Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 14, 2015	2015_271532_0021	017617-15	Resident Quality Inspection

Licensee/Titulaire de permis

KNOLLCREST LODGE LIMITED
50 William Street, Milveton PERTH ON N0K 1M0

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

KNOLLCREST LODGE
50 WILLIAM STREET MILVERTON ON N0K 1M0

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

NUZHAT UDDIN (532), CHAD CAMPS (609), SHERRI GROULX (519)

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): July 21, 22, 23, 24, 27, 28 and 29, 2015

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Resident Care (DOC), Director of Dietary and Environmental Services Manager, Dietitian, Program Manager, Maintenance Supervisor, Resident Assessment Instrument (RAI) / Minimum Data Set (MDS) Coordinator, Pharmacist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse's Aide (NA), Maintenance staff, Resident Council Representatives, Residents and Family members.
Inspector also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident /staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

14 WN(s)
8 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

According to the documentation an identified Resident had areas of altered skin integrity. The Resident Assessment Instrument / Minimum Data Set (RAI/MDS) note stated that the resident had altered skin integrity.

Upon review of the resident's clinical record and assessments there was no evidence of a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument for the altered skin integrity.

Upon interview with the RAI/MDS Coordinator it was confirmed that the identified resident did not receive a skin and wound assessment for the altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a Registered Dietitian who was a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

A) An identified Resident had documented evidence of altered skin integrity.

As per clinical record review, the resident had the quarterly nutrition/hydration risk tool done, however, there was no evidence that the altered skin integrity was assessed in the quarterly assessment and there was no Registered Dietitian (RD) referral for the altered skin integrity.

B) Clinical record review for an identified Resident and Resident Assessment Instrument/Minimum Data Set (RAI/MDS) assessments indicated that there was altered skin integrity and the altered skin integrity had deteriorated, requiring the initiation of antibiotic medication.

Upon review of the resident clinical record it was noted that weekly wound assessments and treatments were done but there was no evidence of a Registered Dietitian (RD) referral for the documented altered skin integrity.

The home's policy indicated for this type of altered skin integrity one of the treatments was to make out a Dietary Referral.

Upon interview with the RAI/MDS Coordinator it was confirmed that there was no dietary referral for the altered skin integrity and that the identified resident was not assessed by a Registered Dietitian and no changes were made to the plan of care related to nutrition and hydration. [s. 50. (2) (b) (iii)]

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

A) Clinical record review for an identified Resident and RAI/MDS assessments, revealed that the resident had altered skin integrity.

Upon review of the documentation and assessments in the clinical record there was no evidence that a weekly skin and wound assessment was done for the resident's altered

skin integrity.

Upon interview with the RAI/MDS Coordinator, it was confirmed that skin and wound assessments were not done weekly by a member of the registered nursing staff for the altered skin integrity. (519)

B) Clinical record review for an identified Resident indicated that they had altered skin integrity.

Clinical record review and the Treatment Administration Record (TAR) indicated that a weekly wound assessment was to be completed on identified dates, however, there was no evidence that a weekly skin and wound assessment was done.

The identified Resident was noted again to have altered skin integrity.

The weekly wound assessment was to be completed as per the TAR schedule, however, there was no evidence of an assessment in the clinical records.

In an interview the RAI/MDS Coordinator confirmed that weekly wound assessments were not completed when the resident exhibited altered skin integrity for dates noted above. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Clinical record review for an identified Resident stated that they required an assistive device.

Upon interview with the identified resident, it was confirmed that they had an assistive device and used it sometimes according to their own choice.

In an interview, a Personal Support Worker (PSW) reported that resident information, including whether they used assistive device or not, was on a piece of paper posted inside of the resident's closet door. The information on this paper, as well as the kardex, was used to provide the PSWs with information about the resident's plan of care when they provided care.

Observations revealed that the information about the assistive device on the paper in the closet was blank.

Upon interview with a PSW it was confirmed that the area referring to the resident's

assistive device was blank and the plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

Plan of care stated that an identified Resident liked to help with an activity between breakfast, lunch and supper.

In an interview the resident informed an Inspector that they were told by a staff member that they were not able to assist as they had altered skin integrity.

The Physiotherapist confirmed that the resident enjoyed assisting with the primary activity and reported that the resident had altered skin integrity and they had decompensated physically and were not safe performing the activity. The Physiotherapist further stated that a reassessment was performed and that the resident will be restarted once a day assisting with the activity and if they were able to tolerate it the activity would be increased to twice a day, and confirmed that they placed the update under activity in the progress notes, in the shift to shift report and in the plan of care.

In follow-up with the identified resident it was confirmed that the activity was not started and it was observed that the resident waited in the dining room for over an hour for the activity to start.

A Personal Support Worker (PSW) placed a call to inquire if the activity was starting for the resident and the department was not aware even though it was documented in progress notes by the Physiotherapist.

Chief Executive Officer (CEO) in an interview reported that it was a communication error and the staff were not aware and confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A review of the plan of care for an identified Resident revealed that the resident was to receive personal care by staff in the morning and evening.

A review of the clinical record for the resident revealed no documentation of personal care in the Point of Care as received.

A review of the documentation for personal care for all residents in a specified home area of the home revealed that there was no documentation tab in the Point of Care system for any residents for the identified personal care.

In an interview a personal support staff confirmed that it was a common practice to provide the care to residents as outlined in the plan of care and not document that the care was provided.

The DRC confirmed that personal care was not being documented by the personal support staff in the Point of Care system for any of the residents, however, they will be expected to complete it in the future. [s. 6. (9) 1.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations revealed the doors leading to the home's physiotherapy clinic remain unlocked and unattended when physiotherapy staff were not in the room.

Both the CEO and the RAI-Coordinator confirmed that the doors leading to the physiotherapy clinic were unlocked when not in use and that residents were able to enter and exit the clinic without supervision. The CEO acknowledged the risk to resident safety by having non-residential areas that were unlocked and unsupervised.

The CEO confirmed that it was the home's expectation that non-residential areas were to be equipped with locks to restrict unsupervised access and were to be locked when not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the Entrapment Inspection Sheet revealed that all beds in the facility had an entrapment risk assessment completed between August 2014 and September 2014.

Observations of the bed for an identified Resident revealed the use of four quarter length rails and a therapeutic mattress which placed the resident at risk of zone five entrapment.

An interview with the RAI-Coordinator confirmed that zone five was not assessed for the identified resident, that the use of split rails placed the resident of zone five entrapment risks and zone five should have been assessed and was not.

In an interview the RAI/MDS-Coordinator reported that the beds were assessed for zones one through four, however, confirmed that zones five through seven were not assessed and the bed system was not evaluated in accordance with evidence-based practices. [s. 15. (1) (a)]

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

A) Review of the Entrapment Inspection Sheet revealed that all beds in the facility had an entrapment risk assessment completed between August 2014 and September 2014. The assessment revealed 61 of 78 or 78 percent of the beds had failed in one or more zones of entrapment. Of the 61 beds identified to be at risk of entrapment 45 or 73 percent did not have in place any intervention to mitigate the entrapment risk to the residents.

Observations made of the bed for an identified Resident revealed that there was a use of two three quarter rails with a low air loss pressure relief surface on the bed.

Review of the Facility Entrapment Inspection Sheet revealed that there was a "fail" in zone four for entrapment. A review of the Entrapment Inspection Sheet and interview with the RAI/MDS Coordinator further revealed that the resident was to have an extra foam to prevent resident entrapment.

Observations and interview with the MDS/RAI Coordinator confirmed that there was no extra foam or any other interventions put in place to mitigate the risk for entrapment. (532)

The RAI-Coordinator also confirmed that beds that failed the entrapment risk assessment were being replaced as the home's finances permit, however, no interventions to mitigate risk until the beds were replaced were implemented for the 61 beds identified and steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (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 where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment and to ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Observations were made during stage one of the Resident Quality Inspection July 21 - 23, 2015 of the walls surrounding the hand sanitizer in 23 resident rooms revealed stained walls with sanitizer solution dripping down, causing discolouration to the walls.

In an interview the Housekeeping Manager confirmed that it was the home's expectation that all walls were to be kept clean and sanitary and in the case of the 23 cited rooms this did not occur and should have. [s. 15. (2) (a)]

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, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The RAI/MDS Coordinator and the CEO confirmed that there were no formal written annual evaluations completed relating to Skin and Wound and Continence programs that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 30. (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 there is a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Annual review assessment of Minimum Data Set (MDS), section H, coded an identified Resident as occasionally incontinent where they would be incontinent of bowel, once a week and bladder, two or more times a week but not daily.

Quarterly review assessment of Minimum Data Set (MDS), Section H, coded the identified resident as frequently incontinent where they would be incontinent of bowel, two to three times a week; bladder, tended to be incontinent daily, but some control present.

In review of the Continence Care and Bowel Management program policy dated June 2013 Policy Number NCP- 10-05 stated under Bladder/Bowel Tracking and Assessment – Quarterly that Resident Assessment Instrument–MDS assessment to be completed each quarter. If there is deterioration in bowel or bladder continence level coding RAI-MDS Coordinator will assign the completion of "Bladder and Bowel Continence Assessment."

In reviewing the identified resident's clinical record it was noted that there was no Bladder/Bowel assessment completed once the resident was identified and coded as frequently incontinent of bladder.

The RAI-MDS coordinator confirmed that they were to assign the Bladder/Bowel assessment once the resident was identified as frequently incontinent, however, the assessment was not assigned and the resident did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

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 who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies and that was secure and locked.

Observations revealed that there were prescription creams in the bedside drawers for two identified residents that were used for personal care and were not secure and locked.

Interviews with personal support staff revealed that it was a common practice to leave the prescription creams in the resident's bathroom or bedside drawer when not in use.

Interview with Registered staff confirmed that it was the home's expectation that all drugs were secure and locked and prescription creams were to be secure and locked in the medication room when not being used. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies and that is secure and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in skin and wound care.

Upon interview with the Resident Assessment Instrument/Minimum Data Set Coordinator (RAI/MDS), it was confirmed that there was no annual education provided on skin and wound care to direct care staff. It was confirmed that the education for direct care staff was done on a case by case basis by lead staff in skin and wound care in the home. [s. 221. (1) 2.]

2. The licensee has failed to ensure that they provided training related to continence care and bowel management to all staff who provide direct care to residents on either an annual basis, or based on individual staff's assessed training needs.

In an interview Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator confirmed that there was no education or training related to continence care and bowel management completed with all staff who provide direct care to residents either on an annual basis, or based on individual staff's assessed training needs. [s. 221. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that direct care staff are provided with training in skin and wound care and to ensure that training related to continence care and bowel management is provided to all staff who provide direct care to the residents on either an annual basis, or based on the staff's assessed training needs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) During Stage One dining observation, on a specified home area, it was observed that a Dietary Aide (DA) handled a grilled cheese sandwich, cut the sandwich with a pair of scissors and then transferred the sandwich to the resident's plate with her hands. This was observed twice during a meal service.

The home's policy titled, "Dietary-Sandwich Preparation", Policy Number: DIET-04-70, effective date May 2014 stated under procedure that tongs were to be used for serving sandwiches.

The Dietary and Environmental Services Manager acknowledged during a phone interview that using scissors for cutting the sandwiches was not a practice used in the home and the staff member should have used a knife to cut the sandwiches and tongs to transfer food on to the plate and the policy on "Dietary-Sandwich Preparation" was not complied with. (519)

B) Observations during the medication administration for an identified Resident revealed that there was no cleansing of the injection site for both the blood sugar testing and the insulin administration.

A review of the home's policy titled "Insulin Pen Administration" effective date July 2009 revealed that the subcutaneous injection sites were to be cleansed prior to injection with a needle.

In an interview the CEO confirmed that it was the home's expectation that the home's policy on cleansing injection sites was to be complied with. [s. 8. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that residents receive oral care to maintain the integrity of the oral tissues, including mouth care in the morning and evening.

In an interview an identified Resident indicated that they did not receive personal care in the morning or evening.

Observations made of the identified resident revealed that the resident was attempting to complete personal care on own without assistance from staff.

A review of the plan of care for the identified resident revealed that the resident required extensive assistance of one staff to ensure good personal care.

Interview with personal support staff confirmed that the resident did not receive assistance with personal care in the morning. Personal support staff confirmed that it was the expectation of the home that the residents received personal care. [s. 34. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items; and (b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Observations in shared resident bathrooms on two specified home areas revealed unlabelled personal care items i.e. unlabelled comb, unlabelled shaver, unlabelled urinals and an unlabelled nail clipper, an unlabelled hairbrush and bedpan and an unlabelled toothbrush and hairbrush.

Policy named Personal Items - Labelling for Shared Resident Washrooms Policy Number -NCP-01-100 stated that: all residents with a shared washroom will have personal items labelled; both when a new resident arrives and when new personal items are received. 4. Personal items to be labelled by PSW: toothbrush, comb, brush, bed pan and urinal and razors.

Interview with a Personal Support Worker and registered staff confirmed that it was the home's expectation that all personal care items were to be labelled with resident's names in the shared bathroom and the items listed above were not labelled as per the home's expectations. [s. 37. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

During Stage One observations of the Resident Quality Inspection (RQI) it was noted that one of the towel bars in an identified resident's bathroom was missing with only the brackets in place on the wall, and a grab bar in the adjoining bathroom was loose on the wall.

Upon interview and tour of these rooms with the Chief Executive Officer (CEO), it was confirmed that these towel bars were missing and the grab bar was loose. She stated that these brackets would be removed from the walls and the areas would be repaired. The CEO acknowledged that the resident's bathrooms should be part of the preventative maintenance list.

Upon interview with a maintenance staff member, it was confirmed that there were no procedures developed and implemented to ensure that the grab bars and washroom fixtures and accessories were maintained and he confirmed that the maintenance department relied on the nursing staff to document any areas of disrepair they noticed in the maintenance book at the nurses station. [s. 90. (2) (d)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Chief Executive Officer (CEO) and the RAI/MDS Coordinator in an interview confirmed that there was no annual interdisciplinary team evaluation completed related to the medication management system.

The RAI/MDS Coordinator confirmed that the home's expectation was to have an annual evaluation of the medication management system completed and confirmed that it will be done in future. [s. 116. (1)]

Issued on this 17th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), CHAD CAMPS (609), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2015_271532_0021
Log No. / Registre no:	017617-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 14, 2015
Licensee / Titulaire de permis :	KNOLLCREST LODGE LIMITED 50 William Street, Milveton, PERTH, ON, N0K-1M0
LTC Home / Foyer de SLD :	KNOLLCREST LODGE 50 WILLIAM STREET, MILVERTON, ON, N0K-1M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUSAN RAE

To KNOLLCREST LODGE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee of a long-term care home shall ensure that:

(a) Every resident of the home exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
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,

(b) Every resident of the home exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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,

(c) Every resident of the home 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; O. Reg. 79/10, s. 50 (2).

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A previous written notification and voluntary plan of correction were issued, in October 2014, related to residents not receiving a skin assessment and not being reassessed at least weekly by a member of the registered nursing staff.

According to the documentation an identified Resident had areas of altered skin integrity. The Resident Assessment Instrument / Minimum Data Set (RAI/MDS) note stated that the resident had altered skin integrity.

Upon review of the resident's clinical record and assessments there was no evidence of a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument for the altered skin integrity.

Upon interview with the RAI/MDS Coordinator it was confirmed that the identified

resident did not receive a skin and wound assessment for the altered skin integrity. [s. 50. (2) (b) (i)] (519)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a Registered Dietitian who was a member of the staff of the home, and had changes made to the plan of care related to nutrition and hydration been implemented.

A) An identified Resident had documented evidence of altered skin integrity.

As per clinical record review, the resident had the quarterly nutrition/hydration risk tool done, however, there was no evidence that the altered skin integrity was assessed in the quarterly assessment and there was no Registered Dietitian (RD) referral for the altered skin integrity.

B) Clinical record review for an identified Resident and Resident Assessment Instrument/Minimum Data Set (RAI/MDS) assessments indicated that there was altered skin integrity and the altered skin integrity had deteriorated, requiring the initiation of antibiotic medication.

Upon review of the resident clinical record it was noted that weekly wound assessments and treatments were done but there was no evidence of a Registered Dietitian (RD) referral for the documented pressure areas.

The home's policy indicated for this type of altered skin integrity, one of the treatments was to make out a Dietary referral.

Upon interview with the RAI/MDS Coordinator it was confirmed that there was no dietary referral for the altered skin integrity and that the identified resident was not assessed by a Registered Dietitian and no changes were made to the plan of care related to nutrition and hydration. [s. 50. (2) (b) (iii)] (519)

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

A) Clinical record review for an identified Resident and RAI/MDS assessments,

revealed that the resident had altered skin integrity.

Upon review of the documentation and assessments in the clinical record there was no evidence that a weekly skin and wound assessment was done for the resident's altered skin integrity.

Upon interview with the RAI/MDS Coordinator, it was confirmed that skin and wound assessments were not done weekly by a member of the registered nursing staff for the altered skin integrity. (519)

B) Clinical record review for an identified Resident indicated that they had altered skin integrity.

Clinical record review and the Treatment Administration Record (TAR) indicated that a weekly wound assessment was to be completed on identified dates, however, there was no evidence that a weekly skin and wound assessment was done.

The identified Resident was noted again to have altered skin integrity.

The weekly wound assessment was to be completed as per the TAR schedule, however, there was no evidence of an assessment in the clinical records.

In an interview the RAI/MDS Coordinator confirmed that weekly wound assessments were not completed when the resident exhibited altered skin integrity for dates noted above. [s. 50. (2) (b) (iv)] (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 14th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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