered.
ii. Interview with the DON who confirmed that screening/offering of the vaccine was not part of the plan of care for the three residents. [s. 229. (10) 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 , to be implemented voluntarily.

WN #10: 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 did not ensure that all doors leading to non-residential areas were kept closed and locked when they are not being supervised by staff.

A) On September 9, 2014, during the initial tour of the home, the doors to non-resident service areas between units on both the first and second floor were noted to be unlocked. All four doors had keypad locks in place but the locks did not latch and therefore the doors could be open by anyone.

i. the first floor non-resident service included access to a service elevator and open food servery area
ii. the second floor non-resident service area included access to a service elevator, open food servery area, and steep service stairway leading to a trap door.

Interview with the Executive Director confirmed that the doors were to be locked and action was taken immediately by maintenance to correct the issue. The doors were noted to be closed and locked at end of day on September 9, 2014. [s. 9. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee did not ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to responsive behaviours were developed to meet the needs of the resident with responsive behaviours.

A) In September 2014, resident #11 was escorted to their room after breakfast. From 945 to 1010 hours, the Inspector observed the resident yelled out for staff.

i. RAPS from September 2013 to present, indicated that the resident continued agitated behaviours with frequent requests for attentions, yelling, and calling out and that care plan goals and interventions in place were usually effective.
ii. Interview with registered staff confirmed that resident #11 yelled/called out for staff on a regular, but not daily, and sometimes was difficult to redirect.
iii. Review of the the document the home refers to as the care plan did not include yelling out or calling out for staff as an identified responsive behaviour; nor did it include techniques or interventions to respond to those behaviours.

Interview with registered staff and the DON confirmed that the resident's behaviour of yelling/calling out was a regular responsive behaviour, and that interventions and techniques for staff to respond to these behaviours were not included in the written plan of care. [s. 53. (1) 2.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee did not ensure that all hazardous substances in the home were labeled properly and were kept inaccessible to residents at all times.

A) On September 9, 2014 at approximately 1100 hours, housekeeping room #1W06 was unlocked and the door was opened by the Inspector. Six bottles of Virex 236 disinfectant and cleaner were noted inside the room and accessible to residents. Interview with housekeeping staff confirmed the door should have been locked; however, due the latch on the door, the lock did not consistently catch. The Executive Director of the home was notified and by end of day on September 9, 2014, the door latch was noted to be locked and in working order. [s. 91.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident’s substitute decision-maker, if any, and any other person specified by the resident, were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

On December 10, 2013, the home was advised of an alleged abuse involving resident #40 and resident #41. The home reported on the critical incident report they they did not inform the substitute decision maker (SDM) for either resident. On September 18, 2014, the Director of Care (DOC) confirmed that the SDM's for the identified residents had not been informed of the alleged abuse. [s. 97. (1) (b)]

WN #14: 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).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident is restrained by a physical device under section 31 or section 36 of the Act, staff applied the physical device in accordance with any manufacturer's instructions.

A) On September 18, 2014 at 1110 hours, resident #80 was observed fidgeting in their wheelchair, a side fastening seat belt was noted to be twisted and loose; approximately five fingers breadth from the residents body.
i. the resident was unable to undo the seat belt upon request.
ii. review of the plan of care indicated the the resident required a side fastening seat belt when up in their wheelchair for safety
iii. direct care staff and registered staff confirmed that the seat belt was too loose and not applied as per manufactures instructions; approximately two fingers breadth from the resident's body. Direct care staff immediately tightened the belt. [s. 110. (1) 1.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that drugs were stored in an area or medication cart that was secured and locked.

A) On the morning of September 11, 2014, the medication cart in the Oakwood home area was observed in the hallway unattended. The cart was unlocked. All drawers, including the drawer containing narcotics were opened by the inspector before registered staff emerged from the resident room. Registered staff confirmed the cart should have been locked.

B)On the morning of September 11, 2014, the medication cart in the Orchard View home area was observed in the hallway outside of the dining room. The registered staff member was in the dining room administering medication to a resident. The cart was unlocked. All drawers, including the drawer containing narcotics were opened by the inspector prior to the registered staff noticing.

C) On the morning of September 15, 2014, the medication cart in the Orchard View home area was observed in the hallway unattended. Two drawers on the cart were opened by the inspector before registered staff emerged from the room. Registered staff confirmed the cart should have been locked.

On September 15, 2014, DON confirmed it is the homes expectation that drugs are stored in a medication cart that is secured and locked. [s. 129. (1) (b)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2013_201167_0032	528
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2013_240506_0001	528

Issued on this 6th day of October, 2014

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