Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Dec 12, 2014	2014_395151_0009	S-000483-14	Resident Quality Inspection

Licensee/Titulaire de permis

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED
70 ROBINSON STREET POSTAL BAG 460 LITTLE CURRENT ON P0P 1K0

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

MONIQUE BERGER (151), FRANCA MCMILLAN (544), MONIKA GRAY (594)

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): November 24,25,26,27,28 and December 1,2,3,4,5, 2014

Concurrent to this RQI Inspection (Log #: S-000483-14), the following was also inspected;
- S-000046-13 related to Follow-up of order in regards to s.8(3) of the Act issued on inspection reference;2013-139163-0003
- S-000238-13 related to Follow-up of order in regards to s.6(7) of the Act issued on inspection reference; 2013-139163-017
- S-000239-13 related to Follow-up of order in regards to s.19(1)of the Act issued on inpsection reference:2013-139166-0017
- S-000187-13 related to Info-line complaint;27816-SU
- S-000493-13 critical incident follow-up
- S-000494-13 critical incident follow-up

During the course of the inspection, the inspector(s) spoke with
- Administrator
- Director of Care
- MDS Rai Coordinator
- Registered Staff (RNs and RPNs)
- Personal Support Workers (PSW's)
- Manager for Maintenance
- Manager for Housekeeping
- Manager for Laundry
- Food Service Suppervisor
- Resident Council Representative
- Residents
- Family and visitors

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **25 WN(s)**
- **9 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2013_139163_0017	151

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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Inspector 151 conducted a follow-up inspection with reference to S-000046-13 and Ministry report to the home 2013-139163-003. The report ordered the home to become compliant with the requirement to provide 24/7 on-site Registered Nurse coverage. The home was given a compliance date of April 2013.

Inspector 151 audited the home's staff schedules for September, October and November 2014 and noted that, in total, the home had a shortfall of 124 hours where there was no Registered Nurse in the home. Inspector noted that 80% of these hours occurred on night shift.

Inspector reviewed the home's annual review of the staffing plan dated November 3, 2014. Inspector noted the following statement: "Upon review of our annual master schedule or the Registered Staff department, we noticed that the 24/7 requirements were not being fulfilled" [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

Inspector 151 did a follow-up inspection on a previous Order regarding this resident. The critical incident referenced in the Order (report #2013-139163-007) recounted that the resident had exhibited inappropriate behaviours towards residents on several occasions after the initial Critical Incident report was filed with the Ministry. In addition, and according to the report, inspectors noted that staff did not follow the plan of care for this focus of behaviour.

Inspector reviewed the resident's health care records and noted that there was no focus for the identified responsive behaviours towards others in the current plan of care. Director of Care confirmed that the issue of inappropriate sexual behaviour was deemed to be resolved as the resident no longer demonstrated this behaviour.

Inspector reviewed the resident's health care records further and noted the following;
- On the current plan of care, there is one mention that the resident continues to exhibit the identified responsive behaviour, however, the plan of care had no focus, goals or interventions in regards to the management of the behaviours.
- The Responsive Behaviour Record of September, 2014 recorded an instance of the identified responsive
- The current Responsive Behaviour Record shows that since Aug. 22, 2014, the resident has had 6 episodes of responsive behaviours where staff were physically abused by the resident

In an interview with Inspector, Staff #206 confirmed that the resident continues to exhibit the identified behaviour.

Inspector did multiple observations of the resident and noticed that the resident was left in unsupervised areas where other residents collected for protracted periods of time; i.e.in the dining room lounge from noon until 1500 h

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 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).

Findings/Faits saillants :

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

Inspector# 544 inspected on several MDS triggered issues involving decline in communication abilities in residents. In tandem with the home's RAI/MDS Co-ordinator, Inspector 544 reviewed the resident health care information which led to the MDS triggers

For Resident # 5463, it was noted that MDS assessments identified the resident as having clear speech on previous assessments until November, 2014 where the resident was identified to have had a decline in this ability of "clear speech" to now having "unclear speech". Through staff interviews, it was confirmed that the resident had suffered a decline in health condition where now the resident spoke only in mumbles and whispers.

Inspector # 544 could find no documentation in Resident # 5463 health care records to support the stated decline in communication, nor was this decline in communication found as a focus in the resident's plan of care. In an interview with Inspector 544, RAI/MDS Co-ordinator confirmed that this decline in communication was not reflected in the care plan and should have been immediately following the MDS coding of decline in

communication. [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 provide direct care to Resident #5469

As a result of Stage 1 Inspection activities during the Resident Quality Inspection, MDS triggered “dental care lacking” for Resident # 5469. This issue was also confirmed through a family interview that was conducted by Inspector #544.

In an interview with Inspector 544, Resident # 5469's family member confirmed visiting the resident on a daily basis and on most of the visits, the resident is in need of mouth care. Both the family member and the resident have made a request of staff for oral care after every meal.

Inspector # 544 reviewed Resident # 5469's most recent plan of care dated and identified that there was no focus, goal or interventions for oral/dental care. Upon further review of the plan of care states under the focus, "ADL- PERSONAL HYGIENE- “Potential for complication in regards to poor balance ." Under the goal for this section, it is written, "[resident] will be able to complete mouth care after meals with set up assistance from staff through next review date". This same goal is written in the exact same place and in the exact same words in the previous plan of care. There was no separate focus, goal or interventions for oral care in the current plan of care and as a result there were no corresponding interventions linked to the resident's and family member’s request.

In an interview with Inspector 544, Staff # 207 confirmed; "there should be a separate focus for oral/dental care on the plan of care with goals and interventions". In an interview with the Inspector, Staff #205 also confirmed that oral and dental care should have been a distinct focus for Resident #5469's plan of care.

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

During Stage 1 activities of the inspection, Inspector 544 observed that resident #05430 had altered skin and wound issue. Inspector # 544 reviewed Resident # 5430's plan and care and identified that there was no focus, goals or interventions for the resident's altered skin and wound issue.

Inspector reviewed Resident # 5430's Treatment Administration Record (TAR) and noted

this record contained a physician's order for treatment of this wound. This treatment was not identified on the plan of care.

Inspector #544 did not find any record in the resident's health care record that indicated that the resident was in receipt of the treatment at any time, even though this condition was noted in progress notes 3 times in September, 2014

Inspector 544 audited the TAR for the month of August 2014 and noted that the treatment) was not documented as being done on any day of that month. Review of the resident's progress notes showed that condition was documented in progress notes 4 times during the month.

4.The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident s. 6. (1) (c)

Inspector 151 did a follow-up inspection on an outstanding order regarding resident #100. The critical incident referenced in the inspection report #2013-139163-007 recounted that the resident had exhibited responsive behaviours towards residents on several occasions after the initial Critical Incident report was filed with the Ministry. In addition, and according to the report, inspectors noted that staff did not follow the plan of care for this focus of behaviour.

Inspector reviewed the resident's health care records and noted that there was no focus of the identified responsive behaviour in the current plan of care. Director of Care confirmed that the issue of identified responsive behaviour was deemed to be resolved on August 22, 2014 as the resident no longer demonstrated this behaviour.

Inspector reviewed the resident's health care records further and noted the following;
- on the current plan of care, the resident had no focus, goals or interventions in regards to the management of the identified responsive behaviour, even though, under the bathing section, there is a notation that the resident still exhibited the identified responsive behaviour.
- the Responsive Behaviour Record of September 27, 2014 recounted an episode where the resident exhibited the responsive behaviour towards a staff member.
- the current Responsive Behaviour Record that shows that since Aug. 22, 2014, the resident has had 6 episodes where physical responsive behaviour was directed to staff.
In an interview with the Inspector, Staff #206 confirmed that the resident continues to

exhibit the identified responsive behaviour.

Inspector did multiple observations of the resident and noted that the resident was left in unsupervised areas where other residents collected for protracted periods of time; i.e.in the dining room lounge from noon until 1500 h.

There is no direction to staff regarding resident #0100's responsive behaviour in the plan of care.

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,
(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 # 05427, 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.

Inspector 544 reviewed Resident # 5427 health care record and noted that the resident had developed an issue of altered skin integrity in November, 2014. Inspector noted that the physician had ordered a wound care protocol regime to manage this wound. Inspector # 544 could find no documentation on Resident # 5427's health care record regarding neither an initial assessment for this wound nor weekly assessments thereafter.

Staff #201 and Staff #205 confirmed that an initial wound and skin assessment was not completed for Resident # 5427's new wound.

2. The licensee has failed to ensure that Resident # 05430, exhibiting altered skin integrity 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.

Inspector # 544 reviewed the health care records for resident #05430: specifically with a focus for progress notes relating to skin and wound care. Inspector audited these progress notes from January 20, 2014 to November 29, 2014. Inspector noted 3 separate recorded altered skin breakdown events.

For each of these incidents, Inspector 544 could find no documentation in Resident # 5430's health care record that indicated that an initial skin and wound assessment was completed by member of the registered staff.

In an interview with the Inspector, for each of the sited examples Staff #201 and #205 confirmed that no assessment was done.

3.The licensee has failed to ensure that Resident # 5458 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.

As a result of Stage 1 Inspection activities, Inspector # 544 interviewed Resident #05458

and in the process, observed several open areas and abrasions.
Inspector 544 reviewed the resident's health care records with a focus of skin and wound care and noted that in regards to the resident's current lesions, no documentation was found that would support that an initial skin and wound assessment was completed by a Registered Nursing Staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In addition, Inspector #544 did not find any skin and wound assessments completed for Resident #05458 from September 2, 2013 to September 25, 2014, however, review of the health care records showed the following:

- Progress note of September, 2013, documented Resident # 5458 had altered skin integrity issue. Inspector noted that the RN did an assessment of the wound but did not complete an initial skin wound assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In an interview with the Inspector, Staff #205 confirmed that the clinical tool was not utilized.

- Progress note of February, 2014, documented that Resident # 5458 had altered skin integrity. Inspector could find no documentation in the health care record to support that an RN nursing staff assessed the wound initially, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In an interview with Inspector 544, Staff #205 confirmed that the wound was not assessed as per the home's clinical tool.

- Progress notes of February , 2014, documented another incident of altered skin integrity. Inspector could not find any documentation in the resident's health care record to support that an RN assessed the wound initially, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In an interview with Inspector 544, Staff #205 confirmed that no assessment was done.

- Progress note of August, 2014, documented that Resident # 05458 had an incident of altered skin integrity. Inspector could not find any documentation in the health care record to support that an RN assessed the wound initially, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In an interview with Inspector 544, Staff #205 confirmed that no assessment was done.

- Progress note of September, 2014, documented Resident #05458 had an incident of altered skin integrity. Inspector could not find any documentation in the health care record to support that an RN assessed the wound initially, using a clinically appropriate

assessment instrument that is specifically designed for skin and wound. In an interview with Inspector 544, Staff #205 confirmed that no assessment was done.

Inspector 544 reviewed the above information with the Director of Care who confirmed that in each instance the initial skin/wound assessments should have been completed.

4.Inspector # 544 reviewed Resident #05430 health care records including progress notes and assessments for November 2014 and identified that on November 6, 2014, Resident # 05430 sustained a small cut to the left great toe .

Inspector # 544 could find no documentation or initial assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment in regards to this wound. Inspector did note a progress note that referenced that the home's wound care protocol was initiated:" [resident] sustained a small cut to Great (L) toe last evening. Wound Care Protocol (WCP) was initiated, and a referral was sent to the dietitian".

In an interview, both Staff #201 and #205 confirmed that no initial assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was completed for this resident.

5.The licensee has failed to ensure that Resident # 05427, 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.

Inspector 544 reviewed Resident # 5427 health care record and noted that the resident had developed an issue of altered skin integrity in November, 2014. Inspector noted that the physician had ordered a wound care protocol regime to manage this wound. Inspector # 544 could find no documentation on Resident # 5427's health care record regarding neither an initial assessment for this wound nor weekly assessments thereafter.

Staff #201 and Staff #205 confirmed that an initial wound and skin assessment was not completed for Resident # 5427's new wound. [s. 50. (2) (b) (iv)]

6. Inspector 544 reviewed Resident #05430's health care records: including skin and wound care progress notes and all nursing progress notes from January 20, 2014 to November 29, 2014. Inspector noted 3 separate incidents where resident experienced altered skin integrity

For all the above examples, Inspector # Inspector # 544 could not find any documentation in Resident # 5430's health care record that weekly skin and wound assessments were completed by registered staff. In an interview with Inspector 544, DOC and Staff #205 confirmed that weekly skin and wound assessments for this resident were not completed.

In addition, resident has a current lesion and this lesion has worsened over time. Inspector 544 noted that the physician has ordered a wound skin protocol for the care of the lesion. Inspector 544 reviewed the resident's health care record in regards to this wound and found the last skin and wound assessment to be dated in October, 2014. Inspector could not find any document to support that the resident was receiving weekly skin assessments by a member of the registered staff.

In an interview with Inspector 544, DOC and Staff #205 confirmed that weekly skin and wound assessments for this resident and this wound were not completed.

7.The licensee has failed to ensure that Resident # 5458, exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Inspector # 544 interviewed Resident # 5458 and identified several open areas and abrasions .Inspector # 544 could not find any documentation that could support weekly skin and wound assessments were completed by a Registered Nursing Staff.

In addition, Inspector 544 could find no documentation to support that weekly skin and wound assessments were done by a member of the registered staff for the f5 other incidents of altered skin integrity documented in progress notes
In an interview with the Inspector, DOC and Staff #205 confirmed that weekly skin assessments by a member of the registered staff were not completed but should have been for all the above stated examples.
[s. 50. (2) (b) (iv)]

8.The licensee has failed to ensure that Resident # 05430, exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff.
Inspector reviewed the health care records for resident #05430 and noted that in November, 2014, resident exhibited altered skin integrity. The progress note states that a referral was sent to the dietitian, wound care protocol was initiated. Inspector # 544 could find no documentation on Resident # 5430's health care record supporting weekly skin and wound assessments were completed. In an interview with Inspector 544, DOC and Staff #205 confirmed that weekly skin and wound assessments for this resident were not completed.
[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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #544 reviewed the home's Skin and Wound Program. Inspector reviewed the following policy:POLICY SKIN TREATMENTS - CLINICAL PROCEDURES, Current Version June 2010 Policy # 03-05.
Inspector noted that the policy states the following:

- " Registered Staff will carry out skin care treatments as prescribed by the physician/ nurse practitioner or regional protocol and will evaluate the need for treatment on a weekly basis"
- "Registered Staff will initiate the Weekly Treatment Reassessment Form to Support the weekly re-evaluation of the need for treatment."
- "Registered Staff will complete the treatments as ordered documenting the completion on the Treatment Administration Record (TAR) and once a week will re-evaluate the need for the treatment on the appropriate form."
- " The Care Plan is to be updated to reflect current skin care needs and treatments being performed."
- "Progress Notes- used to document the initial assessment of the skin issue."
- "Weekly Treatment Reassessment Forms- used to document the re-evaluation of the treatment weekly."
- "Care Plan- updated to indicate the location of skin alteration, interventions and treatment required."

Inspector reviewed resident #05430' health care records and noted the resident was found to have current and historical wounds over the last year where staff did not follow any of the above policy directions. In an interview with Inspector #544, Staff #201 and #205 confirmed that staff had not followed the protocol directions of the skin and wound program as stated in the policy for this resident [s. 8. (1) (a),s. 8. (1) (b)]

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

Inspector #544 reviewed the home's Skin and Wound Program. Inspector reviewed the following policy:POLICY SKIN TREATMENTS - CLINICAL PROCEDURES, Current Version June 2010 Policy # 03-05.
Inspector noted that the policy states the following:
- " Registered Staff will carry out skin care treatments as prescribed by the physician/ nurse
practitioner or regional protocol and will evaluate the need for treatment on a weekly basis"
- "Registered Staff will initiate the Weekly Treatment Reassessment Form to Support the weekly
re-evaluation of the need for treatment."
- "Registered Staff will complete the treatments as ordered documenting the completion on the

Treatment Administration Record (TAR) and once a week will re-evaluate the need for the treatment
on the appropriate form."
- " The Care Plan is to be updated to reflect current skin care needs and treatments being performed."
- "Progress Notes- used to document the initial assessment of the skin issue."
- "Weekly Treatment Reassessment Forms- used to document the re-evaluation of the treatment weekly."
- "Care Plan- updated to indicate the location of skin alteration, interventions and treatment
required."

Inspector reviewed resident #05427 health care records and noted the resident was found to have had wounds over the last year where staff did not follow any of the above directions in regards to the resident's wound care. In an interview with Inspector #544, Staff #201 and #205 confirmed that staff had not followed the protocol directions of the skin and wound program as stated in the policy for this resident [s. 8. (1) (a),s. 8. (1) (b)]

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

Inspector #544 reviewed the home's Skin and Wound Program. Inspector reviewed the following policy:POLICY SKIN TREATMENTS - CLINICAL PROCEDURES, Current Version June 2010 Policy # 03-05.
Inspector noted that the policy states the following:
- " Registered Staff will carry out skin care treatments as prescribed by the physician/ nurse
practitioner or regional protocol and will evaluate the need for treatment on a weekly basis"
- "Registered Staff will initiate the Weekly Treatment Reassessment Form to Support the weekly
re-evaluation of the need for treatment."
- "Registered Staff will complete the treatments as ordered documenting the completion on the
Treatment Administration Record (TAR) and once a week will reevaluate the need for the treatment
on the appropriate form."
- " The Care Plan is to be updated to reflect current skin care needs and treatments

being performed."
- "Progress Notes- used to document the initial assessment of the skin issue."
- "Weekly Treatment Reassessment Forms- used to document the re-evaluation of the treatment weekly."
- "Care Plan- updated to indicate the location of skin alteration, interventions and treatment
required."

Inspector reviewed resident #05458 health care records and noted the resident was found to have wounds over the last year where staff did not follow any of the above directions in regards to the resident's wound care. In an interview with Inspector #544, Staff #201 and #205 confirmed that staff had not followed the protocol directions of the skin and wound program as stated in the policy for this resident [s. 8. (1) (a),s. 8. (1) (b)]

4. In regards to pain management, the licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

During an interview with Inspector #544, resident #05477 identified pain management as a concern and stated, in addition to pain medication, 2 specific non-phamacological interventions helped relieve pain.
Inspector #594 reviewed the resident's health care record to identify pain medication strategies. Inspector noted resident #05477's care plan addressed only pharmacological interventions. Inspector #594 interviewed staff #205 who stated non-pharmacological interventions for resident #05477 should be included in the resident's care plan and verified that these interventions were absent from the plan of care. In an interview with Inspector #594, the Director of Care verified non-pharmacological interventions are to be included in the care plan.

Inspector #594 reviewed the PAIN MANAGEMENT POLICY: #RESI-10-03-01 which states residents who are identified as experiencing pain will have an interdisciplinary plan for pain management including pharmacological and non-pharmacological approaches completed by the interdisciplinary team. [s. 8. (1) (a),s. 8. (1) (b)]

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

Inspector reviewed Resident #45429's health care records and reviewed the hourly

monitoring flow sheets for the restraint for this resident. Inspector noted that 17 of 30 days have periods where there is no documentation of hourly monitoring of the restraint after the code "A" [Applied] was initialized.

Inspector reviewed the home's policy and procedure in regards to restraints reference PHYSICAL RESTRAINTS;RESI-10-01-01, NOVEMBER 2012. Inspector noted that on page 3 of the record, the role and responsibility for "care staff" is identified as follows; "Ensure the Restraint Record is completed. Monitoring of restraint use must be competed with hourly safety checks and two hourly position changes which requires the release of the restraint and documented on the restraint record". On this same page, in the section for "Registered Staff and Care Staff, the policy directs staff to visually check residents at least every hour and that the minimum frequency for release and repositionning is every two hours". [s. 8. (1) (a)]

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

Inspector reviewed Resident #45463's health care records and reviewed the hourly monitoring flow sheets for the resident's restraint. Inspector noted that 6 of 30 days have periods where there is no documentation of hourly monitoring of the restraint after the code "A" [Applied] was initialized.

Inspector reviewed the home's policy and procedure in regards to restraints reference PHYSICAL RESTRAINTS;RESI-10-01-01, NOVEMBER 2012. Inspector noted that on page 3 of the record, the role and responsibility for "care staff" is identified as follows; "Ensure the Restraint Record is completed. Monitoring of restraint use must be competed with hourly safety checks and two hourly position changes which requires the release of the restraint and documented on the restraint record". On this same page, in the section for "Registered Staff and Care Staff, the policy directs staff to visually check residents at least every hour and that the minimum frequency for relase and repsotionning is every two hours". [s. 8. (1) (a)]

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

Inspector # 544 reviewed the home's policy entitled "WEIGHT CHANGE PROGRAM":Policy Reference: RESI-05-02-07, Activities of Daily Living Version November 2013 and noted the following reference;

" This program also includes the recording of the Resident's Body Mass Index (BMI) and height upon admission and annually thereafter."

Inspector conducted an audit of residents' heights where it was found that 13 of 20 residents did not have their heights taken in the last year. In an interview with the Inspector, Staff #205 reviewed the results of the audit and confirmed that residents' heights should have been taken annually. [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 #6: 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 are kept clean and sanitary.
On a daily basis, Inspector 151 walked through the home and observed the following recurring on a consistent basis;
- Persistent lingering odors; especially in 2 specific resident rooms
- Carpet stains throughout the home; both in general resident spaces and resident rooms
- Build-up of dust on television in dining room lounge
- Wall stains: i.e. near room 207
- Soil and grime build up of the flooring on Level 1
- Soil and grime accumulation on service doors where staff push the doors open [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2). O. Reg. 79/10, s. 47 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all the persons hired on or after July 1, 2011 as personal support workers or to provide personal support services, regardless of title, completed a personal support worker program that meets the requirements listed below

The personal support worker program must meet:

* the vocational standards established by the Ministry of Training, Colleges and Universities,
* the standards established by the National Association of Career Colleges, or
* the standards established by the Ontario Community Support Association, and
* must be a minimum of 600 hours in duration, counting both class time and practical experience time.

Inspector 151 audited the home's records in regards to the provision of qualified Personal Support Workers. The result of this audit is as follows;
- the home did not have on file and had to request staff to bring in proof of qualifications for 6 of 31 staff (19.4 %)
- the home did have one staff member who was hired after July 2011, who presently worked in the home and who had not completed the course required and was not currently enrolled in a program to complete the qualification. [s. 47. (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 all person's hired on or after July 1, 2011 as personal support workers or to provide personal support services, regardless of title, have completed a personal support worker program that meets the qualification requirements as per the Act., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there written protocols for the referral of residents to specialized resources where required.

Inspector reviewed the home's policies in respect to the Management of Responsive Behaviours; reference; POLICY;RESPONSIVE BEHAVIOURS, POLICY NUMBER 09-05 -01 DATED; SEPTEMBER 2010.
Inspector noted that though the policy references that "the home will establish community linkages to support the care of resident in the home that are displaying challenging responsive behaviours", the policy does not go further to identify the resources and referral sources available to this home, nor does the policy provide a protocol for referral to the specialized resources. In an interview with the Inspector, Staff #201 concurred that the policy lacked this direction for staff [s. 53. (1) 4.]

2. The licensee has failed to ensure that the Responsive Behaviour Program was being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

In an interview with Inspector 151, Administrator and Director of Care confirmed that there has no report of the annual review for this program as the program did not receive an annual review. [s. 53. (3) (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 home's Management of Responsive Behaviours Program, provides for written protocols for the referral of residents to specialized resources where required and that the Managment of Responsive Behaviours Program is evaluated annually and updated in accordance with evidence-based practices or prevailing practices, to be implemented voluntarily.

WN #9: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually related to, he Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections.

In an interview with Inspector #544, Administrator confirmed there was 63- 64 staff members currently on staff. The Director of Care provided Inspector # 544 with documentation and staff attendance record in regards to staff retraining related to Residents' Bill of Rights and Abuse Policy. It was found that in the last 12 months,only 21 of 64 staff members have attended the mandatory training.

Inspector, Administrator and Director of Care were not able to find any staff training record that supported that staff had received retraining in regards to:
- duty to make mandatory reports
- whistle-blowing protection. [s. 76. (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 all staff receive annual retraining related to the Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and Whistle Blowing protection, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee once in every calendar year:

* conduct an evaluation to determine the effectiveness of the policy, and
* identify what changes and improvements are required to minimize restraining and ensure that restraining is done in accordance with the Act and Regulation

In an interview with the Inspector, Administrator confirmed that the Least Restraint Program has not been evaluated in the last 12 months.
Inspector noted that the policies and procedures reviewed in regards to restraints had the following most recent review dates:
- ENVIRONMENTAL CONTROLS; Policy reference RESI: 10-01-05; October 2013
- PHYSICAL RESTRAINT MONITORING:RESI-10-01-04;NOVEMBER 2012
- CONSENT FOR RESTRAINT USE:RESI-10-01-03; NOVEMBER 2012
- CHEMICAL RESTRAINTS: RESI-10-01-02 NOVEMBER 2012 [s. 113. (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 once in every calendar year,the Least Restraint Program, receives an evaluation as per the requirements of O.Reg.79/10, s.113 (b), to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee developed an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Inspector observed a medication pass by Staff #204. Inspector observed that in the administration of insulin injection, Staff did not reference the medication system's record of site rotation in order to determine where next to inject the resident. Inspector observed that in the administration of a skin patch medication, Staff #204 did not reference the medication system's record of site rotation before administration of the skin patch medication. Inspector asked to see where in the medication system was the historical record of injection and patch application previous administration sites. Staff #204 easily found the record. Inspector noted that for the previous day of the insulin injection, the registered staff person had not registered any site of injection.

In addition, Inspector 151 inspected the medication room on Level 2 of the home and noted that, in the room, an upper level cabinet was compartmentalized to accommodate

each resident on the unit. Inspector observed that the compartments contained a variation of items;
- Medications that were sent from local pharmacy to cover until contract pharmacy could send
  resident medications
- PRN medications
- Ointments and creams
- Out-dated medications no longer in use for that resident
- In one instance, supply of prescribed dental cleaner ordered for a resident who is now deceased
  and had a white label applied over the pharmacy sticker and that staff had re-purposed it to
  another resident
- Dentures of a resident who is no longer in the home

In an interview with Inspector 151, Staff #204 confirmed that the bulk of the medications in the compartments was the result of staff's reluctance to destroy medications when no longer needed;i.e. surplus of medications that the local pharmacy sent to cover until the contract pharmacy could send the regular supply. Staff #205 stated that staff say that the medications might be needed for another resident and so were reluctant to destroy the extra medications. Staff #204 stated further that when staff have to remove a discontinued medication from a unit dose packet, some staff accumulate them in the medication cart. Staff #204 stated that when [Staff #204] finds these, [Staff #204] immediately destroys them. [s. 114. (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 there is developed and interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In an interview with the Inspector, Administrator confirmed that there has been no annual review of the medication program in the last 12 months. [s. 116. (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 licensee ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system., to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to ensure the security of the drug supply including all areas where drugs are stored shall be kept locked at all times, when not in use.

On November 24, 2014, Inspector # 544 observed the lunch dining service to residents. Inspector #544 observed that Resident #101 had an inhalation medication at the resident's place setting at the table. Resident was not at table as yet, however, table mate was at table and other residents had arrived in the dining room. Inspector observed that when Resident #101 arrived at the place setting in the dining room, resident self-administered the medication.

Inspector observed that Staff #208, responsible for the medication administration, was in the dining room but engaged in other duties at the time of the resident self-adminitration of the medication. Inspector observed that Staff #208 did retrieve the medication dispensing equipment once the resident had used it. [s. 130. 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 steps are taken to ensure the security of the drug supply, to be implemented voluntarily.

WN #14: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Every resident has the right to be afforded privacy in treatment and in caring for his or her needs.

Upon entrance to the home on November 24, 2014, Inspector 151 walked-through the home and noted that a resident was receiving eye drops in the dining room during the morning meal. In addition,
Inspector 544 observed that during a noon day meal a resident received inhalation therapy during the meal. On November 28, 2014, Inspector #544 observed that, at the breakfast meal, a resident received inhalation therapy at table during the breakfast meal. [s. 3. (1) 8.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Resident # 5496 told Inspector # 151 of an alleged staff to Resident abuse where the reporting resident stated they were afraid for another resident because of the way staff treated that resident. Resident #05496 stated that after instances of such, resident #001 was observed to be crying. Resident #059496 was able to provide details in regards to the incidents.

Inspector # 151 reported this to the Administrator on November 26, 2014 @1036 hours.

On November 27, 2014, in an interview with Inspectors #151 and #544, the Director of Care stated that a Critical Incident Report regarding the allegation of abuse would be sent to the Ministry AFTER the home's investigation was completed. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director,

On November 25, 2014, a family member reported to Inspector 544 an allegation of staff to resident physical abuse.

On November 25, 2014, and as soon as the interview with the family member was over, Inspector # 544 immediately reported the allegation to the Administrator.

On November 27, 2014, in an interview with Inspectors #151 and #544, the Director of Care stated that a Critical Incident Report regarding the allegation of abuse would be sent to the Ministry AFTER the home's investigation was completed.

The licensee failed to ensure immediate report of the suspicion and the information to the Director. [s. 24. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the Resident's communication abilities, including hearing and language.

Inspector #544 inspected a MDS trigger of "communication decline" for resident #05424. Inspector #544 reviewed the resident's health care records which included the resident's plan of care. Inspector noted that for the resident's most recent plan of care, there was no focus, goals or interventions that related to the resident having communication deficits.
In review of the resident's most recent MDS Assessments, Inspector noted that the resident was identified to be dependent for vision on the use of eye glasses. Inspector noted that the need to provide these to the resident was also not on the resident's plan of care.

In an interview with the Inspector, RAI/MDS Coordinator, Staff #205 and Staff #207 confirmed that the resident has never had issues of communication and that the MDS trigger was a coding error. Staff confirmed that even though it was a coding error, when the issue was coded, the care plan should have reflected the need to address communication issues and it did not. [s. 26. (3) 3.]

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

Inspector #544 observed that resident #05430 had an issue of altered skin integrity. Inspector reviewed the resident's health care records and noted that the there were

physician orders for the care of the wound. Inspector reviewed the resident's most recent plan of care and could find no focus, goals or intervention for wound care.

In addition, Inspector # 544 reviewed Resident #5430's Treatment Administration Records (TARS) for the month of June, July, August, September, October and November 2014. The physician had ordered a wound care treatment protocol when certain conditions occurred. Review of progress notes showed that conditions occurred frequently.
The audit showed that there was no entry in the six months of audit where staff documented that the resident had received the physician ordered treatment.

In an interview with Inspector #544, Director of Care and Staff #205 confirmed that the resident's wound should have been a focus for goals and interventions in the plan of care. [s. 26. (3) 18.]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraint by a physical device was included in the resident's plan of care.

Inspector 151 reviewed the home's policies on restraints: reference; PHYSICAL RESTRAINTS; RESI-10-01-01, NOVEMBER 2012. On page 5 of the policy, Inspector noted a reference under the section; Approved Physical Restraints that "tilt feature, when engaged, on a wheelchair or Geriatric Chair" is listed as an approved physical restraint."

During Stage 1 of the Ministry's Resident Quality Inspection at the home, Inspector 151 noted that resident #5456 was in a tilt wheelchair. Inspector 151 reviewed the resident's health care records and noted that the resident did not have the tilt wheelchair identified as a restraint, however registered staff and personal support workers were documenting on a restraint record once a shift. The restraint record identified the restraint to be "Posey alarm and wheelchair". Inspector did not find a physician or Nurse-Practionner order for the tilt feature of the wheel chair as a restraint, did not find consent for the tilt wheelchair and did not find hourly documentation for the restraint. Inspector made multiple observation of the resident, further reviewed the resident's health care records and interviewed Director of Care and Staff #205. It was concluded, and DOC concurred, that the resident had the capability to rise out of the chair, the tilt feature on the wheel chair was preventing the resident from attempting to rise and the tilt feature on the wheelchair should have been treated as a restraint. [s. 31. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to meet the needs of those residents with compromised communication and verbalization skills, residents with cognitive impairment and residents who cannot communicate in the languages used in the home.

Inspector #544 inspected a MDS triggered indicator of "communication decline" for resident #05469. Inspector audited all of the last year's MDS assessment for the resident and found that for all four assessments, the resident was identified to be the following: "usually understands and is usually understood, clear speech".

Inspector # 544 reviewed Resident # 5469's plan of care and could find no focus, goals or interventions in relation to a communication deficit.

Inspector #544 did note that the resident was identified in the assessments as moderately cognitively impaired.

In an interview with the Inspector, RAI/MDS Co-ordinator, Staff #207 and Staff #205 confirmed that because of the resident's cognitive impairment, communication was made difficult. Both confirmed that the issues should have been a focus for goals and interventions in the resident's plan of care. [s. 43.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Inspectors 151 and 544 toured the home on a daily basis and noted issues with persistent and lingering offensive odors, in particular 5 resident rooms,
In addition, Inspector 544 observed the following:
- In a resident room, the floor was sticky, there was urine on the floor of the bathroom around the base of the toilet bowl and that the room had a pervasive smell of urine.
- In a resident room the flooring in the bathroom was cracked and that there was urine on the floor.
- In a resident room, the mesh sling holding resident personal care equipment was soiled and stained. [s. 87. (2) (d)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented to ensure there is a process to report and locate residents' lost clothing and personal items.

Resident #5499 stated to Inspector #594 they had lost item of personal clothing. The inspector interviewed staff #206, #212, #209 and, #213 who all stated when a resident identifies lost clothing staff are to check in the resident's closet and notify laundry verbally. Inspector #594 interviewed Laundry Aide Staff #214 who stated they will receive verbal communication from staff and residents about missing items, and will look within the laundry department and other resident rooms for missing clothing item and leave a note in the laundry communication book alerting other laundry staff of missing items.

Inspector reviewed the home's LOST CLOTHING POLICY and noted that the policy directs staff to do the following: when a resident or family member notices an item of clothing is lost, they are to fill in the Lost Clothing form and return it to the Charge Nurse who will provide the form to laundry staff. The Inspector interviewed the Administrator who stated, staff are to complete the Lost Clothing Form and give it to the laundry staff, where the form is kept in a binder in the laundry department.

As the 2 accounts varied from policy direction;the Administrator spoke with staff #214 who confirmed to the Inspector and the Administrator that staff no longer complete the Lost Clothing Form. [s. 89. (1) (a) (iv)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to inform the Director immediately of an outbreak of a reportable disease.

Inspector #594 inspected on issues of delayed reporting regarding Critical Incident Reports submitted to the Director by the home.
- First issue of delayed reporting; Outbreak at the home was declared by the Public Health Unit on October 02, 2013, however, the Critical Incident report was not sent until a day later.
- Second issue of delayed reporting: Outbreak at the home was declared by the Public Health Unit on December 1, 2013 but was not reported to the Ministry until a day later.

Inspector #594 reviewed documentation by the Triage Inspector of the Ministry of Health and Long-Term Care which states the Designated Infection Control Lead at the home was notified the evening of declaration but failed to inform the Director immediately. [s. 107. (1)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that he licensee ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

During inspection of drug storage area medication room on Level 2, Inspector 151 observed supply of prescribed dental cleaner ordered for a resident who is now deceased and that had a white label applied over the pharmacy sticker and that staff had re-purposed it to another resident. Inspector showed this to the DOC and Staff #205, both of whom confirmed that this practice was against their policies. [s. 126.]

WN #23: 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. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff receive the required training:

* annually, or
* if the licensee has assessed the individual training needs of a staff member, was the training received based on these assessed needs

Inspector 151 reviewed the home's staff education records for the last year and noted that only 18 of 33 direct care staff received training the management of responsive behaviours in the last 12 months. [s. 221. (2)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's quality improvement and utilization review system provide a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review.

Inspector noted that in the Licensee Confirmation Checklist for Quality Improvement and Required Programs, the Administrator answered "no" to the following question:
"Is the QI system ongoing, interdisciplinary and provide a written description of its goals, objectives, polices, procedures and protocols, and a process to identify initiatives for review".
In an interview Dec. 2, 2014, Administrator confirmed that the home has no terms of reference for the Continuous Quality Improvement Committee or Program and that the QI committee had not met since July 2014. [s. 228. 1.]

2. The licensee has failed to ensure that the home's quality improvement and utilization review system is ongoing and interdisciplinary.

In an interview with Inspector 151, Administrator confirmed that the home has not had a Continuous Quality Improvement Committee meeting since July 2014. The committee was to have been meeting on a monthly basis. [s. 228. 2.]

3. The licensee has failed to ensure that the home maintain a record setting out the improvements made to the quality of the accommodation, care, services, programs and goods provided residents.

In an interview with Inspector 151, Administrator confirmed that to date, the home has not maintained a record setting out the improvements made to the quality of the accommodations, care, services, programs and goods provided to residents. [s. 228. 4. i.]

4. The licensee has failed to ensure that the home maintain a record of:

* the names of the persons who participated in evaluations, and
* the dates improvements were implemented

In an interview with Inspector 151, Administrator confirmed that with the exception of the staffing program, the home has no record of program evaluations for this year. [s. 228. 4. ii.]

WN #25: 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 participate in the implementation of the infection prevention and control program.

Inspector 151 walked through the home on a daily basis during the Ministry's Resident Quality Inspection of the home. Inspector observed the following:
- November 24, 2014, during initial tour of the home,
  - Bath 5; used brief, used towels, and resident clothing on the floor
  - Bath 3; used incontinent products on top of the lid of the trashcan
  - most individual nail care compartments for each resident were devoid of clippers. Large set of clippers on top of the bin, soiled with clippings, no identifying label as to which resident these clippers belonged to.
  - upon entrance to the home, Inspector detected odor of urine. Lingering offensive odors are issue throughout the period of inspection
  - a small black fridge located on Lower Level of the home in front of the nursing station was found to have food not dated, was unclean and had several empty and soiled containers within it
  - flooring on Level 1 was noted to have accumulated grime build up throughout the hallways and into resident rooms
  - service doors have accumulated grime build up where staff push the doors open; i.e door to kitchen, door to stairwell [s. 229. (4)]

Issued on this 12th day of December, 2014

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) :	MONIQUE BERGER (151), FRANCA MCMILLAN (544), MONIKA GRAY (594)
Inspection No. / No de l'inspection :	2014_395151_0009
Log No. / Registre no:	S-000483-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 12, 2014
Licensee / Titulaire de permis :	MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT 70 Robinson Street, Postal Bag 460, LITTLE CURRENT, ON, P0P-1K0
LTC Home / Foyer de SLD :	MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED 70 ROBINSON STREET, POSTAL BAG 460, LITTLE CURRENT, ON, P0P-1K0
	CAROL MCIIVEEN

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

Name of Administrator /
Nom de l'administratrice ou de l'administrateur :

To MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT, 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)

Linked to Existing Order / Lien vers ordre existant: 2013_139163_0003, 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 shall ensure compliance with s.8.(3) fo the Act. The home is required to develop, implement and submit a plan on how they will ensure that at least one registered nurse is both and 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. This plan is to be submitted by December 19, 2014. Date for compliance with Act. s.8.(3) is January 19, 2015. The plan is to be submitted via e-mail to : gail.peplinskie@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Inspector 151 conducted a follow-up inspection with reference to S-000046-13 and Ministry report to the home 2013-139163-003. The report ordered the home to become compliant with the requirement to provide 24/7 on-site Registered Nurse coverage. The home was given a compliance date of April 2013.

Inspector 151 audited the home's staff schedules for September, October and November 2014 and noted that, in total, the home had a shortfall of 124 hours where there was no Registered Nurse in the home. Inspector noted that 80% of these hours occurred on night shift.

Inspector reviewed the home's annual review of the staffing plan dated November 3, 2014. Inspector noted the following statement: "Upon review of our annual master schedule or the Registered Staff department, we noticed that the 24/7 requirements were not being fulfilled" (151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 19, 2014

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2013_139163_0017, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents and staff are protected from abuse by resident # 100. The plan is to be submitted to Gail Peplinskie by December 19, 2014; e-mail address: gail.peplinskie@ontario.ca. Compliance to this order is due December 19, 2014

Grounds / Motifs :

1. Inspector 151 did a follow-up inspection on a previous Order regarding this resident. The critical incident referenced in the Order (report #2013-139163-007) recounted that the resident had exhibited inappropriate behaviours towards residents on several occasions after the initial Critical Incident report was filed with the Ministry. In addition, and according to the report, inspectors noted that staff did not follow the plan of care for this focus of behaviour.

Inspector reviewed the resident's health care records and noted that there was no focus for the identified responsive behaviours towards others in the current plan of care. Director of Care confirmed that the issue of inappropriate sexual behaviour was deemed to be resolved as the resident no longer demonstrated this behaviour.

Inspector reviewed the resident's health care records further and noted the following;
- On the current plan of care, there is one mention that the resident continues to exhibit the identified responsive behaviour, however, the plan of care had no focus, goals or interventions in regards to the management of the behaviours.
- The Responsive Behaviour Record of September 27, 2014 recorded an instance of the identified responsive
- The current Responsive Behaviour Record shows that since Aug. 22, 2014, the resident has had 6 episodes of responsive behaviours where staff were physically abused by the resident

In an interview with Inspector, Staff #206 confirmed that the resident continues to exhibit the identified behaviour.

Inspector did multiple observations of the resident and noticed that the resident was left in unsupervised areas where other residents collected for protracted periods of time; i.e.in the dining room lounge from noon until 1500 h

(151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 19, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that will ensure that for residents #05430, #00100,# 05469. #5363 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. The plan is to be submitted by December 19, 2014 via e-mail to; gail.peplinskie@ontario.ca. The compliance plan for this order is December 19, 2014

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident s. 6. (1) (c)

Inspector 151 did a follow-up inspection on an outstanding order regarding resident #100. The critical incident referenced in the inspection report #2013-139163-007 recounted that the resident had exhibited responsive behaviours towards residents on several occasions after the initial Critical Incident report was filed with the Ministry. In addition, and according to the report, inspectors noted that staff did not follow the plan of care for this focus of behaviour.

Inspector reviewed the resident's health care records and noted that there was no focus of the identified responsive behaviour in the current plan of care. Director of Care confirmed that the issue of identified responsive behaviour was deemed to be resolved on August 22, 2014 as the resident no longer demonstrated this behaviour.

Inspector reviewed the resident's health care records further and noted the following;
- on the current plan of care, the resident had no focus, goals or interventions in regards to the management of the identified responsive behaviour, even though, under the bathing section, there is a notation that the resident still exhibited the identified responsive behaviour.
- the Responsive Behaviour Record of September 27, 2014 recounted an episode where the resident exhibited the responsive behaviour towards a staff member.
- the current Responsive Behaviour Record that shows that since Aug. 22, 2014, the resident has had 6 episodes where physical responsive behaviour was directed to staff.
In an interview with the Inspector, Staff #206 confirmed that the resident continues to exhibit the identified responsive behaviour.

Inspector did multiple observations of the resident and noted that the resident was left in unsupervised areas where other residents collected for protracted periods of time; i.e.in the dining room lounge from noon until 1500 h.

There is no direction to staff regarding resident #0100's responsive behaviour in the plan of care.

(151)

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

Inspector # 544 reviewed Resident # 5430's plan and care and identified that there was no focus, goals or interventions for the resident's altered skin and wound issue.

Inspector reviewed Resident # 5430's Treatment Administration Record (TAR) and noted this record contained a physician's order for treatment of this wound. This treatment was not identified on the plan of care.

Inspector #544 did not find any record in the resident's health care record that indicated that the resident was in receipt of the treatment at any time, even though this condition was noted in progress notes 3 times in September, 2014

Inspector 544 audited the TAR for the month of August 2014 and noted that the treatment) was not documented as being done on any day of that month. Review of the resident's progress notes showed that condition was documented in progress notes 4 times during the month.
(544)

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Resident #5469

As a result of Stage 1 Inspection activities during the Resident Quality Inspection, MDS triggered "dental care lacking" for Resident # 5469. This issue was also confirmed through a family interview that was conducted by Inspector #544.

In an interview with Inspector 544, Resident # 5469's family member confirmed visiting the resident on a daily basis and on most of the visits, the resident is in need of mouth care. Both the family member and the resident have made a request of staff for oral care after every meal.

Inspector # 544 reviewed Resident # 5469's most recent plan of care dated and identified that there was no focus, goal or interventions for oral/dental care. Upon further review of the plan of care states under the focus, "ADL-PERSONAL HYGIENE- "Potential for complication in regards to poor balance ." Under the goal for this section, it is written, "[resident] will be able to complete mouth care after meals with set up assistance from staff through next review date". This same goal is written in the exact same place and in the exact same words in the previous plan of care. There was no separate focus, goal or interventions for oral care in the current plan of care and as a result there were no corresponding interventions linked to the resident's and family member's request.

In an interview with Inspector 544, Staff # 207 confirmed; "there should be a separate focus for oral/dental care on the plan of care with goals and interventions". In an interview with the Inspector, Staff #205 also confirmed that oral and dental care should have been a distinct focus for Resident #5469's plan

of care.

(544)

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

Inspector# 544 inspected on several MDS triggered issues involving decline in communication abilities in residents. In tandem with the home's RAI/MDS Co-ordinator, Inspector 544 reviewed the residents health care information which led to the MDS triggers

For Resident # 5463, it was noted that MDS assessments identified the resident as having clear speech on previous assessments until November 2014 where the resident was identified to have had a decline in this ability of "clear speech" to now having "unclear speech". Through staff interviews, it was confirmed that the resident had suffered a decline in health condition where now the resident spoke only in mumbles and whispers.
Inspector # 544 could find no documentation in Resident # 5463 health care records to support the stated decline in communication, nor was this decline in communication found as a focus in the resident's plan of care. In an interview with Inspector 544, RAI/MDS Co-ordinator confirmed that this decline in communication was not reflected in the care plan and should have been immediately following the MDS coding of decline in communication.

(544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 19, 2014

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that will ensure that resident's exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, 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 and that, when clinically indicated, these residents' wounds are reassessed at least weekly by a member of the registered staff. The plan is to be submitted by December 19, 2014 via e-mail to; gail.peplinskie@ontario.ca. The compliance date for the plan is January 19, 2015

Grounds / Motifs :

1. Inspector # 544 reviewed Resident # 05430 health care records including progress notes and assessments for November 2014 and identified that on November 6, 2014, Resident # 05430 sustained a small cut to the left great toe .

Inspector # 544 could find no documentation or initial assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment in regards to this wound. Inspector did note a progress note that referenced that the home's wound care protocol was initiated:" [resident] sustained a small cut to Great (L) toe last evening. Wound Care Protocol (WCP) was initiated, and a referral was sent to the dietitian".

In an interview, both Staff #201 and #205 confirmed that no initial assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was completed for this resident.
(544)

2. The licensee has failed to ensure that Resident # 5458 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.

As a result of Stage 1 Inspection activities, Inspector # 544 interviewed Resident #05458 and in the process, observed several open areas and abrasions. Inspector 544 reviewed the resident's health care records with a focus of skin and wound care and noted that in regards to the resident's current lesions, no documentation was found that would support that an initial skin and wound

assessment was completed by a Registered Nursing Staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In addition, Inspector #544 did not find any skin and wound assessments completed for Resident #05458 from September 2, 2013 to September 25, 2014, however, review of the health care records showed the following:

- Progress note of September, 2013, documented Resident # 5458 had altered skin integrity issue. Inspector noted that the RN did an assessment of the wound but did not complete an initial skin wound assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In an interview with the Inspector, Staff #205 confirmed that the clinical tool was not utilized.

- Progress note of February, 2014, documented that Resident # 5458 had altered skin integrity. Inspector could find no documentation in the health care record to support that an RN nursing staff assessed the wound initially, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In an interview with Inspector 544, Staff #205 confirmed that the wound was not assessed as per the home's clinical tool.

- Progress notes of February , 2014, documented another incident of altered skin integrity. Inspector could not find any documentation in the resident's health care record to support that an RN assessed the wound initially, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In an interview with Inspector 544, Staff #205 confirmed that no assessment was done.

- Progress note of August, 2014, documented that Resident # 05458 had an incident of altered skin integrity. Inspector could not find any documentation in the health care record to support that an RN assessed the wound initially, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. In an interview with Inspector 544, Staff #205 confirmed that no assessment was done.

- Progress note of September, 2014, documented Resident #05458 had an incident of altered skin integrity. Inspector could not find any documentation in the health care record to support that an RN assessed the wound initially, using a clinically appropriate assessment instrument that is specifically designed for

skin and wound. In an interview with Inspector 544, Staff #205 confirmed that no assessment was done.

Inspector 544 reviewed the above information with the Director of Care who confirmed that in each instance the initial skin/wound assessments should have been completed.

(544)

3. The licensee has failed to ensure that Resident # 05430, 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.

Inspector # 544 reviewed the health care records for resident #05430: specifically with a focus for progress notes relating to skin and wound care. Inspector audited these progress notes from January 20, 2014 to November 29, 2014. Inspector noted 3 separate recorded altered skin breakdown events.

For each of these incidents, Inspector 544 could find no documentation in Resident # 5430's health care record that indicated that an initial skin and wound assessment was completed by member of the registered staff.

In an interview with the Inspector, for each of the sited examples Staff #201 and #205 confirmed that no assessment was done.

(544)

4. The licensee has failed to ensure that Resident # 05427, 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.

Inspector 544 reviewed Resident # 5427 health care record and noted that the resident had developed a an issue of altered skin integrity in November, 2014. Inspector noted that the physician had ordered a wound care protocol regime to manage this wound. Inspector # 544 could find no documentation on Resident # 5427's health care record regarding neither an initial assessment for this wound nor weekly assessments thereafter.

Staff #201 and Staff #205 confirmed that an initial wound and skin assessment was not completed for Resident # 5427's new wound.

(544)

5. The licensee has failed to ensure that Resident # 05430, exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff.

Inspector reviewed the health care records for resident #05430 and noted that in November, 2014, resident exhibited altered skin integrity. The progress note states that a referral was sent to the dietitian, wound care protocol was initiated. Inspector # 544 could find no documentation on Resident # 5430's health care record supporting weekly skin and wound assessments were completed. In an interview with Inspector 544, DOC and Staff #205 confirmed that weekly skin and wound assessments for this resident were not completed.
(544)

6. The licensee has failed to ensure that Resident # 5458, exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Inspector # 544 interviewed Resident # 5458 and identified several open areas and abrasions .Inspector # 544 could not find any documentation that could support weekly skin and wound assessments were completed by a Registered Nursing Staff.

In addition, Inspector 544 could find no documentation to support that weekly skin and wound assessments were done by a member of the registered staff for the f5 other incidents of altered skin integrity documented in progress notes

In an interview with the Inspector, DOC and Staff #205 confirmed that weekly skin assessments by a member of the registered staff were not completed but should have been for all the above stated examples.

(544)

7. Inspector 544 reviewed Resident #05430's health care records: including skin and wound care progress notes and all nursing progress notes from January 20, 2014 to November 29, 2014. Inspector noted 3 separate incidents where resident experienced altered skin integrity

For all the above examples, Inspector # Inspector # 544 could not find any documentation in Resident # 5430's health care record that weekly skin and wound assessments were completed by registered staff. In an interview with Inspector 544, DOC and Staff #205 confirmed that weekly skin and wound assessments for this resident were not completed.

In addition, resident has a current lesion and this lesion has worsened over time. Inspector 544 noted that the physician has ordered a wound skin protocol for the care of the lesion. Inspector 544 reviewed the resident 's health care record in regards to this wound and found the last skin and wound assessment to be dated in October, 2014. Inspector could not find any document to support that the resident was receiving weekly skin assessments by a member of the registered staff.

In an interview with Inspector 544, DOC and Staff #205 confirmed that weekly skin and wound assessments for this resident and this wound were not completed.
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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

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(544)

8. The licensee has failed to ensure that Resident # 05427, 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.

Inspector 544 reviewed Resident # 5427 health care record and noted that the resident had developed an issue of altered skin integrity in November, 2014. Inspector noted that the physician had ordered a wound care protocol regime to manage this wound. Inspector # 544 could find no documentation on Resident # 5427's health care record regarding neither an initial assessment for this wound nor weekly assessments thereafter.

Staff #201 and Staff #205 confirmed that an initial wound and skin assessment was not completed for Resident # 5427's new wound.

(544)

Ontario

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This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 19, 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 12th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MONIQUE BERGER

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