Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 1, 2015	2015_332575_0019	015796-15	Resident Quality Inspection

Licensee/Titulaire de permis

The Board of Management for the District of Manitoulin
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

LINDSAY DYRDA (575), CHAD CAMPS (609), FRANCA MCMILLAN (544), TIFFANY BOUCHER (543)

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): October 26-30 and November 2-4, 2015

During the course of the inspection, two critical incidents and a follow up to three previous compliance orders were also inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI-MDS Coordinator, Maintenance staff, Office and Administrative staff, Physiotherapy staff, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, Activity staff, Family Members, and Residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **13 VPC(s)**
- **0 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. 19. (1)	CO #003	2015_380593_0005	544
O.Reg 79/10 s. 50. (2)	CO #002	2015_380593_0005	544
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2015_380593_0005	575

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #001's plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During an interview, resident #001 told Inspector #544, that at times they felt staff rushed them when they attended to their care needs and that staff were not aware of their preferences. Resident #001 told the inspector of their specific care routines.

Inspector #544 reviewed resident #001's care plan and the inspector noted that the tasks and preferences that the resident stated were not identified in the resident's plan of care.

Inspector #544 interviewed S #103 and S #104 and they confirmed that these routines and preferences were to be respected when providing care to resident #001. They also confirmed that new staff are not always aware of these routines and preferences and must be directed by senior staff to follow the resident's preferences.

Inspector #544 interviewed the DOC who confirmed that these care needs, tasks and preferences were not outlined in resident #001's care plan. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in resident #008's plan of care was provided as specified in the plan.

Inspector #609 and #575 spoke with resident #008's family, who stated that staff do not assist the resident with mouth care, specifically with brushing their teeth after each meal. The resident's family member stated that in terms of cleaning the resident's teeth, it was difficult for the resident to perform this task independently due to environmental issues.

Inspector #543 reviewed the resident's most recent plan of care specifically related to mouth care. The plan of care indicated that resident #008's oral/dental status had physiological changes related to the aging process, that the resident required the use of dentures and that food particles remained in the resident's mouth after eating. The goal identified that the resident's mouth would be cleaned daily after every meal. Staff were to provide the resident assistance after every meal.

On November 3 and 4, 2015, the inspector observed S #108 assist resident #008 to bed after lunch. The inspector did not observe any mouth care performed after lunch on either day.

On November 3, 2015, Inspector #543 spoke with S #105 and S #108 regarding mouth care for resident #008 after every meal. S #105 and S #108 stated that they do not assist the resident with their mouth care after meals and that the resident would perform mouth care independently.

Inspector #543 reviewed resident #008's most recent plan of care specifically related to toileting. The plan of care identified that the resident required the assistance of staff to support the resident in improving their bladder control with a scheduled toileting routine. The resident was to be toileted in the morning, before and after meals, and at bedtime with extensive assistance of one staff member.

On November 4, 2015, Inspector #543 spoke with S #108 regarding the toileting needs for this resident. They stated that the resident was toileted in the morning and at bedtime, as well as after meals (and any other time required). On this day, the inspector informed S #108 that they observed resident #008 transferred to their bed after lunch and the inspector did not see the resident toileted nor did the inspector observe the staff member ask the resident if they needed to be toileted. S #108 indicated that they thought another PSW may have toileted the resident after lunch. The inspector spoke with S #121 who reported that they had not toileted the resident after lunch. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the care set out in the plan of care is provided to resident #008 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On October 26 and 29, 2015, Inspector #575 observed one half and one quarter bed rail in the up position on resident #003's bed. During interviews, S #105 and S #112 indicated to the inspector that resident #003 was able to get in and out of bed independently with the bed rails engaged (up).

On October 28 and 29, 2015, Inspector #609 and #575 observed one half and one quarter bed rail in the up position on resident #005's bed. During interviews, S #113 indicated to the inspector that resident #005 had one half and one quarter bed rail in the up position.

On November 2 and 3, 2015, Inspector #543 observed resident #008's bed rails. It was noted that one bed rail was in the down position and one bed rail was in the up position (assist position). The inspector spoke with S #108 regarding the use of bed rails for resident #008 who stated that the one bed rail remained in the down position, for safety purposes and the one bed rail remained in the up position, for transferring and repositioning.

Inspector #575 interviewed the DOC regarding the use of bed rails. The DOC indicated that the use of bed rails were determined upon admission. If a resident was cognitively well, the home would ask the resident if they wanted bed rails; if the resident was not cognitively well, assessments were conducted based on the resident's mobility. The DOC informed the inspector that the home had not completed bed system evaluations for residents using bed rails and the home did not have the required tools to perform entrapment testing.

The inspector reviewed a memo from the Ministry of Health and Long-Term Care dated August 21, 2012 sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document outlines entrapment testing zones, required tools (cone and cylinder, spring scale), side rail height, side rail latch reliability requirements and test methods, mattress compatibility
information, other hazards, etc. [s. 15.(1)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On October 30, 2015, Inspector #609 entered the home's main reception/lobby area observed a resident in distress. The resident was unsupervised and unattended and the inspector searched for a resident-staff communication and response station in the lobby to call for assistance and could not locate one.

In an interview, S #109 and S #110 confirmed that there was no resident-staff communication and response station in the reception/lobby area and confirmed that residents have fallen in that area previously and that there was no way for the residents who required assistance in the area to call for help.

A review of the location of all falls entered into Risk Management on Point Click Care (PCC) for a period of approximately one year, revealed that two residents had fallen in the reception/lobby area.

Observations made throughout the course of the inspection revealed that residents used the reception/lobby throughout the day as a congregate area.

In an interview, the Administrator confirmed that residents had fallen in the reception/lobby, that it was the expectation of the home that the resident-staff communication and response system was available in every area accessible by residents, that there was no resident-staff communication and response stations in the reception/lobby area and should be. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to minimize the restraining of residents was complied with.

On October 27, 2015, Inspector #609 observed resident #005 in a wheelchair with a device applied. On four additional occasions, Inspector #575 observed resident #005 in a wheelchair with the same device applied. S #105 confirmed to Inspector #575 that the device was used as a restraint for the resident.

The inspector reviewed the resident's health care record regarding the device. The inspector noted that the resident was initially ordered the restraint upon admission and the device was not included on the most recent medication review. S #105 indicated that the order was recently added to the online Medication Administration Record (MAR). The home's policy titled 'Physical Restraints, #RESI-10-01-01' effective November 2012 indicated that the restraint order was to be reassessed and reordered every three months as part of the quarterly medication and treatment review. The DOC confirmed that the restraint was not re-ordered since admission, however it had been used since admission.

The home's policy also indicated that a restraint assessment was to be completed prior to the implementation of a restraint. The inspector was provided resident #005's restraint assessment dated approximately three weeks after the resident's admission. S #105 confirmed to the inspector that the resident's restraint was initiated upon admission and the DOC confirmed that the assessment should have been completed prior to the application of the restraint.

S #113 told the inspector that the PSWs are to indicate on the restraint record when a restraint is applied, when the resident was repositioned, and when the restraint was removed. The inspector reviewed the restraint record for resident #005 for a period of 28 days. The inspector noted on multiple occasions the repositioning of the resident was

not included and staff were using codes not on the legend. The DOC confirmed that the staff were not completing the restraint record properly and that they were not documenting all repositioning and were using codes not included on the legend. During the inspection, the inspector reviewed the resident's restraint record and noted that the record was completed for a period of time that had not occurred yet, indicating that the resident was repositioned and checked hourly. The inspector reported and showed the restraint record that was initialed before the care was provided, to the DOC, who confirmed that was not correct practice. The home's policy stated that staff are to ensure the restraint record is completed with hourly safety checks and two hour position changes which required the release of the restraint and this was to be documented on the restraint record. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

During an interview on October 26, 2015, S #111 indicated to Inspector #609 that resident #005 did not receive nutrition interventions for weight gain.

On October 29, 2015, Inspector #575 reviewed the resident's health care record. The inspector noted a physician's order for an intervention required during afternoon nourishment. The resident's progress notes entered by the RD were reviewed from admission to present. A progress note indicated that the order remained for the nourishment intervention, however upon audit, noted that resident #005 was not receiving the intervention. The RD requested the Dietary Manager to re-initiate the supplement. The resident's most recent MDS RAPS were reviewed. The RD noted that the resident continued to receive the intervention during afternoon nourishment, which staff verbally reported, however there was no documentation that the intervention was provided.

During an interview, the DOC indicated that the resident's nourishment intervention should be recorded on the food and fluid record under 'labelled item at nourishment'. The inspector and DOC reviewed the resident's food and fluid record for a period of 28 days. During this time, it was only recorded that the resident received the nourishment on one occasion. The RD confirmed to the inspector that the nourishment intervention was not documented as required which made it difficult to determine if the intervention was given. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001, #008, and #012 were bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On October 27, 2015, resident #001 told Inspector #544 that they had missed 2-3 baths in the last two months.

Inspector #575 conducted an audit of the resident's health care record regarding bathing. The inspector reviewed the bath list and noted the resident's scheduled bath days. The PSW flow sheets for a period of approximately three months were reviewed. According to the documentation, during this time, the resident did not receive 7/27 scheduled baths. The resident's current care plan indicated that resident #001 would be bathed two times per week with extensive assistance of two staff.

Inspector #575 and #543 conducted an audit of two other resident's health care records regarding bathing: Resident #012's and resident #008. The PSW flow sheets for a period of three months were reviewed. According to the documentation, during this time, resident #012 did not receive 2/26 scheduled baths. The resident's current care plan indicated that resident #012 would be bathed two times per week with extensive assistance of two staff; The PSW flow sheets for a period of three months were reviewed for resident #008. According to the documentation, during this time, the resident did not receive a bath on five occasions. The resident's current care plan indicated that resident #008 required extensive assistance by two staff members for the bathing process.

Inspector #543 spoke with S #121 regarding documentation related to bathing who confirmed that staff would document on the flow sheet when a bath is completed. If for some reason the resident's bath was not done, they would not check off the bath portion on the flow sheet and there was no further documentation recorded elsewhere in the resident's health care record. The DOC reported that if the baths were not documented then they were not done. The DOC provided the policy titled 'Personal Hygiene/Grooming, Bathing, #RESI-05-07-23' revised August 2006 that indicated staff are to document the care provided on the daily care record. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring.

Observations during Stage 1 of the Resident Quality Inspection (RQI) revealed 15 out of 34 shared resident bathrooms or 44 per cent had unlabelled personal aids from toothbrushes, brushes, denture cups, razors to respiratory supplies in an unlabelled kidney basin.

In an interview, the DOC confirmed that it was the expectation that all personal aids such as dentures, glasses and hearing aids, were labelled within 48 hours of admission and in the case of new items, of acquiring, and that in the case of the 15 cited shared resident bathrooms this did not occur and should have. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Upon admission, a continence care and bowel management assessment was completed for resident #002 which indicated that the resident was continent. Another assessment was then completed approximately six months later which identified that the resident was occasionally incontinent of urine.

Inspector #544 reviewed the progress notes and most recent MDS assessment for the resident which indicated that the resident was frequently incontinent.

Inspector #544 interviewed the DOC who confirmed that a continence care and bowel assessment should have been completed when the resident returned from the hospital approximately two years after the last assessment was completed as there was a significant change in the resident's bowel and bladder routine. The DOC and S #110 confirmed that resident #002 was frequently incontinent and an assessment was not completed. [s. 51. (2) (a)]

2. The licensee has failed to ensure that resident #005 who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

During the inspection, it was identified that resident #005 was incontinent. Inspector #575 reviewed the resident's MDS assessment that indicated the resident was occasionally incontinent of bowel and frequently incontinent of bladder. During an interview, S #105 indicated that continence assessments are sometimes on paper and sometimes online. The inspector and S #105 reviewed the resident's health care record and did not locate a continence assessment for resident #005.

On October 29, 2015, the DOC confirmed during an interview that resident #005 did not have a bowel or bladder assessment upon admission and that the resident still required the assessment to be completed. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, and the assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 with a weight change of 7.5 per cent of body weight, or more, over three months was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

During an interview on October 26, 2015, S #111 indicated to inspector #609 that resident #005 did not receive nutrition interventions for weight gain. On October 28, 2015, Inspector #575 reviewed the resident's health care record. The inspector noted a physician order for an intervention required at afternoon nourishment. The inspector reviewed the MDS assessment notes which indicated that the resident received the intervention once daily to support gradual weight gain.

The inspector reviewed the resident's recorded weights for a period of approximately six months. During this time, the resident had a -9.5% weight loss in a three month period. During an interview with the RD, they indicated that when there was a significant weight change, the registered staff are to send a referral through PCC to the RD informing them of the weight change. The RD confirmed that no referral was sent for this weight change. S #105 confirmed that registered staff should have sent a referral for the weight change and that it was not done.

The home's policy titled 'Changes in Resident Weight, #RESI-05-02-07' reviewed December 2002, indicated that registered staff are to report significant weight changes to the Physician and RD/Dietary Manager, record in the resident's progress notes, on 24-hour report and weight communication sheet. The inspector reviewed the resident's progress notes and noted there was no progress notes regarding the resident's weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month;
2. A change of 7.5 per cent of body weight, or more, over three months;
3. A change of 10 per cent of body weight, or more, over six months;
4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance regarding the communication and response system.

A Critical Incident (CI) Report was submitted to the Director on March 5, 2015, which revealed the communication and response system failed. The system was then repaired on March 12, 2015.

A second CI Report was submitted to the Director on March 26, 2015, which revealed the communication and response system failed again from March 25, 2015 to April 30, 2015 when an outside contractor repaired the malfunctioning communication and response system.

An interview with maintenance staff #100 revealed that since the repair of the communication and response system on April 30, 2015, there have been no audits of the communication and response system to verify that the system was functioning properly. S #100 revealed that the home relied on staff to alert maintenance of any malfunction in the communication and response system.

An interview with the Administrator confirmed that it was the expectation of the home that there were schedules and procedures in place for routine, preventive and remedial maintenance, that the communication and response system was not a component of the preventative maintenance schedule and should have been. [s. 90. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there are schedules and procedures in place for routine, preventative and remedial maintenance regarding the communication and response system, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours.

On October 27, 2015, Inspector #609 observed resident #005 in a wheelchair with a device applied. On October 29, 30 and November 2, 3, 2015, Inspector #575 observed resident #005 in a wheelchair with the same device applied. S #105 confirmed to Inspector #575 that the device was a restraint for the resident.

During an interview, the DOC indicated that the registered staff sign the restraint record each shift to identify that the restraint had been reassessed and continued to be effective. The inspector reviewed the restraint record for a period of 28 days and on 10 occasions there was no signature by registered staff. The DOC confirmed that the registered staff did not fill out the restraint record as required to identify that the restraint had been assessed and continued to be effective. [s. 110. (2) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where a resident is being restrained by a physical device, the resident's condition is reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the mandatory training for direct care staff for the 2014 year revealed that 26 of 42 staff or 62 per cent did not complete the home's training in continence care and bowel management.

An interview with the Administrator confirmed that it was the expectation that all direct care staff were to complete the mandatory training in continence care and bowel management, that in the case of the 2014 mandatory training this did not occur and should have. [s. 221. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that continence care and bowel management training is provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #13: 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.

A review of the home's policy titled 'Practising Hand Hygiene' last updated September 2015, required staff to perform hand hygiene before and after contact with any resident, their body substances or items contaminated by them.

On October 29, 2015, observations of two morning snack programs on two units of the home, revealed that no hand hygiene was performed before or after going into resident rooms with snacks and fluids, assisting residents to consume their snacks and fluids or when removing dirty dishes from the resident rooms.

In an interview, S #106 confirmed that it was the expectation that PSWs performed hand hygiene between resident rooms during the morning snack program.

In an interview, the DOC confirmed that it was the expectation that all staff were to perform hand hygiene before and after contact with any resident, their body substances or items contaminated by them, that in the case of the two observed morning snack programs this did not occur and should have. [s. 229. (4)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that if there was no Family Council, the licensee convenes semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

On October 28, 2015, Inspector #575 interviewed the Administrator regarding the Family Council. The Administrator confirmed that the home did not have a Family Council and that the home did not convene semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee failed to ensure that the records of the residents of the home are kept at the home.

On November 3, 2015, Inspector #575 asked S #118 where the residents' initial physiotherapy assessments were located. S #118 indicated that they were in a binder that was not currently in the home. S #118 indicated that they would return the binder to the home the following day.

On November 4, 2015, the inspector interviewed the DOC regarding the physiotherapy assessments. The DOC indicated that S #118 was no longer a staff member of the home and that they were in on November 3, 2015 to provide training to the new Physiotherapist. The DOC was not sure why S #118 took the assessments out of the home and indicated that the assessments should have not been removed from the home.

As of 1400 hours on November 4, 2015, the records were still not available in the home. [s. 232.]

Issued on this 3rd day of December, 2015

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

Original report signed by the inspector.