Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection Sept 28, 29 Oct 3, 4, 5, 6, 7	**Inspection No/ No de l'inspection**	**Type of Inspection/Genre d'inspection**
Oct 12, 13, 14, 19, 20, 21, 24, 25, 26, Nov 25, Dec 7, 16, 19, 22, 2011	2011_027192_0043	Follow up

Licensee/Titulaire de permis

KING NURSING HOME LIMITED
49 Sterne Street, Bolton, ON, L7E-1B9

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

KING NURSING HOME
49 Sterne Street, Bolton, ON, L7E-1B9

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

DEBORA SAVILLE (192), ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, Director of Care, Assistant Director of Care, Resident Assessment Instrument (RAI) Co-ordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Environmental Manager, Activation Manager, Recreation Assistants, Food Service Manager, Dietary Staff and Housekeeping Aides related to Follow-up Inspection H-001880-11.

During the course of the inspection, the inspector(s) toured the home, observed meal preparation and service, reviewed menus and recipes, observed care and environmental services, reviewed policy and procedure, and medical health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Food Quality

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

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 subsections:

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;
(b) the goals the care is intended to achieve; and
(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
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary. [s. 6(10)b]

a) A specified resident was not reassessed and the plan of care not reviewed and revised when care set out in the plan was not effective in relation to constipation. October 14, 2011, the plan of care for the specified resident was reviewed and noted documented nutritional interventions for constipation initiated in 2011. Food and fluid intake records for a four month period has indicated that the resident has been refusing the identified intervention.
October 14, 2011, a review of medical administration record and the daily bowel movement flow sheets had identified that the resident had an increase in the amount of constipation and has been requiring use of laxatives frequently without an evaluation of the effectiveness of nutritional interventions. The registered dietitian verified that nutritional intervention for constipation initiated had not been evaluated and the plan of care was not revised. The registered dietitian confirmed that a referral had not come through in any of those instances.

b) The registered dietitian who is the member of the staff of the home did not complete a nutritional assessment for a specified resident when there was a significant unplanned weight loss. The resident had a 15% weight loss over a five month period.
October 14, 2011, the progress notes reviewed noted that a referral was made to the registered dietitian by the registered staff. The contributing factor initiating the referral was the resident had undesirable weight change.
The dietitian's assessment documented on the referral form stated " review of progress notes and discussion with Registered Practical Nurse reveals no change in status from last month and no new interventions are required". This was contrary to the home's computerized monthly weight record and the referral made by the nursing staff to the dietitian for weight loss. The weight changes were not assessed with action taken and outcomes evaluated.

c) A specified resident was identified to have pain. On September 6, 2011 the resident was identified to have redness and tenderness of a designated area. No assessment of this pain was completed. The plan of care was not updated to include this new source of pain or interventions to protect the area from further tissue damage and promote comfort.

d) A specified resident sustained a medical emergency, was hospitalized and returned to the home with a new diagnosis. The plan of care has not been updated to reflect this new diagnosis or interventions.

2. The licensee failed to ensure that when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan of care has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. [s. 6 (11)]

a) The plan of care for a specified resident was not revised and different approaches considered when care set out in the plan was not effective in relation to significant weight loss and poor oral intake. Interventions for weight loss and poor intake were implemented, however the resident continued to have poor oral intake, loose weight and without evaluation of the effectiveness of the strategies. The Triggered Resident Assessment Protocol (RAP) summary related to Nutrition and Hydration completed by the Registered Dietition, indicated the resident's nutritional intake is poor, the resident is not consuming at meals and snacks. However, the assessment completed by the dietitian did not include an evaluation and effectiveness of strategies/interventions in relation to unplanned weight loss and poor intake. There is no documentation regarding any different approaches or different nutritional interventions tried during this six month period.

b) A specified resident is at a high risk for falls as identified in assessment completed in 2011. The plan of care in use on September 28, 2011 indicates that staff should; reinforce need to call for assistance, clip call bell to pillow at all times, assist resident to walk as is at risk of falls and 1 side rail at all times when in bed. Interview with the director of care confirms that strategies to reduce or mitigate falls are not currently in place. Interventions within the plan of care were ineffective in preventing falls, no new interventions were included in the plan of care following falls sustained by the resident.

c) A specified resident is assessed as at high risk for falls and recently sustained two falls. There is no evidence in the medical record as of September 28, 2011 that physiotherapy has been involved in assessment related to falls and fall prevention. Interview with the Director of Care identified that physiotherapy is to complete an assessment on residents

post fall, effective September 15, 2011. Interventions to prevent falls and mitigate injury related to falls do not include interdisciplinary input.

3. The licensee has failed to ensure that staff and others involved in different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6(4)a]

a) A specified resident has multiple wounds. Analgesic is ordered for pain relief including medication for breakthrough pain. Personal Support Workers documented on the flow sheet that the resident was in pain. Weekly pain assessment completed by registered staff indicates that the resident had no pain for the previous 7 days.

b) A specified resident's plan of care created by the Activation Department indicates that "the resident is to be put back to bed after each meal, staff will provide 1:1 around when the resident is up, or if awake in bed." The nursing plan of care under mobility indicates "Observe resident for signs of fatigue and if present, resident will go back to bed." The resident was observed to be sitting in a chair in the lounge area each morning. The resident was not observed participating in 1:1 or group programs on the specified days.

c) A specified resident is on a regular dose of medication and has weekly pain assessments completed. The assessment completed, indicates that "the resident complained of pain this morning and analgesic was administered with good effect. The resident voiced no complaints of pain during the past week. Analgesic continues to be effective in controlling the resident's pain." A review of the progress notes identified the resident sustained a painful injury during the identified time frame, required a treatment affecting the injured area, and was ordered treatments by the physician, including treatment for pain relief. The staff member completing the weekly pain assessment did not include assessment of all sources of pain as identified in documentation by other nursing staff.

d) On a specified date a contracted service provider identified that a specified resident had a vulnerable pressure point that was slightly reddened and tender to touch. The resident's power of attorney also made staff aware of complaints of pain made by the resident. The specified resident is identified to have pain from other sources. Weekly pain assessments completed over a specified period of time in 2011, indicate that there was no breakthrough pain. These new sources of pain were not included in the weekly pain assessments completed.

e) The pain assessment completed for a specified resident indicates that "the resident states the pain never goes away." The Minimum Data Set (MDS) assessment completed states that "pain is present less than daily". Flow sheets completed by the Personal Support Workers indicate that for the month of September 2011 pain was present on 18 of 30 days and 3 of 30 nights. Weekly pain assessments completed through the month of September 2011 indicate that regular analgesic is effective, no complaints of breakthrough pain. Assessments related to pain are inconsistent and the presence of pain for the specified resident is not being addressed.

4. A specified resident exhibits responsive behaviours. The plan of care is not readily available to all staff responsible for the resident's care. The staff member interviewed confirmed no plan of care was immediately available and she was not aware of the contents of the plan of care. [s.6(8)]

5. The licensee failed to ensure that the plan of care sets out clear direction for the staff and others who provide direct care to the resident. [s.6(1)c]

a) A specified resident is identified to require toileting with assistance. The resident exhibits ongoing behaviours and has sustained several falls through the month of September 2011. There is no direction in the plan of care to address the resident physical needs such as the frequency of toileting in order to improve comfort and potentially minimize behaviours and falls. Staff interviewed indicated the resident is toileted three - four times during the day, but could not identify a schedule for toileting.

b) A specified resident is identified to have an injury and was observed to have redness and tenderness in another area in September 2011. During interview with staff routinely responsible for the resident's care it was identified that a device is used to download pressure from designated areas while in bed. This intervention is not included in the plan of care for

direction to all staff and others who provide direct care.

c) The plan of care indicates that a specified resident is on an antibiotic. A review of the physicians orders indicates that the resident was last on antibiotic three months prior. The plan of care was not updated to reflect this change in status.

d) The plan of care in effect on September 29, 2011 indicates that a specified resident is to be supervised by 1 staff member to use the toilet, goes to the bathroom on own and needs to be toileted by staff after each meal and as necessary. Staff interviewed indicate that the resident is routinely taken to the bathroom immediately following meals. If not assisted by staff, behaviours identified in the plan of care can occur. The plan of care under bladder function and toileting indicate the need for Personal Support Worker assistance but do not include a routine toileting schedule identified by Personal Support Workers to be effective in managing the resident's continence.
{It is noted that the plan of care was updated during the course of this inspection.}

e) For a specified resident instructions related to transferring to the toilet vary; under Toileting - Two staff members to provide weight bearing support for toileting to transfer on/off the toilet. Under Transfers - One staff member to provide physical assistance by interlocking arms with resident. The Personal Support Worker interviewed indicated that the resident is a one person transfer for toileting.

f) The plan of care for a specified resident indicates that the resident "uses 2 bedrails for mobility while in bed." The resident was observed with one bed rail in place. Interview with the resident and a Personal Support Worker confirm one bed rail is up at all times.

g) The plan of care for a specified resident does not provide direction to staff related to positioning in the wheelchair. On October 3, 2011 the resident was observed in the lounge, sitting upright in a wheelchair. Two staff members approached the resident to adjust clothing, a slight disagreement arose between the care givers with one care giver insisting the chair be reclined. During interview on October 6, 2011 a Personal Support Worker identified that the resident's wheelchair needs to be reclined as the resident is at risk of falls and is unpredictable. It is noted that the resident has fallen from the chair. There is no clear direction to staff related to when the resident's chair should be reclined or related to positioning for meals.

h) A specified resident was noted on September 28 and 29 sitting in a wheelchair with disheveled hair and no eye glasses in place. The plan of care under Dressing indicates: "Wears glasses at all times. Ensure glasses are cleaned and adorned at all times when up in wheelchair." Under vision the plan of care states: "Resident has eyeglasses but refuses to keep them on." Staff interviewed indicated that the resident does not wear glasses.

6. The licensee has failed to ensure that care set out in the plan of care is provided as specified in the plan. [s.6(7)]

a) The plan of care for a specified resident specifies that the PSW is to instruct the resident regarding a specified activity of daily living. Interview with the PSW responsible for the resident's care indicates that staff complete part of the activity of daily living for the resident and instruct the resident on part of the activity.

b) The plan of care for a specified resident indicates "staff ensure clothing and foot wear are clean and appropriate". The resident was observed on October 3, 2011 with old food on the clothing, a sweater bunched up behind the back and not fully donned and a food soiled blanket placed on the lap. On October 4, 2011 the resident was noted to be sitting in the lounge area with the same soiled blanket wrapped around the arms and shoulders.

c) The plan of care for a specified resident indicates "staff to escort". On October 3, 2011 the resident was observed ambulating independently in the lounge. On October 6, 2011 it was reported that the resident had sustained a fall while ambulating independently.

d) The plan of care for resident a specified resident indicates to be "toileted mid morning and evening". A review of a record maintained for the resident indicates that the resident has not consistently been toileted each morning and evening as per the plan of care.

Additional Required Actions:

CO # - 001, 004, 005, 006, 007 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. 53. Responsive behaviours
Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the behavioural triggers have been identified for the resident demonstrating responsive behaviours. [r.53(4)a]

a) A specified resident is identified to have responsive behaviours. A review of the plan of care identified that triggers have not been identified for these behaviours. The resident has a prescription for medication to be given for severe agitation. On October 3, 2011 the resident was noted to have a painful injury. At approximately 2130 the resident required a specified treatment affecting the injured area. When this was attempted the resident struck out at staff. Medication was administered to control the resident's actions. Pain was not considered as a trigger for the behaviour and analgesic was not offered to the resident.

b) The licensee has failed to ensure that behavioural triggers have been identified for a specified who exhibits responsive behaviors daily. The resident is identified to put self and others at risk on a daily basis. There is no record of assessment of triggers related to behaviours exhibited. Documentation and interview include potential tirggers, such as pain as a result of multiple falls with injury. A physiotherapy note on September 23, 2011 indicates that the resident should be observed for signs of fatigue; the plan of care was not updated to include interventions related to fatigue. The resident requires assistance with toileting; the need for toileting has not been considered as a trigger and no toileting schedule has been established.

c) The licensee has failed to ensure that behavioural triggers have been identified for a specified resident. The plan of care indicates that the resident demonstrates specified behaviours. Dementia Observation Records have been initiated but triggers for behaviours exhibited have not been established. There is no indication that physical or psychological needs have been considered for behaviours exhibited. Staff interviewed are able to identify the type of behaviour exhibited, but are unable to verbalize the possible triggers for the behaviour.

2. The licensee has failed to ensure that actions taken to meet the needs of the resident with responsive behaviours include assessment, reassessment , interventions and documentation of the resident's responses to the interventions.

a) A specified resident exhibits responsive behaviours daily. The only intervention documented through September 2011 was the use of medication. Non-pharmaceutical interventions identified in the plan of care such as using a calm voice, cueing to take deep breaths, 1:1 monitoring or other interventions were not documented through the month of September 2011. Pharmaceutical interventions initiated were not always evaluated.

b) The documentation completed by Personal Support Workers on the Flow sheet indicates that a specified resident exhibited responsive behaviours 14 of 16 days and a sad, pained, worried facial expression 15 of 16 days between September 1 and 16, 2011. This documentation does not include documentation of interventions attempted or the resident's response to those interventions. A review of the progress notes finds no documented behaviours for the month of September 2011.

c) A specified resident demonstrated responsive behaviours. The resident was observed wandering on the home area on October 5, 2011, the wandering behaviour observed was not recorded in the residents medical record. Behaviours documented on October 2 and 4, 2011 do not include interventions used or the effectiveness of those interventions.

d) A review of the progress notes for a specified resident identified 3 documented incidents of verbal aggression during the month of September in spite of almost daily recorded incidents of aggression on the flow sheets and within DOS documentation. Interventions and evaluation of those interventions are not consistently recorded in behaviour notes within the progress notes. It is also noted that the identified behaviour is not always addressed. A contracted service was provided even though the resident was resistive.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service
Specifically failed to comply with the following subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluid is being served at a temperature that is both safe and palatable to the residents. [r.73(1)6]

a) October 13, 2011, at the observed lunch meal 1st floor at 12:25 pm food temperatures were tested in the kitchen in the presence of the cook and a dietary aide. The cold food temperatures recorded were found to be: coleslaw 12.23 degree Celsius, beet salad 20.23 degree Celsius, corned beef sandwiches 13.2 degree Celsius and minced corned beef sandwiches 11.4 degree Celsius, cold foods should have been 5 degree Celsius or less.

a) Food temperatures were tested by Inspector # 192 on the 3rd floor at 12:15 pm and were recorded: Cream of celery pureed soup 58.7 degree Celsius, the hot food temperatures should have been 60 degree Celsius or higher. The cold foods tested were found to be: beet salad 21.2 degree Celsius, mandarine oranges 14.4, degree Celsius, corned beef sandwiches 17.2 degree Celsius, and creamy coleslaw 13.3 degree Celsius. All cold food temperatures should have been 5 degree Celsius or below.

Hot and cold food not served at safe temperatures compromises palatabality, reduces food intake and also increases risk for food contamination.

Additional Required Actions:

CO # - 003 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. 72. Food production
Specifically failed to comply with the following subsections:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality; and prevents adulteration, contamination and food borne illness. [72(3)(b)]

Standardized recipes at lunch meal October 13, 2011 were not consistently followed:
a) For cream of celery soup ingredients were not weighed or measured. Dietary staff was observed making roux for the cream soup(mixing flour and margarine)without measuring or weighing ingredients.
b) Recipe for cream of celery soup was not individualized for the number of servings required. The recipe available for the cream soup was for 55 servings, where as the quantities required on the production sheet were for 85 servings. Dietary staff (cook) interviewed confirmed that he had simply multiplied out the recipe for 55 serving, without making adjustments in amount of liquid and other ingredients. The consistency of the cream soup was thin.
c) Canned diced beets prepared with vinegar and sugar were served at lunch, the planned menu for that day had pickle beets. Recipe for pickle beets was not followed. The recipe called for 6.5/8 liter beets for 55 servings, only 5.68 liter canned diced beets were used for 55 servings. Lack of adherence to recipe compromises food quality.

Additional Required Actions:

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

WN #5: 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 subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
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.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that 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. [s. 3(1)1]

a) A specified resident was observed on October 4, 2011 being repositioned in a wheelchair by 1 staff member. The staff member approached the resident from behind, reaching under both arms and grabbing the wrists. The staff member then pulled the resident's torso back in the chair. The plan of care does not provide direction related to positioning while in the wheelchair. Discussion with the Director of Care on October 5, 2011 confirms that repositioning for the comfort and dignity of the resident should be completed by two staff members, lifting the resident out of the chair and repositioning her back into the chair in an upright position.

b) A specified resident is dependent on staff for transfers and positioning in the chair. The plan of care indicates that the resident is to use a specified chair. On October 4, 2011 the resident was observed having slid down in the chair. The resident was positioned at the table in a reclined position and required a position adjustment that was provided by two staff - one staff on each side. The resident was taken by the arms and under one leg and lifted to an upright position. The second Personal Support Worker (PSW) grabbed the sweat pants the resident was wearing to use as a lifting device. Interview with the Director of Care confirmed that two staff would be required to reposition the resident and that using resident clothing as a lifting device is not accepted practice within the home. On October 5, 2011 a staff member was observed pulling the same resident up in the chair by grabbing under the arms and pulling the resident up in the chair without the assistance of a second staff member. The resident was not repositioned in the chair using a professional approach that would promote comfort and dignity.

2. The licensee has failed to ensure that every resident has the right to live in a safe and clean environment. On October 6, 2011 a spray bottle containing Per Diem Disinfectant Cleaner was found in an unlocked cupboard under the sink in the dining room which is accessible to all residents (including cognitively impaired residents) at all times. The warning label indicates that the product can cause irritation to skin and eyes. [s.3(1)5]

3. The licensee failed to ensure that a specified resident had their personal health information kept confidential in accordance with the Act. On September 28, 2011 the flow sheet binder was found sitting open in the third floor lounge to specified resident's personal health information. Other resident's, and staff were present in the lobby and could readily access this 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 ensuring that every resident has the right to live in a safe and clean environment and have his or her personal health information kept confidential, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs. [r.134(a)]
A specified resident has multiple wounds. A review of the medication administration record identified that the resident received analgesic prior to dressing changes. The effectiveness of analgesic given was not documented within the progress notes. The Pain Management note dated September 25, 2011 confirms that PRN (as necessary) medication was given three times in the previous week prior to dressing changes. Interview with registered staff confirms that documentation of the effectiveness of a medication would be recorded in the progress notes.

2. A specified resident receives medication orally, if required, for responsive behaviours in addition to a regular dose of the same medication twice daily. The "if required" dose was administered 43 times through the month of September 2011. The resident's response to the medication and effectiveness of the drug was not consistently documented in the progress notes. The resident is observed to have a shuffling gait and excessive drooling both of which are identified side effects to the prescribed medication.

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 ensuring that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that a specified resident who was exhibiting altered skin integrity, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [r.50(2)(b)(iv)]
A contracted provider noted that a specified resident identified pressure point was slightly reddened and tender to touch. The Director of Care confirmed that skin and wound assessments are documented in the progress notes within Point Click Care. There is no documentation of an assessment of the resident's designated pressure point. Documentation present acknowledges vulnerability of a pressure point and interventions to be implemented. Subsequent Skin Narrative notes do not consistently include assessment of areas of altered skin integrity identified. Skin narrative notes dated September 2011 refer to a pressure point, but do not clarify which area was assessed, what was observed or the presence or absence of pain in the affected area.

2. A specified resident has multiple wounds. Assessments were completed on designated dates in September 2011 on one specified area and designated dates in September 2011 on another designated area. During interview with the Director of Care it was confirmed that all areas of altered skin integrity for the specified resident were not consistently assessed weekly by a member of the registered staff.

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 ensuring 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 #8: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

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 ensuring that the pain management program provides for communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired, to be implemented voluntarily.

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

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).

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
(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 registered dietitian did not assess a specified resident when there was a significant change in health status. A review of electronic multidisciplinary progress notes had identified that the resident had experienced a Gastrointestinal problem. The resident had several off and on episodes of emesis and loose bowel movements over a three month period in 2011. There was no documentation found that a referral was initiated for assessment by the registered dietitian regarding the resident's gastrointestinal problem. The resident was not assessed by the registered dietitian using an interdisciplinary approach.

Issued on this 24th day of January, 2012

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

Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
September 28, 29 October 3, 4, 5, 6, 7, 12, 13, 14, 19, 20, 21, 24, 25, 26 November 25, December 7, 16, 19, 22, 2011	2011_027192_0043 / H-001880-11	Follow-up on: RQI H-001332-11 CI H-001690-11

Licensee/Titulaire de permis
King Nursing Home Limited
49 Sterne Street, Bolton, Ontario L7E 1B9

Long-Term Care Home/Foyer de soins de longue durée
King Nursing Home
49 Sterne Street, Bolton, Ontario L7E 1B9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs
Debora Saville Nursing Inspector # 192 Asha Sehgal Dietary Inspector #159

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:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007, S.O. 2007 c. 8, s. 3(1)4	WN #1 CO # 001	2011_070141_0022	192
LTCHA, 2007, S.O. 2007 c. 8, s.5	WN #2 CO #002	2011_070141_0022	192
O. Reg. 79/10 s.53(1)	WN #4 CO #004	2011_070141_0022	192
O. Reg. 79/10 s.49(2)	WN # 37 CO #012	2011_071159_0012	192
O. Reg. 79/10 s.36	WN #7 CO # 009	2011_071159_0012	192
O. Reg. 79/10 s.26(3)	WN #11 CO #013	2011_071159_0012	192
O. Reg. 79/10 s.26(4)a	CO #014	2011_071159_0012	192

Issued on this 22nd day of December, 2011

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