Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Sep 24, 2015	2015_303563_0031	021705-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

MAITLAND MANOR
290 SOUTH STREET GODERICH ON N7A 4G6

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

MELANIE NORTHEY (563), CHAD CAMPS (609), INA REYNOLDS (524)

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): August 24 - 26, and August 31 - September 2, 2015

The following inspections were conducted concurrently during this RQI inspection:
Log # 014858-15: Follow-up Inspection to L-001389-14 for compliance order # 001 related s. 8. (3)
Log # 010798-15: Anonymous Complaint Letter related to responsive behaviours and staffing concerns
Log # 014904-15/CI 0965-000008-15: Staff to resident neglect
Log # 021986-15/CI 0965-000010-15: Staff to resident neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Long Term Care Consultant from Extendicare Assist, the Registered Dietitian, the Food Service Manager, the Maintenance Manager, the Resident Assessment Instrument Coordinator, the Resident Assessment Instrument Coordinator Back-up, one Activity Assistant, two Registered Nurses, two Registered Practical Nurses, eleven Personal Support Workers, the Resident Council President, one Family Council Member, three Family Members and 40 Residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **16 WN(s)**
- **11 VPC(s)**
- **1 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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 at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times, except as provided for in the regulations.

Record review of the "Quality Program Evaluation for Nursing & PSW Staffing Services" dated May 2015 identified there was no Registered Nurse (RN) in the home three to four times a week. Documented recruitment strategies included actively advertising monthly in either newspaper, on the Extendicare website or the SouthWest Health Line website, accommodating schedule for staff with other jobs, and reaching out to agencies who were unwilling to service the area.

Record review of the "Sufficient Staffing Quality Protocol" completed July 22, 2015 addressed “24 hour nursing care where by at least one registered nurse who was an employee of the home and a member of the registered nursing staff was on duty and present at all times” and answered "No" to this question with a documented strategy to review staffing records/staffing schedules.

Record review of the Staffing Plan: May 2015 for each home area revealed:
- North and South wing: 1.5 RNs on days, equaling 3 RNs in the building
- North and South wing: 1 RN on evenings, equaling 2 RNs in the building
- North and South wing: 0.5 RN on nights, equaling 1 RN in the building

Record review of the RN Schedule between August 1 - 31, 2015 revealed 87% of the night shifts and 26% of the evening shifts had no RN scheduled on duty and present at all times.

Staff interview with the Administrator on September 1, 2015 confirmed that despite recruiting strategies the home did not have a registered nurse on duty for 26 night shifts and four evening shifts in August 2015. The Administrator shared that on average there was not an RN on duty approximately four night shifts, two day shifts and three evening shifts biweekly, but with the recent hiring of a new RN graduate the night vacancy will hopefully improve.

This area of non-compliance was previously issued on March 13, 2014, September 23, 2014 and January 19, 2015. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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:
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. The licensee has failed to ensure that every resident’s right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs were fully respected and promoted.

A critical incident submitted to the Ministry of Health revealed that Resident # 040 was left unattended during toileting routine for one hour.

A review of the RAI-MDS revealed Resident # 040 required assistance and this remained unchanged for the resident for two years.

A review of the plan of care for Resident # 040 revealed the resident required extensive assistance.

An interview with Resident # 040 revealed the resident was unable to verbalize understanding of the use of the call bell system or what the resident would do to request assistance when required.

An interview with personal support staff revealed that Resident # 040 was left alone and unattended with the call bell clipped to the resident's clothing when toileted. Personal support staff revealed that the resident was unable to pull the call bell for assistance.

An interview with the RAI-Coordinator confirmed that Resident # 040 required extensive assistance by two staff for toileting and the resident left unattended for any period of time when toileted did not provide care in a manner consistent with his/her needs. [s. 3. (1) 4.]

2. Record review of the paper care plan that was printed in Resident # 010 chart documented that the resident is not to receive an intervention if he/she refuses their meals.

Staff interview with the Administrator confirmed the care plan intervention if the resident refused a meal was inappropriate and did not fall in line with the resident's right to be properly fed and cared for in a manner consistent with the resident's 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 to ensure that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 6. (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 set out clear directions to staff and others who provided direct care to the resident related to the use of side rails.

Observation of Resident # 005's bed system revealed two bed rails in use while the resident was in bed and asleep. Record review of the current care plan in PointClickCare (PCC) revealed the resident does not use the bed rails. Record review of the MDS Assessments indicated that Resident # 005 used other types of bed rails daily.

Observation of Resident # 011's bed system revealed two bed rails in use. Record review of the current care plan revealed there were no interventions documented for the use of bed rails. Record review of the MDS Assessments indicated that Resident # 011 did not use bed rails.

Observation of Resident # 012's bed system revealed two bed rails in use while resident was in bed and asleep. Record review of the current care plan revealed there were no interventions documented for the use of bed rails. Record review of the MDS Assessments indicated that Resident # 012 did not use bed rails.

Observation of Resident # 003's bed system revealed two bed rails in use. Interview with the resident on confirmed the resident has always had both rails in use. Record review of the current care plan revealed there were no interventions documented for the use of bed rails. Record review of the MDS Assessments indicated that Resident # 003 did not use bed rails.

Observation of Resident # 006's bed system revealed two bed rails. Record review of the current care plan revealed the bed rail was used for repositioning for bed mobility and staff were to ensure bed rails were engaged. Record review of the MDS Assessments indicated that Resident # 006 used bed rails.

Staff interview with the Registered Nurse (RN) confirmed there were inconsistencies noted in the plan of care related to the use of bed rails and there was no clear direction to staff and others who provided direct care to residents. [s. 6. (1) (c)]

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

Record review of the current care plan in PointClickCare (PCC) for Resident # 008 revealed the resident was independent for transfers and the paper copy of the care plan documented that the resident will call for assistance with transfers. The care plan printed in the resident's chart describes the use of an assistive aide for transfers. Staff interview with a PSW revealed the assistive aide was not used for Resident # 008, as the resident was transferred with the assistance of two staff.

Observation of resident's room revealed the transfer logo posted above the resident's bed did not match the interventions listed in the care plan.

Staff interview with the Director of Care, the Administrator and the Resident Assessment Instrument Coordinator all confirmed the care plan in PointClickCare (PCC) and the care plan printed in the residents' charts are not always consistent in interventions because the paper copy was updated immediately and the PCC care plan was updated as late as quarterly. [s. 6. (1) (c)]

3. Record review of the current care plan in PCC for Resident # 006 revealed the resident's ability to ambulate does not match the interventions on the care plan printed in the resident's chart.

Staff interview with the Registered Nurse and a PSW on September 2, 2015 confirmed the plan of care for Resident # 006 does not provide clear direction related to ambulation. [s. 6. (1) (c)]

4. Record review of the current care plan in PCC for Resident # 004 revealed the resident's ability to transfer and level of assistance does not match the care plan printed in the resident's chart. Observation of Resident # 004's room revealed the logo posted above the resident's bed did not match the interventions listed in the care plan for use of a transfer device.

The printed care plan section related to altered skin integrity revealed the use of a therapeutic appliance and this intervention was not mentioned on the care plan in PCC.

The PSW confirmed the plan of care did not set out clear directions to staff and others who provided direct care to the resident related to transfers. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of the plan of care for Resident # 040 instructed staff provide assistance for transfers and balance assistance when toileted. The plan of care did not identify the use of a transfer aide for transfers. A review of the Kardex for Resident # 040 instructed staff to use a transfer aide. Observations of the room for Resident # 040 revealed there was no transfer aide.

An interview with PSW revealed the resident had not used a transfer aide for an undetermined amount of time and the resident required assistance with transfers without

a transfer aide.

An interview with the DOC confirmed that Resident # 040 no longer used a a transfer aide when transferred, that the plan of care was not revised with the change in transfer status and should have been. [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 to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident and to ensure that the plan of care is 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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the home's policy titled "Pain Management" reference number RESI-10-03-01 indicated that a pain assessment was to be completed when a "Resident is scored on

the RAI-MDS assessment under section J as1 (pain less than daily) or 2 (pain daily)" or a resident had a "change in condition". (609)

Record review of the significant change in status MDS Assessment revealed that Resident # 004 complained or showed evidence of moderate pain less than daily.

Record review of the pain assessments in PointClickCare (PCC) revealed the "EO Pain Assessment Tool Jan 2011" was last completed July 2014. [s. 8. (1) (a),s. 8. (1) (b)]

2. Record review of the last five MDS Assessments completed for Resident # 010 since July 2014 revealed the resident complained or showed evidence of horrible or excruciating pain less than daily and at times daily.

Record review of the pain assessments in PCC for Resident # 010 revealed the "EO Pain Assessment Tool Jan 2011" was completed once in 2015. There was a missing pain assessment for four quarterly reviews where pain was identified. [s. 8. (1) (a),s. 8. (1) (b)]

3. A review of the RAI-MDS for Resident # 045 revealed a change in pain intensity from moderate pain to times when pain was horrible or excruciating compared to the previous assessment.

A review of clinical records for Resident # 045 revealed no pain assessment was completed related to the change in the resident's condition related to increased pain.

An interview with the RAI-Coordinator confirmed that it was the home's expectation that for residents who have experienced pain less than daily or daily, as well as when residents experience a change in condition, that a pain assessment was completed. The RAI-Coordinator confirmed Resident # 045 should have had a pain assessment related to the increase in the resident's pain and that the home's policy related to pain assessments was not complied with. [s. 8. (1) (b)]

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

Record review of the "Urinary Continence Program" policy # 05-04-01 dated May 2010 revealed the following: "On admission registered staff will initiate a comprehensive

assessment of the resident's urinary continence status using the Bowel and Bladder Continence Assessment Tool as well as the Bowel and Bladder 5 Day Elimination Pattern Monitoring Tool."

Resident # 034 was admitted to the home in 2015. Record review on PointClickCare and the hard copy of the resident's chart revealed there was no documented evidence that a urinary continence assessment was completed and that the resident's individual bowel and bladder elimination pattern was monitored on admission. The registered staff confirmed there was no comprehensive continence assessment completed.

Staff interview with the Administrator confirmed the lack of a comprehensive assessment of the resident's continence status on admission and stated that the home's expectation was that on admission, the Urinary Continence Program policy should have been complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was 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 observations on August 25 and 26, 2015 during stage 1 of the Resident Quality Inspection revealed 37 of 40 residents had one or more bed rails in use.

Record review of resident clinical records revealed the absence of a documented resident assessment for the use of bed rails. Interview with the LTC Consultant with Extendicare Assist on August 31, 2015 confirmed the home had not completed a Bed Rail Risk Assessment for those residents using bed rails.

Staff interview with the Administrator on September 2, 2015 confirmed where bed rails were used, the resident was not assessed and his or her bed system was not evaluated in accordance with evidence-based practices to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident has 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of admission of the resident's admission to the home.

Resident # 036 was admitted to the home and record review of the progress notes revealed the resident had specific unique needs related to communication and other activities of daily living.

Record review revealed there was no documented evidence to support that a 24-hour care plan was developed for Resident # 036.

The Administrator confirmed the absence of a 24-hour care plan and indicated that the home's expectation is that a 24-hour admission care plan should have been completed within 24 hours of admission to the home. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of admission of the resident's admission to the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was 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: the program was evaluated and updated at least annually in accordance with evidence-based practices and there was a written record related to each evaluation under paragraph 3 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.

Record review of the "Continence Care & Bowel Management," "Palliative Care & Pain Management" and "Skin Care" Quality Program Evaluation on September 1, 2015 revealed the program evaluations were not yet completed for 2015 and the Administrator confirmed there was no documented evidence that the programs were evaluated in 2014. [s. 30. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is complied with in respect to 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: the program was evaluated and updated at least annually in accordance with evidence-based practices and there was a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident that exhibited 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.

The "Skin - Head to Toe Skin Assessment" for Resident # 008 was completed and documented multiple wounds.

The "EO Weekly Wound Care Record" documented the assessment of only one wound present. The "Skin - Weekly Wound Assessment - includes Bates-Jensen - V 2" documented the assessment of another wound, but did not capture all wounds present.

Staff interview with the Resident Assessment Coordinator (RAI-C) confirmed there was no paper version of the weekly skin assessment in use and all weekly wound assessments were completed in PointClickCare (PCC). The RAI-C confirmed there should have been weekly wound assessments completed for all wounds identified on the admission "Skin - Head to Toe Skin Assessment." The RAI-C confirmed weekly wound assessment were not completed for one month for any of the identified wounds for Resident # 008. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

An interview with the SDM for Resident # 041 during Stage one of the RQI revealed she was informed of an incident involving Resident # 041 and the resident verbalized fear and anxiety. The notification of the SDM occurred two days after the incident happened.

A review of the home's policy titled "Resident Abuse" policy number OPER-02-02-04 indicated that "the resident's SDM/POA, if any and family" were to be immediately notified if the resident experienced abuse that resulted in distress that could be detrimental to the health and well-being of the resident.

An interview with the Clinical Consultant for the home confirmed that it was the home's expectation that incidents between residents that could be detrimental to the health and well-being of the resident was to be immediately reported to the SDM/POA and in the case of the incident between Resident # 041 and # 043 this did not occur and should have. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #10: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. 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. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

In an interview Resident # 010 revealed personal items from her room went missing two months ago. The resident confirmed that he/she informed registered staff of the missing items.

In an interview Resident # 046 revealed that personal items went missing from his/her room and confirmed that staff were made aware.

In an interview personal support staff confirmed they were aware of the missing personal item for Resident # 046 but were unaware of the outcome of the complaint. Personal support staff were unaware of the complaint by Resident # 010.

A review of clinical records as well as the home's complaint log revealed no documentation of the complaints brought forward by Resident # 010 and # 046.

In an interview the Administrator confirmed that there was no written documentation of the two cited complaints, that the two complaints were unresolved after 24 hours of receipt and confirmed no written response was provided to the complainants within 10 business days and should have been. [s. 101. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, to be implemented voluntarily.

WN #11: 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).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training was provided to all staff who provide direct care to residents:
- Skin and wound care,
- Continence care and bowel management and
- Pain management, including pain recognition of specific and non-specific signs of pain.

Record review of the "Maitland Manor Mandatory Education Session 2014" agenda revealed it did not include education related to skin and wound care, continence care and bowel management and pain management.

Staff interview with the Administrator on September 2, 2015 confirmed there was no documented evidence that direct care staff received education in skin and wound care, continence care and bowel management or pain management. The Administrator confirmed the home did not meet the education requirements for 2014. [s. 221. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure 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: skin and wound care, continence care and bowel management and pain management, including pain recognition of specific and non-specific signs of pain, to be implemented voluntarily.

WN #12: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

In the Poplar dining room during lunch service two Personal Support Workers were observed to be clearing tables of dirty dishes and picking debris off floor. Both PSWs were observed not to have cleansed their hands after performing the cited tasks and were also observed serving food. This was observed three times during the lunch service.

When questioned during an interview with one of the PSWs revealed that he used a soiled rag to clean his hands if his hands were not visibly soiled.

In an interview, the Food Service Manager (FSM) revealed that the home's expectation was that after handling dirty dishes or picking up debris off the floor staff were to wash hands with soap and water or hand sanitizer. The FSM acknowledged that hand washing expectations were not followed by the two cited PSWs and should have been. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Observations made during the initial tour and throughout the RQI revealed 20 out of 116 (17 %) of light fixtures in hallways and common areas did not have covers.

An interview with the Maintenance Manager confirmed that light fixtures maintained without covers were not in safe condition. The Maintenance Manager confirmed that it was the home's expectation that light fixtures were to be maintained in a safe condition and in the care of the 20 light fixtures without covers this did not occur and should have. [s. 15. (2) (c)]

WN #14: 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, each resident 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 that where the condition or circumstances of the resident required an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A clinical record review for Resident # 034 revealed the resident had a decline in bladder function since admission. There was no documented evidence of a continence assessment for this resident. This was confirmed by the Registered Practical Nurse after review of PointClickCare.

Record review of the "Urinary Continence Program" policy # 05-04-01 dated May 2010 revealed the following: "where indicated by a change in continence status, the Quarterly Continence Assessment form will be completed".

Interview with the Administrator and the RAI (Resident Assessment Instrument) Coordinator confirmed the expectation that the resident should have received a continence assessment with any significant change in continence. [s. 51. (2) (a)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with a member of Resident's Council revealed he/she could not recall if the home sought the advice from Resident Council in developing and carrying out the satisfaction survey.

Record review of the Residents' Council (RC) Minutes for August 2014 revealed the survey was mailed out to all residents / families in August 2014. Meeting minutes between September and November 2014 revealed the "surveys have been mailed and once returned will be sent to head office." There was no mention of the review of the satisfaction survey with RC prior to the survey being mailed out to residents and families.

Staff interview with the Administrator confirmed the home did not seek the advice of the Residents' Council in developing and carrying out the survey and acting on its results. [s. 85. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations on two occasions with the Environmental Manager revealed significant corrosion in the bathroom sinks and/or rust coloured stains and holes in the sink surface of 10/33 (30 per cent) of resident bathrooms.

The Environmental Manager confirmed the need for sink replacements and that there was no documented evidence to support that all resident rooms were audited on a regular basis to ensure the equipment was maintained and kept free from corrosion. The Environmental Manager stated that it was the home's expectation that procedures were implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

Issued on this 24th day of September, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), CHAD CAMPS (609), INA REYNOLDS (524)
Inspection No. / No de l'inspection :	2015_303563_0031
Log No. / Registre no:	021705-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 24, 2015
Licensee / Titulaire de permis :	CVH (No.2) LP c/o Southbridge Care Homes, 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	MAITLAND MANOR 290 SOUTH STREET, GODERICH, ON, N7A-4G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amanda Beddow

To CVH (No.2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_181105_0002, CO #001;

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 must achieve compliance 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 is on duty and present in the home at all times, except as provided for in the regulations.

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 S.O. 2007, c.8, s. 8. (3).

The plan must include:
1. Recruitment Strategies.
2. Strategies to ensure a Registered Nurse is on duty and present in the home.
3. Time lines for completion.
4. Person accountable for this task.

Please submit the plan, in writing, to Melanie Northey, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, be email to melanie.northey@ontario.ca by October 2, 2015.

Grounds / Motifs :

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

Record review of the "Quality Program Evaluation for Nursing & PSW Staffing Services" dated May 2015 identified there was no Registered Nurse (RN) in the home three to four times a week. Documented recruitment strategies included actively advertising monthly in either newspaper, on the Extendicare website or the SouthWest Health Line website, accommodating schedule for staff with other jobs, and reaching out to agencies who were unwilling to service the area.

Record review of the "Sufficient Staffing Quality Protocol" completed July 22, 2015 addressed “24 hour nursing care where by at least one registered nurse who was an employee of the home and a member of the registered nursing staff was on duty and present at all times” and answered "No" to this question with a documented strategy to review staffing records/staffing schedules.

Record review of the Staffing Plan: May 2015 for each home area revealed:
- North and South wing: 1.5 RNs on days, equaling 3 RNs in the building
- North and South wing: 1 RN on evenings, equaling 2 RNs in the building
- North and South wing: 0.5 RN on nights, equaling 1 RN in the building

Record review of the RN Schedule between August 1 - 31, 2015 revealed 87% of the night shifts and 26% of the evening shifts had no RN scheduled on duty and present at all times.

Staff interview with the Administrator on September 1, 2015 confirmed that despite recruiting strategies the home did not have a registered nurse on duty for 26 night shifts and four evening shifts in August 2015. The Administrator shared that on average there was not an RN on duty approximately four night shifts, two day shifts and three evening shifts biweekly, but with the recent hiring of a new RN graduate the night vacancy will hopefully improve.

This area of non-compliance was previously issued on March 13, 2014, September 23, 2014 and January 19, 2015. (563)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of September, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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