Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Mar 24, 31, 2015	2015_226192_0015	L-001882-15	Resident Quality Inspection

Licensee/Titulaire de permis

LAPOINTE-FISHER NURSING HOME, LIMITED
1934 DUFFERIN AVENUE WALLACEBURG ON N8A 4M2

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

LAPOINTE-FISHER NURSING HOME
271 METCALFE STREET GUELPH ON N1E 4Y8

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

DEBORA SAVILLE (192), DOROTHY GINTHER (568), NUZHAT UDDIN (532), TAMMY SZYMANOWSKI (165)

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): March 4, 5, 6, 9, 10, 11, 12 and 13, 2015

Critical Incident Inspections related to 002736-15 and 003224-15 were completed during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with residents, family member, the Administrator, Director of Nursing, Resident Care Plan Coordinator, Environmental Services Supervisor, Maintenance Manager, Program Manager, Nutrition Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Nurses Aides, and a Restorative Aide.

The inspectors also, conducted a tour of the home, observed meal service, food preparation, medication administration, medication storage areas, recreation activities and care provided to residents, reviewed relevant clinical records, reviewed relevant policies and procedures, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

20 WN(s)
14 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A review of the home's personal support staffing schedule and the Administrator confirmed that on a specified date 2015, the home was short 26.5 hours of personal support worker hours for the day. Records indicated that at least eight residents did not receive their scheduled bath and the re-scheduling of the baths did not occur.

A review of the personal support staffing schedule indicated that the home was short personal support hours on specified dates in 2015. During stage one observations fifteen residents were identified to be uncleaned and ungroomed. Observations of residents included dirty and uncombed hair, dirty and untrimmed fingernails, soiled clothing, unshaven facial hair, and debris on their teeth. A Personal Support Worker and the Registered Nurse confirmed that during this period, one scheduled bath was not completed and the bath was not rescheduled.

Personal Support Workers interviewed confirmed that when they were short staffed resident baths were not always completed as the staff have insufficient time to provide the care. Staff reported that they do their best to provide care to the residents however, shortages affected completing all their responsibilities.

Two residents interviewed confirmed that scheduled baths were not always provided. Four residents interviewed indicated that at times they have to wait extended periods of

time sometimes up to an hour for staff assistance related to shortage of staff. One family member identified that a resident was found incontinent and had not been changed for an extended period of time related to insufficient staffing.

A review of the home's personal support staffing schedule for a specified 28 day period in 2015 indicated that the home was short personal support staff hours for 10 of the 28 days. The Administrator verified that the home frequently worked short and confirmed that there was not a written back up plan for when personal care staff cannot come to work.

The licensee of a long term care home failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents. [s. 8. (1) (b)]

2. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A review of the home's schedule indicated that there was not at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at the identified times.

The Director of Care confirmed that the home did not have at least one registered nurse on duty and present in the home during these times.

The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there was an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

Staff interview with a Personal Support Worker revealed that they commenced work at the home in 2014. The staff member shared that they received shift orientation by one of the floor staff. This included a review of the home procedures and specific orientation related to tasks that should be done on the different shifts. When asked if they had received an orientation package from the home the staff member replied, "no, not yet". The staff member denied having had any education or training with regards to the prevention of abuse or resident rights. The staff member reported that they had read a few home postings that were on the bulletin board outside the staff room on the lower level of the home and attended a training on Gentle Persuasive Approach two weeks prior.

The personnel records for the identified staff member were reviewed and confirmed the date of hire. There was no documentation in the staff members personnel file to indicate that they had received orientation, which included training on the home's prevention of abuse and neglect policy, prior to performing their responsibilities.

The personnel file for a second Personal Support Worker with a date of hire in 2014 was also reviewed. There was no documentation in the staff members personnel file to indicate that they had received orientation, which included training or a review of the home's policy on the prevention of abuse and neglect.

Interview with the Director of Nursing (DON) revealed that it is the home's expectation that staff receive training on the home's policy regarding the prevention of abuse and neglect prior to performing their duties. The completion of the orientation checklists which includes review of the home's Prevention of Abuse Policy, and as well as the signed documentation indicating that the policies and procedures were reviewed would be found in the staff members personnel file. The Director of Nursing acknowledged that the personnel files for the two identified staff members did not contain completed orientation checklists or signed documentation that the Prevention of Abuse Policy was reviewed. The licensee did not ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities. [s. 76. (2) 3.]

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. 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. Resident #011 was observed with a full bed rail raised on the right side on two occasions. On two different occasions the resident had a full bed rail raised on the left side.

Interviewed with the Director of Care who revealed that registered staff conduct an assessment of each resident with respect to the use of bed rails and this is documented in the progress notes on Point Click Care (PCC).

Record review failed to reveal a bed rails assessment for Resident #011. Registered staff indicated that they document the type of bed rail and the number being used by the resident in the care plan. They were not aware of a bed rails assessment that was to be completed and documented in the progress notes.

The Director of Care acknowledged that Registered staff were not following the home's process with regards to resident assessment where bed rails are used and the results of the assessment being documented on PCC. [s. 15. (1) (a)]

2. The Licensee has failed to ensure that where bed rails were used, the resident had

been 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.

Resident #014 was observed on one occasion with one bed rail on left side raised and on two occasions with two quarter bed rails raised at the head of the bed.

The resident and their substitute decision maker confirmed in interview that two bed rails are used.

The Director of Nursing (DON) reported that the registered staff were to complete a Progress Note in Point Click Care indicating the purpose of the bed rails being used.

The Resident Care Plan Coordinator stated that they were not aware of an assessment that was being completed but would check with the Director of Nursing.

Three different registered staff were interviewed regarding the resident assessment where bed rails were used and all three staff were not aware of the need to make a note regarding the bed rails unless it was a restraint for the resident and it was then that they would make a note on Point Click Care and receive consent from family.

Record review indicated that there was no note documented in the progress notes to indicate that bed rails were used for the resident.

The Director of Nursing confirmed that where bed rails were used, the residents were not being assessed by the registered staff although the staff were all educated as this was a concern previously. [s. 15. (1) (a)]

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. 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,
(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; O. Reg. 79/10, s. 50 (2).

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 resident #004 who was exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff upon return from hospital.

Resident #004 was confirmed by the Director of Nursing and record review to have altered skin integrity.

Resident #004 was admitted to hospital in 2015 and returned to the home 20 days later.

Interview with the Director of Nursing and record review confirmed that no skin assessment was completed by a member of the registered nursing staff on return of resident #004 from hospital. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of the resident from hospital.

Record review revealed that Resident #011 had a fall in 2014. The Resident was transferred to hospital because of injury and was re-admitted to the home five days later.

Interview with the Director of Nursing revealed that when a resident returns from hospital, it is the home's expectation that a Head to Toe Assessment be completed, in addition to a transfer reassessment, skin/wound assessment and Seven Day Pain Evaluation. The home's Skin and Wound Assessment is completed on Point Click Care (PCC).

Clinical record review did not reveal a completed skin/wound assessment for Resident #011 when they returned from hospital in 2014. Registered staff confirmed that Resident #011 did not receive a skin assessment by a registered nurse upon return from hospital. [s. 50. (2) (a) (ii)]

3. The licensee has failed to ensure that resident #004, who was exhibiting altered skin integrity, received 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.

The Director of Nursing confirmed that skin assessments would be completed by registered nursing staff using the clinically appropriate assessment instrument specifically designed for skin and wound assessment on Point Click Care under the assessment tab.

Progress notes identified that resident #004 developed altered skin integrity in identified area in 2014 and 2015.

Review of the medical record and Point Click Care assessments failed to identify skin assessments related to altered skin integrity in progress notes. The Director of Care confirmed that skin assessments were not completed by registered staff of the home on the appropriate assessment instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

4. The licensee 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 is specifically designed for skin and wound assessment.

Resident #010 was identified in the progress notes to have several areas of altered skin integrity in 2014.

Interview with the Director of Nursing confirmed that skin and wound assessments would be completed on Point Click Care electronic documentation. Documentation review was unable to locate assessment of altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.[s. 50. (2) (b) (i)]

5. 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 is 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.

Resident #010 was identified to have recurring altered skin integrity. Documentation review from May 2014 through to March 2015 identified that resident #010 sustained ongoing altered skin integrity.

Interview with the Nutrition Manager identified that no referral to the Registered Dietitian (RD) was completed when resident #010 was identified to have altered skin integrity.

Resident #010 was identified to have altered skin integrity at a specified time in 2015. A referral was completed and the resident was assessed. This area of altered skin integrity was documented to be resolved. Another area of altered skin integrity was identified. No referral related to this new altered skin integrity was sent to the RD.

The licensee failed to ensure that when resident #010 exhibited altered skin integrity including skin breakdown, pressure ulcers and skin tears, they were assessed by a Registered Dietitian who is a member of the staff of the home.
[s. 50. (2) (b) (iii)]

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

Record review and interview with the Director of Care confirmed that not all areas of altered skin integrity identified for resident #004 were reassessed at least weekly by a member of the registered nursing staff. The Director of Care confirmed that weekly wound assessments would be located in Point Click Care under "Weekly Wound Assessment Rounds".

Resident #004 was identified to have specified areas of altered skin integrity. Weekly wound assessments were not completed related to each of these areas of altered skin integrity.[s. 50. (2) (b) (iv)]

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

Record review and weekly wound assessment indicated that resident #014 had altered skin integrity.

Resident interview reported that the resident had the dressing changed often.

Weekly wound assessments were reviewed and identified that weekly wound assessments were not completed for four specified weeks in 2014 and 2015.

The Resident Care Plan Coordinator confirmed that the weekly assessments were not completed for the resident as identified and reported that the weekly wound assessments were to be completed on the weekend as the physician comes on Monday and any concerns would be discussed with the Physician. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During initial tour of the home it was observed that the small lounge, large lounge and physiotherapy room in the basement level of the home did not have a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times, is on at all times and allows calls to be cancelled only at the point of activation.

Interview with the Program Manager confirmed that there is no call-bell accessible in the small lounge, large lounge and physiotherapy room in the basement level of the home. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

A staff member was witnessed approaching resident #030 in the hallway and adjusted their clothing. Resident #030 became agitated and hit out. The Personal Support Worker was observed grabbing the Resident's hand and pulling it down in that the resident lost their balance and became unsteady however, they did not fall.

Resident quarterly assessment revealed that the resident was at risk of falls.

Interview with the Director of Care revealed that the staff member involved in the incident had been educated on the Prevention of Abuse and Neglect during annual training and the incident occurred the day following training.

The Director of Care confirmed that the resident was not treated with respect and courtesy when the staff member grabbed resident #030's hand and pulled down causing them to become unsteady. [s. 3. (1) 1.]

2. The licensee failed to 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.

It was reported that resident #040 was not treated with courtesy and respect when a Personal Support Worker used force when providing care to the resident. The incident was witnessed by another Personal Support Worker who indicated that the resident was yelling and agitated by the actions of the staff member.

Interview with the Director of Nursing who had completed the investigation confirmed that it was their belief that the incident had occurred and the staff member had been disciplined.

Review of the record identified that the resident was observed to have been held with force, by the staff member, during the provision of care.

The licensee failed to ensure that resident #040 was treated with courtesy and respect and in a way that fully recognized the resident’s individuality and respected the resident’s dignity. [s. 3. (1) 1.]

3. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Resident #014 reported that when staff assist the resident with dressing, they didn't always cover the resident properly.

On specified dates in 2015, the resident was observed with their skin exposed.

The resident's spouse was observed approaching the nurse’s station to ask for assistance as the clothing for the resident needed to be adjusted. A Registered Practical Nurse was observed redirecting the spouse without acknowledging the spouses concern and no assistance was provided.

During this inspection interview with the Director of Nursing confirmed that action had been taken to address the residents concern.

The resident's right to be treated with respect and dignity was not met when staff failed to take action to ensure that the resident was not left exposed. [s. 3. (1) 1.]

4. The licensee failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

During an interview with Resident #013 they shared that during their regularly scheduled shower the water was cold. The resident indicated that the shower was very uncomfortable and they don't wish to have another shower until there is hot water.

Review of the first floor Bathing Schedule revealed that Resident #013 had a shower during the day shift on a specified date in 2015. The schedule had a note written at the top indicating that for two specified dates, there was no hot water in showers/bathrooms.

The Environmental Services Manager acknowledged that the home ran out of hot water during the morning on the specified dates in 2015. He was notified of the situation and had since changed the settings for the hot water. Registered staff confirmed that they were aware that there was no hot water on the specified dates in 2015 which may have affected some of the residents' showers.

The licensee failed to ensure that resident #013 was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs. [s. 3. (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 ensuring every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and that every resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #7: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The plan of care for resident #004 indicated that the resident was to have a pressure relieving device applied. A review of the medical record identified that a specified device was to be used when the the resident was in bed.

Interview with the Director of Care confirmed that the plan of care does not provide clear direction to the staff and others who provide direct care to the resident and that the device should only be applied to the resident when the resident is in the wheelchair.

The resident was observed to be laying in bed. No device had been applied for the resident. Staff interviewed confirmed that the resident was not using the specified device.

The licensee failed to ensure that the plan of care sets out clear direction to staff and others who provide direct care to resident #004. [s. 6. (1) (c)]

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

During stage one of the inspection resident #011 was observed with the right full bed rail in the up position. At another time resident #011 was observed lying on their right side with a full bed rail in the up position on the right side. The resident appeared restless and was pulling on the rail. When this inspector entered the room a short time later a Personal Support Worker was putting the right bed rail down and the left bed rail up. The staff member shared that the resident should have the left bed rail up as they often roll and they don't want the resident to fall out of bed.

Interview with a second Personal Support Worker revealed that Resident #011 was to have one full bed rail in the up position when they are in bed. The side the bed rail is up on varies depending on what side the resident is resting on. If the Resident is on the left side then the right bed rail should be up so that they can exit on the left; if they are lying on the right then the left bed rail would be up. The staff member shared that the resident is unable to reposition themselves on the opposite side without assistance so they want to ensure that the rail does not restrain the resident.

The plan of care for Resident #011 indicated that they are a high risk for falls. Interventions to mitigate the risk of falls included one full bed rail up. Staff are directed to put the left bed rail up as the resident turns this way and lies on the left side too close to the edge.

Registered staff revealed that Resident #011 should have the bed rail in the up position on the opposite side to which they are lying. The resident usually lies on the right side so that is why the left bed rail should be raised. The staff member acknowledged that the plan of care does not provide clear directions to staff who provide direct care to Resident #011 as to which bed rail should be raised. [s. 6. (1) (c)]

3. 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.

The plan of care for resident #014 indicated that two staff were to provide care to the resident at all times, this was confirmed by the Director of Care.

A review of the clinical health record and the Director of Care confirmed that on specified

dates in 2014 a Personal Support Worker provided personal care independently to the resident. On both occasions the resident alleged the Personal Support Worker was rough when providing personal care.

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. [s. 6. (7)]

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

Record review revealed that resident #015 spends the day in their room. Family visits routinely and in between the resident rests in bed.

The plan of care for resident #015 related to supervised/organized recreation indicated that the resident was to be offered an activity program directed toward specific interests/needs of the resident.

Review of the attendance records for recreation and activities revealed that resident #015 had not attended any activities, nor were any one to one visits provided during the period of the review.

Staff interview with a Recreation Aide revealed that resident #015 was usually in bed except when family visits. The resident does not leave their room so they have to provide one to one activities. These activities could include reading or visiting with the resident, hand massages and music programming. The staff member was unsure why the resident had not had any one to one visits during the review period.

Interview with the Activation Manager revealed that resident #015 no longer attended group activities but staff provide one to one visits. The Activation Manager acknowledged that resident #015 had not been provided any one to one visits during the review period and confirmed that the plan of care for recreation was not provided to the resident. [s. 6. (7)]

5. 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.

The plan of care for resident #003, related to falls, indicated that two full side rails would be raised when the resident was in bed for safety.

In 2015 the resident was observed laying in bed with one full side rail raised.

A Personal Support Worker confirmed that only one bed rail was raised at the time and reported that they were unaware if one or two side rails were to be raised.

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. [s. 6. (7)]

6. 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.

The plan of care for resident #010 indicated that the resident was to be put to bed after lunch. The resident had recurring altered skin integrity.

Interview with a Personal Support Worker identified that resident #010 remained in their wheelchair following lunch. Interview with the Director of Nursing indicated that it would be the resident's choice whether they were to go to bed after lunch or not and that resident #010 is at times resistant to care.

The DON confirmed that the plan of care had not been updated to include that the resident may be resistive to going to bed after lunch and that they should have their position changed while in the chair when this occurs.

The licensee failed to ensure that the plan of care was reviewed and revised with a change in resident #010's care needs. [s. 6. (10) (b)]

7. The licensee failed to 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, the resident’s care needs change or care set out in the plan was no longer necessary.

The plan of care for resident #040 indicated under sleep and rest that resident #040 was to have an adequate amount of sleep to function without fatigue and that the resident was up and goes to bed at a specified times with naps after meals.

Record review and interview with the Director of Nursing (DON) identified that staff of the home had noted that the resident is frequently awake earlier than the identified time and

that they are more cooperative with the provision of care at this time. The DON confirmed that the plan of care had not been updated to include this change in the care. [s. 6. (10) (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 ensuring that the plan of care sets out clear directions to staff and others who provide direct care to the resident; ensuring that the care set out in the plan of care is provided to the resident as specified in the plan and that the residents are 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, to be implemented voluntarily.

WN #8: 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 failed to ensure that 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 is in compliance with and is implemented in accordance with applicable requirements under the Act.

The home's policy titled Skin and Wound Care, Treatment of Skin Tears and Pressure

Ulcers, Section S, Page 1.0, dated as reviewed Feb 12, 2015 indicated under 5) that evaluation of care will occur in this period to ensure the resident is comfortable and healing process is advancing. Referrals need to be made to the dietitian.

Interview with the Director of Nursing identified that staff are referring residents to the dietitian when a stage II or greater pressure area is identified for a resident.

Interview with the Nutrition Manager failed to identify a policy that would direct staff when a Registered Dietitian referral would be required related to a resident with altered skin integrity.

Regulation 79/10 s. 50 (2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds is to be 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.

Resident #010 who was identified in 2014 to have ongoing altered skin integrity including pressure ulcers, skin tears and skin breakdown was not assessed by a registered dietitian related to their altered skin integrity until February 2015.

The licensee failed to ensure that there was a policy that was in accordance with applicable requirements under the Act and implemented. [s. 8. (1) (a)]

2. The licensee failed to ensure that 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 is complied with.

The home's policy titled Skin and Wound Care, Treatment of Skin Tears and Pressure Ulcers, Section S, page 1.0, dated as reviewed February 12, 2015 indicated that documentation of skin tears and ulcers is to be completed on assessment sheets, the date and time, size of the wound, amount of drainage, color and odour, peri-wound, pain, wound bed, tunneling and undermining to be included. One wound assessment sheet is to be used per ulcer/skin tear. The skin treatment record is part of the chart and to be left on the Treatment Assessment Record (TAR). Skin assessments to be completed on admission, quarterly and readmission.

Interview with the Director of Nursing and registered staff confirmed that TARs are

electronic. No treatment record containing assessments is maintained.

Residents #004 and #010 were confirmed by the Director of Nursing and record review to have altered skin integrity in multiple locations. Interview with the Director of Nursing indicated that weekly wound assessments would be completed on Point Click Care using the Weekly Wound Assessment Rounds document.

Record review and interview confirmed that the Weekly Wound Assessment Rounds document was not completed for altered skin integrity present on resident #004 and #010 and that weekly assessments using a wound assessment sheet designated in the home's policy were not completed for each area of altered skin integrity.

Documentation review and interview with the Director of Nursing confirmed that weekly assessments completed by registered staff did not include information as identified in the policy.

Resident #004 was readmitted from hospital in 2015. Interview with the Director of Nursing and record review confirmed that no skin assessment was completed on resident #004's readmission to the home following hospitalization.

The licensee failed to ensure that the Skin and Wound Care, Treatment of Skin Tears and Pressure Ulcers Policy was complied with. [s. 8. (1) (b)]

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

The policy titled Personal Clothing Section III page 5.8 Effective Date of December 2011 stated under Unlabeled Personal Laundry "to prevent confusion as to ownership, special arrangements must be made for processing unlabeled personal clothing for new admissions."
"upon being informed of an addition to the laundry list the laundry Supervisor will provide a labeled meshed laundry bag in the resident's room for collecting residents clothing."

In 2015 resident #003 reported that they lost an article of clothing shortly after admission.

In 2015 a resident reported that they had an article of clothing go missing just after the Holidays.

In an interview the Environmental Services Supervisor (ESS) explained the process for labeling for the new admissions. They reported that they were responsible for taking the unlabeled items for a new admission down to laundry on the days that they worked and label them and bring the items back to the home area however, nursing staff were to bring unlabeled items on the days that the ESS did not work and leave it in their office for it to be labeled. The ESS further stated that the clothes that the resident would be wearing during the admission were sent down with the regular laundry, down the laundry chute. The ESS further shared that those were the clothing items that would usually go missing and that the process needed to be tightened-up as most of the clothes that were reported missing were shortly after admission.

Policy was reviewed with the ESS and confirmed that labeled meshed bags were not provided in resident’s room for collecting clothing and the policy was not complied with however, it will be reviewed with the laundry staff. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that 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 is in compliance with and is implemented in accordance with applicable requirements under the Act and is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy was complied with.

The home's Abuse policy last revised March 2014, indicated that all staff were required to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the Ministry of Health and Long Term Care and to the appropriate supervisor in the home on duty or on call at the time of the alleged incident. Clinical staff responsible for the care of the resident were to ensure that the resident was not left in the responsibility of the person alleged to have caused the abuse, conduct a head to toe physical assessment on the resident and document findings.

In 2014, resident #014 reported to the Registered Nurse that they felt they were not treated well in the morning. The resident reported that an identified staff member treated them inappropriately during morning care. The resident reported to the Registered Nurse that it made them feel dizzy and caused pain. Review of documentation indicated that the resident reported to a Personal Support Worker that they had pain.

The Director of Nursing confirmed that the Registered Nurse did not immediately and directly report the allegation of abuse to the appropriate supervisor (Director of Nursing) at the time of the alleged incident. The Director of Nursing confirmed that the alleged incident was not immediately reported to the Ministry of Health and Long Term Care and a critical incident report was not submitted until identified by the inspector.

The Personal Support Worker alleged to have caused the abuse continued to provide care following the initial incident. Record review indicated that on the date of the incident, resident #014 was overheard by the Registered Practical Nurse from the hallway. The resident stated to the Personal Support Worker that they did not want them to provide care as they were not gentle. Records indicated that the Registered Nurse on duty was notified and an occurrence report was provided to the Director of Nursing. The Director of Nursing confirmed they were aware of the allegation however, it was not reported to the Ministry of Health and Long Term Care.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with. [s. 20. (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 ensuring that the written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that there were written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

A review of the home's Concerns, Suggestions, Complaints policy last revised February 6, 2014 did not comply with regulation 101 for how the licensee deals with complaints.

The following requirements for how the licensee deals with every written and verbal complaint made to the licensee or a staff member, concerning the care of a resident or operation of the home, under regulation s. 101 were not included in the home's policy:

The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

A response shall be made to the person who made the complaint, indicating what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.

The licensee shall ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow up action required, the final resolution if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

The licensee shall ensure that the documented record is reviewed and analyzed for trends at least quarterly; the results of the review and analysis are taken into account in determining what improvements are required in the home and a written record is kept of each review and of the improvements made in response.

Interview with the Administrator confirmed that the home's Concerns, Suggestions, Complaints policy did not incorporate the specific requirements identified in regulation 101 for how the licensee deals with complaints. [s. 21.]

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 there are written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers’ instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers instructions.

A review of resident #003's clinical health record indicated that the resident sustained a fall on at least two occasions and in 2015 the use of a seat belt was implemented.

Resident #003 was observed in their wheel chair with a seat belt applied. The seat belt was observed to be loose and there was five inches from the resident's pelvic crest to the seat belt. The resident was capable when requested by the inspector to undo the seat belt.

The Director of Nursing observed and confirmed that the seat belt was applied loosely. The Director of Nursing indicated that the home did not have manufacturers instructions available for staff however; the expectation was that staff apply the seat belt snuggly.

The licensee of the long term care home failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers instructions. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers instructions, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents’ assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when staff, cannot come to work.

Review of the home's nursing and personal care staffing schedule indicated that the home frequently worked short staff which was confirmed by the home's Administrator.

The Administrator confirmed that the home did not have a written back up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work. [s. 31. (3)]

2. The licensee has failed to ensure that a written record relating to each evaluation under clause (3) (e) 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.

The Administrator confirmed that the written annual evaluation for the staffing plan did not include the date of the evaluation, the names of the persons who participated in the evaluation and a summary of the changes made and the date that those changes were implemented. [s. 31. (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 ensuring that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff, cannot come to work and maintaining a written record relating to each evaluation under clause (3) (e) 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 #13: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

In 2015, a Personal Support Worker was independently transferring resident #003 and was unable to control the resident and lowered the resident to the floor.

The resident's plan of care related to transferring indicated the resident required two persons for transfers and extensive physical assistance.

The Resident Care Plan Coordinator confirmed that the resident was not safely transferred and two persons should have been assisting the resident during the transfer.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #003. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written response is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with the Residents' Council Chair and the Residents' Council Assistant revealed that any concerns or recommendations raised during their meetings are documented in the minutes. These minutes are given to the different managers of the home and depending on the issue it will be answered by the appropriate manager. The response is recorded in the minutes and reviewed at the next council meeting the following month.

Review of the Residents' Council meeting minutes revealed that concerns and recommendations are documented in the minutes of the meeting. In some cases the response is identified as immediate but in the remaining situations the written response is not provided to the council until the next Residents' Council meeting one month later. The Residents' Council Assistant confirmed that a written response to all concerns or recommendations is not provided within 10 days. [s. 57. (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 ensuring that a written response is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

The Residents' Council Chair and the Assistant to the Residents' Council indicated that they could not recall that the meal and snack times were reviewed during Residents' Council meetings. Review of the minutes of Residents' Council meetings for the last four months did not reveal that the meal and snack times were reviewed.

During an interview with the Food Services Manager they revealed that because of poor attendance the Food Committee is no longer meeting. This committee is now being done in conjunction with the Residents Council meetings. The Food Services Manager attends the meetings and addresses any menu concerns, seeks recommendations and reviews the new menus. The Food Services Manager acknowledged that the meal and snack times were not reviewed by the Residents' Council as she was not aware this was required. [s. 73. (1) 2.]

2. The licensee has failed to ensure that the home has a dining and snack service that included, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

A Personal Support Worker was observed during the lunch meal assisting resident #020 with eating. The Personal Support Worker was feeding the resident with a large rubber coated spoon loaded with large bites. The resident was not able to consume the entire spoonful on each bite causing food to fall from the resident's mouth. The resident was

observed still chewing when the Personal Support Worker would attempt to provide another bite.

The resident's plan of care related to high nutritional risk indicated that staff were to provide a rubber coated teaspoon for feeding.

The Registered Dietitian confirmed that the rubber coated spoon being used was too large and the resident should have a smaller teaspoon for eating.

A Personal Support Worker was observed standing while assisting resident #021 to finish their meal.

The long term care home failed to ensure that proper techniques to assist residents with eating were provided. [s. 73. (1) 10.]

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 dining and snack service includes a review of the meal and snack times by the Residents' Council and includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record was kept of each review and of the improvements made in response.

Interview with the Administrator confirmed that there was no written record for the review and analysis of complaint trends completed quarterly. [s. 101. (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 ensuring that the documented record of complaints was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record was kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #17: 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:
1. Falls prevention and management. 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:
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 training was provided to all staff who provide direct care to residents related to falls prevention and management.

Review of the home's education records indicated that all staff who provided direct care to residents did not receive falls prevention and management training in 2014, this was confirmed by the Director of Nursing. [s. 221. (1) 1.]

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

Record review and interview with the Director of Nursing confirmed that not all direct care staff received training in skin and wound care during 2014. It is noted that training had been scheduled for registered staff. [s. 221. (1) 2.]

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

Record review and interview with the Director of Nursing confirmed that training related to continence care and bowel management was not provided to all staff who provide direct care to residents on either an annual basis or based on the staff's assessed training needs.

A review of the education binder for 2014 identified that fourteen staff had participated in training related to continence care.

The licensee failed to ensure that training related to continence care and bowel management was provided to all staff who provide direct care to residents on an annual basis or based on the 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 ensuring that training is provided to all staff who provide direct care to residents related to falls prevention and management, skin and wound care and related to continence care and bowel management, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the program.

During the lunch meal service a Personal Support Worker was observed clearing dirty dishes from tables and then, serving entrees and feeding residents without washing or sanitizing their hands in between. [s. 229. (4)]

2. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interview with the Director of Nursing and review of monitoring system in place identified that not all residents with identified symptoms of infection were included for monitoring.

Resident #004 was identified to have symptoms of infection in 2015 with documentation of additional symptoms and hospitalization nine days later. Interview with the Director of Nursing identified that at this time in 2015, six other residents were monitored for symptoms of infection. The DON confirmed that resident #004 was not included on the monitoring system in place for the home until seven days after first demonstrating symptoms of infection.

The DON confirmed on March 10, 2015 that no monitoring had been initiated for March 2015 for the first floor and that a resident was, at the time, demonstrating signs and symptoms of a worsening respiratory infection and had been started on antibiotic related to these symptoms.

The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift. [s. 229. (5) (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 ensuring that all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #19: 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 failed to ensure that the following is complied with in respect of the Continence Care and Bowel Management Program. 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.

Documentation review and interview with the Resident Care Plan Coordinator responsible for the Continence Care and Bowel Management Program and the Director of Nursing confirmed that a gap analysis of the program was completed in February 2015.

The record related to the gap analysis was provided as the evaluation of the Continence Care and Bowel Management Program and failed to include a summary of changes made to the program and the dates that changes were implemented. [s. 30. (1) 4.]

WN #20: 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 resident #004, who was 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 is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #004 was assessed as continent of bladder at the time of admission and at the time of Minimum Data Set (MDS) review over a year after admission. Review of MDS records conducted quarterly in 2014 identified the resident to be frequently incontinent of bladder.

Record review and interview with the Director of Nursing confirmed that resident #004 had not been assessed for incontinence including identification of causal factors, patterns, types of incontinence and the potential to restore function with specific interventions using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

The licensee failed to assess resident #004 who was assessed as incontinent during MDS review in 2014. [s. 51. (2) (a)]

Issued on this 17th day of April, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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) :	DEBORA SAVILLE (192), DOROTHY GINTHER (568), NUZHAT UDDIN (532), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2015_226192_0015
Log No. / Registre no:	L-001882-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 24, 31, 2015
Licensee / Titulaire de permis :	LAPOINTE-FISHER NURSING HOME, LIMITED 1934 DUFFERIN AVENUE, WALLACEBURG, ON, N8A-4M2
LTC Home / Foyer de SLD :	LAPOINTE-FISHER NURSING HOME 271 METCALFE STREET, GUELPH, ON, N1E-4Y8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Laura Black

To LAPOINTE-FISHER NURSING HOME, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A review of the home's schedule indicated that there was not at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at the identified times.

The Director of Care confirmed that the home did not have at least one registered nurse on duty and present in the home during these times.

The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall ensure that all staff hired in 2014 and identified through audit to have not yet received training on the policy to promote zero tolerance of abuse and neglect receive training on the policy to promote zero tolerance of abuse and neglect; and

Shall ensure that all newly hired staff receive training on the home's policy to promote zero tolerance of abuse and neglect prior to performing their responsibilities.

Grounds / Motifs :

1. The licensee has failed to ensure that staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

Staff interview with a Personal Support Worker revealed that they commenced work at the home in 2014. The staff member shared that they received shift orientation by one of the floor staff. This included a review of the home procedures and specific orientation related to tasks that should be done on the different shifts. When asked if they had received an orientation package from the home the staff member replied, "no, not yet". The staff member denied having had any education or training with regards to the prevention of abuse or resident rights. The staff member reported that they had read a few home postings that were on the bulletin board outside the staff room on the lower level of the home and attended training on Gentle Persuasive Approach two weeks prior.

The personnel records for the identified staff member were reviewed and confirmed the date of hire. There was no documentation in the staff members personnel file to indicate that they had received orientation, which included training on the home's prevention of abuse and neglect policy, prior to performing their responsibilities.

The personnel file for a second Personal Support Worker with a date of hire in 2014 was also reviewed. There was no documentation in the staff members personnel file to indicate that they had received orientation, which included training or a review of the home's policy on the prevention of abuse and neglect.

Interview with the Director of Nursing (DON) revealed that it is the home's expectation that staff receive training on the home's policy regarding the prevention of abuse and neglect prior to performing their duties. The completion of the orientation checklists which includes review of the home's Prevention of Abuse Policy, and as well as the signed documentation indicating that the policies and procedures were reviewed would be found in the staff members personnel file. The Director of Nursing acknowledged that the personnel files for the two identified staff members did not contain completed orientation checklists or signed documentation that the Prevention of Abuse Policy was reviewed. The licensee did not ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The licensee shall ensure that resident #011 and #014 and all other residents where bed rails are used are assessed to minimize the risk of entrapment to the resident.

Grounds / Motifs :

1. The Licensee has failed to ensure that where bed rails were used, the resident had been 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.

Resident #014 was observed on one occasion with one bed rail on left side raised and on two occasions with two quarter bed rails raised at the head of the bed.

The resident and their substitute decision maker confirmed in interview that two bed rails are used.

The Director of Nursing (DON) reported that the registered staff members were to complete a Progress Note in Point Click Care indicating the purpose of the bed rails being used.

The Resident Care Plan Coordinator stated that they were not aware of an assessment that was being completed but would check with the Director of Nursing.

Three different registered staff members were interviewed regarding the resident assessment where bed rails were used and all three staff were not aware of the need to make a note regarding the bed rails unless it was a restraint for the resident and it was then that they would make a note on Point Click Care and receive consent from family.

Record review indicated that there was no note documented in the progress notes to indicate that bed rails were used for the resident.

The Director of Nursing confirmed that where bed rails were used, the residents were not being assessed by the registered staff although the staff members were all educated as this was a concern previously. (532)

2. Resident #011 was observed with a full bed rail raised on the right side on two occasions. On two different occasions the resident had a full bed rail raised on the left side.

Interviewed with the Director of Care who revealed that registered staff conduct an assessment of each resident with respect to the use of bed rails and this is documented in the progress notes on Point Click Care (PCC).

Record review failed to reveal a bed rails assessment for Resident #011. Registered staff indicated that they document the type of bed rail and the number being used by the resident in the care plan. They were not aware of a bed rails assessment that was to be completed and documented in the progress notes.

The Director of Care acknowledged that registered staff were not following the home's process with regards to resident assessment where bed rails are used and the results of the assessment being documented on PCC. (568)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :** May 29, 2015

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents with altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds:

i) receive 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) receive a skin assessment by a member of the registered nursing staff upon return of the resident from hospital.

iii) are assessed by a registered dietitian who is a member of the staff of the home, and have any changes made to the plan of care related to nutrition and hydration implemented.

iv) are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The plan shall be submitted electronically to Debora Saville, Long Term Care Homes Inspector for the Ministry of Health and Long Term Care, London Service Area Office, 130 Dufferin Avenue, 4th Floor, London, Ontario,N6A 5R2 at debora.saville@ontario.ca by April 3, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of the resident from hospital.

Record review revealed that Resident #011 had a fall in 2014. The Resident was transferred to hospital because of injury and was re-admitted to the home five days later.

Interview with the Director of Nursing revealed that when a resident returns from hospital, it is the home's expectation that a Head to Toe Assessment be completed, in addition to a transfer reassessment, skin/wound assessment and Seven Day Pain Evaluation. The home's Skin and Wound Assessment is completed on Point Click Care (PCC).

Clinical record review did not reveal a completed skin/wound assessment for

Resident #011 when they returned from hospital in 2014. Registered staff confirmed that Resident #011 did not receive a skin assessment by a registered nurse upon return from hospital. (568)

2. The licensee has failed to ensure that resident #004 who was exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff upon return from hospital.

Resident #004 was confirmed by the Director of Nursing and record review to have altered skin integrity.

Resident #004 was admitted to hospital in 2015 and returned to the home 20 days later.

Interview with the Director of Nursing and record review confirmed that no skin assessment was completed by a member of the registered nursing staff on return of resident #004 from hospital. (192)

3. The licensee 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 is specifically designed for skin and wound assessment.

Resident #010 was identified in the progress notes to have several areas of altered skin integrity in 2014.

Interview with the Director of Nursing confirmed that skin and wound assessments would be completed on Point Click Care electronic documentation. Documentation review was unable to locate assessment of altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. (192)

4. The licensee has failed to ensure that resident #004, who was exhibiting altered skin integrity, received 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.

The Director of Nursing confirmed that skin assessments would be completed by

registered nursing staff using the clinically appropriate assessment instrument specifically designed for skin and wound assessment on Point Click Care under the assessment tab.

Progress notes identified that resident #004 developed altered skin integrity in identified area in 2014 and 2015.

Review of the medical record and Point Click Care assessments failed to identify skin assessments related to altered skin integrity in progress notes. The Director of Care confirmed that skin assessments were not completed by registered staff of the home on the appropriate assessment instrument specifically designed for skin and wound assessment. (192)

5. 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 is 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.

Resident #010 was identified to have recurring altered skin integrity. Documentation review from May 2014 through to March 2015 identified that resident #010 sustained ongoing altered skin integrity.

Interview with the Nutrition Manager identified that no referral to the Registered Dietitian (RD) was completed when resident #010 was identified to have altered skin integrity.

Resident #010 was identified to have altered skin integrity at a specified time in 2015. A referral was completed and the resident was assessed. This area of altered skin integrity was documented to be resolved. Another area of altered skin integrity was identified. No referral related to this new altered skin integrity was sent to the RD.

The licensee failed to ensure that when resident #010 exhibited altered skin integrity including skin breakdown, pressure ulcers and skin tears, they were assessed by a Registered Dietitian who is a member of the staff of the home. (192)

6. The licensee failed to ensure that the resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review and weekly wound assessment indicated that resident #014 had several areas of altered skin integrity

Resident interview reported that the resident had the dressing changed often.

Weekly wound assessments were reviewed and identified that weekly wound assessments were not completed for four specified weeks in 2014 and 2015.

The Resident Care Plan Coordinator confirmed that the weekly assessments were not completed for the resident as identified and reported that the weekly wound assessments were to be completed on the weekend as the physician comes on Monday and any concerns would be discussed with the Physician. (532)

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

Record review and interview with the Director of Care confirmed that not all areas of altered skin integrity identified for resident #004 were reassessed at least weekly by a member of the registered nursing staff. The Director of Care confirmed that weekly wound assessments would be located in Point Click Care under "Weekly Wound Assessment Rounds".

Resident #004 was identified to have specified areas of altered skin integrity. Weekly wound assessments were not completed related to each of these areas of altered skin integrity. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Grounds / Motifs :

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

During initial tour of the home it was observed that the small lounge, large lounge and physiotherapy room in the basement level of the home did not have a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times, is on at all times and allows calls to be cancelled only at the point of activation.

Interview with the Program Manager confirmed that there is no call-bell accessible in the small lounge, large lounge and physiotherapy room in the basement level of the home. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 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 24th day of March, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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