Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 24, 2015	2015_157210_0004	T-1710-15	Resident Quality Inspection

Licensee/Titulaire de permis

MARKHAVEN, INC.
54 PARKWAY AVENUE MARKHAM ON L3P 2G4

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

MARKHAVEN, INC.
54 PARKWAY AVENUE MARKHAM ON L3P 2G4

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

SLAVICA VUCKO (210), JUDITH HART (513), SARAH KENNEDY (605), SHIHANA RUMZI (604)

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): February 18, 19, 20, 23, 24, 26, 27 , March 2, 3, 2015

The following complaint intake inspection was completed during this inspection: T-1512-14.

During the course of the inspection, the inspector(s) spoke with personal support workers(PSW), registered practical nurses (RPN), registered nurses (RN), acting director of care (DOC), administrator, physiotherapist (PT), director of personal support services, dietary aid, registered dietitian (RD), program assistants, maintenance manager, housekeepers, RAI MDS coordinator, clinical support nurse manager, resident services manager, residents, families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

17 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that height for every resident is measured annually.

Record review revealed that the following residents did not have their height measured since the following dates:

#001 - February 2014
#008 - October 2013
#011 - January 2014
#013 - October 2013
#016 - October 2013

A registered staff member indicated that the expectation is heights to be measured on an annual basis and confirmed that the heights were not collected annually. [s. 68. (2) (e) (ii)]

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 height for every resident is measured annually, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the clinical records and interview with clinical nurse manager indicated the fist floor of the facility was declared in respiratory outbreak by Public Health on December 19, 2014.

A public health nurse attended the outbreak meeting on December 19, 2014, and gave the following written direction: "ensure that antiviral treatment is started as soon as possible and no later than 48 hours after the onset of symptoms. If the outbreak continues to the end of the treatment period and antiviral prophylaxis is being used for well residents, restart prophylaxys and continue for the duration of the outbreak. Ensure that well residents receive antiviral prophylaxis as soon possible, regardless of vaccination status. Continue until outbreak is over."

Review of the respiratory outbreak line-listing indicated there were 11 residents affected on the north unit and one on the south unit. Review of the clinical records of the affected residents and interview with the clinical nurse manager confirmed that only two residents who were confirmed positive for influenza by lab results were treated with antiviral treatment dose, whereas the rest of the residents who were on the respiratory outbreak line-listing with signs and symptoms of influenza were treated with a prophylactic dose instead of a treatment dose.

Interview with the clinical nurse manager and the public health nurse and review of the clinical records confirmed that the directions from Public Health for antiviral drug administration were not followed accordingly. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 plan of care sets out clear directions to staff and others who provide direct care to the resident.

Review of the written plan of care for resident #9 indicated the resident had impaired vision and the interventions were: "corrective lens (refuse to wear), to ensure that there is adequate lighting in the room, to be able to see people and things around her, monitor/document/report to MD the following signs and symptoms of acute eye problems: change in ability to perform activity of daily living, decline in mobility, sudden visual loss, pupils dilated, gray or milky, complain of halos around lights, double vision, tunnel vision, blurred or hazy vision."

Interview with the PSW revealed the resident did not wear corrective lenses nor use any other visual appliances.

Review of the clinical record indicated that the resident was seen by optometrist on an identified date in 2012, and report stated that the resident had vision problems in one of the eyes because of disease that is not treatable, and reduced vision.

Review of the clinical record and interview with the registered nursing staff confirmed that the written plan of care did not give clear direction in regards to the vision. [s. 6. (1) (c)]

2. Interviews with PSWs revealed that staff providing direct care to resident #013 were not aware of his/her risk for falls.

Record review revealed that resident #013 had a fall on an identified date in 2014, and a subsequent fall on an identified date in 2015. After the initial fall in 2014, a post falls assessment was completed as per the policy "Falls Prevention Program", revised February 2014. Interventions to prevent falls were recommended by the physiotherapist and these recommendations were not updated in the resident's written plan of care.

Interview with the clinical nurse manager indicated the expectation is the written plan of care be updated so that staff are provided with clear direction and are aware of any interventions in place to minimize risk for falls.

Interview with registered nursing staff confirmed that resident #013's written plan of care was not updated after the initial fall. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of the clinical record for resident #6 indicated the resident was prescribed a medication for seven days, and to be reassessed in seven days. Review of the progress notes for the period when the medication was given indicated the resident temperature was checked and it was documented that no signs and symptoms of distress were noted. Review of the progress notes indicated on an identified date in 2014, the foot care nurse documented that there was drainage from the wound on one of the toes; the wound was cleansed, dressing was applied and staff was advised.

Further review of progress notes revealed on identified date in 2014, the resident started having hoarse voice, coughing, and the temperature was checked every day. On

December 19, 2014, the facility (first floor units) was declared in respiratory outbreak.

The clinical nurse manager provided to the inspector a monthly infection statistics collected by the infection prevention and control (IPAC) leader that indicated, in the period before the outbreak was declared, resident #6 was treated because of skin infection.

Interview with identified registered nursing staff and the clinical nurse manager, and review of the clinical records were not able to identify why the resident was started on antibiotic nor what needed to be reassessed.

Review of the clinical record and interview with registered nursing staff indicated resident #6 had skin problems on the foot and was treated on identified dates in 2014.

Review of the skin and wound program policy indicated the skin care coordinator should be notified of new lesions and the skin care coordinator will assess for a therapeutic surface.

Interview with the skin care coordinator confirmed that he/she was not notified nor was made aware that resident #6 had skin problems on identified dates in 2014. [s. 6. (4) (a)]

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

Observation conducted on an identified date in February 2015, at 12:00 p.m. revealed that resident #021 did not receive certain nutrient with lunch and that a staff member assisting resident #022 with eating was not using a utensil as per the plan of care.

Interview with the cook and an identified registered staff member confirmed that resident #021 should receive the certain nutrient with all meals and that the resident should be assisted with feeding using the appropriate utensil. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a policy put in place is in compliance in accordance with all applicable requirements under the act.

A review of the policy 'Admission Height', revised June 2014, stated that resident height needs to be recorded upon admission. There is no mention in the policy about collecting resident heights on an annual basis thereafter.

An interview with the Nurse Supervisor confirmed that the policy does not include collecting heights annually and the policy is not in compliance with all applicable requirements under the act. [s. 8. (1) (a)]

2. The licensee has failed to ensure that any policy put in place is complied with.

A record review revealed that resident #001 was weighed on an identified date in 2015, which indicated a 15.5% weight loss in one month. The resident was re-weighed 21 days later and his/her weight was approximately the same as the previous month weight.

A review of the policy "Resident Weight Monitoring", revised June 2014, stated that for any weight change of 5% or more than 2.0 kg from the previous month the PSW must re-weight the resident on the same shift.

Review of the clinical record and interview with a registered staff member confirmed that resident #001 was not re-weighed on the same day and that the policy was not complied with. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways or doors that residents do not have access to are kept closed and locked.

On an identified date in February 2015, inspector #604 found the 2nd floor C-2 exit door leading to stairs to be unlocked as the pin pad on the door was not locking.

Acting director of care and HR/business manager were informed and both confirmed that five out of six times the door did not lock therefore residents had access to stairways. The door was fixed to work properly immediately. [s. 9. (1) 1.]

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 equipment is kept clean and sanitary.

Observation performed on a specified date and time indicated resident #008's wheelchair seat and wheelchair foot supports were soiled with white particles. On a later specified date and time resident #008's wheelchair seat and wheelchair foot supports continued to be soiled with white particles and additional white streaks.

A review of the "Wheelchair/Walker Cleaning Schedule" revealed that resident #008's wheelchair was not on the list of equipment to be cleaned. The identified registered staff member confirmed that resident #008 was not included on the "Wheelchair/Walker Cleaning Schedule". The staff member stated that the expectation is for resident #008's wheelchair to be identified on the cleaning schedule to ensure that the wheelchair stays clean and sanitary.

Observation and interview with an identified registered staff member confirmed that resident #008's personal equipment was not clean. [s. 15. (2) (a)]

WN #7: 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 home is equipped with a resident-staff communication and response system that can be used by residents, staff and visitors at all times.

On February 20, 2015, at 10:21 a.m. it was observed that one call bell was jammed and not functioning at all.

An interview with an identified registered staff member confirmed that the call bell was not functioning and that the expectation is that it can be used at all times. The call bell was fixed immediately. [s. 17. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for the skin and wound management program, that there is a written description of the program that includes protocols for referral of resident to specialized resources where required.

Interview with the skin and wound coordinator-the clinical nurse manager, indicated when a skin problem is identified in the facility, he/she gets notified by the registered nursing staff.

Review of the policy RCSM-D-041, skin and wound program, dated March 2014, described the role of the registered staff, the health care aid/personal support worker, registered dietitian, entrostomal therapist (ET)/wound care specialist, physiotherapist (PT)/rehab assistant (RA), activation/recreation, foot care/chiropodist/podiatrist, physician. The policy describes the process for reporting skin problems (PSWs report any areas of redness to registered staff, registered staff to notify the skin care coordinator and physician of new lesions, send referral to CCAC for wound care specialist when ordered by physician, send a referral to physio and dietary.

Review of the clinical report for resident #6 indicated when he/she had skin problems and treatment on identified dates in 2014, no referral was sent to skin care coordinator, nor PT or RD.

Review of the policy and interview with the skin care coordinator confirmed that the policy does not describe clearly when or for which skin problems to send a referral to PT and RD. [s. 30. (1) 1.]

WN #9: 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 the restraining of the resident is included in the resident's plan of care.

A review of resident #10's plan of care did not contain the use of bed rails as a restraint when in bed.

Documentation review of resident #10 indicated resident has increased tremors which intensify when agitated and poor ability to determine proximity to edge of bed due to excessive body movements.

The doctor's notes from an identified date in 2015, indicated the resident continued to have falls due to lack of insight to her limitations and strong will to be independent.

An interview conducted with a PSW staff indicated the reason for the use of side rails was for resident safety and uncontrolled body movements. During the interview with the RAI coordinator she confirmed that the side rails are being used for resident #10 as a restraint after the review of staff interview and doctors notes. [s. 31. (1)]

WN #10: 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 a resident is bathed, at a minimum, twice a week.

Interview with resident #013 and his/her family member revealed that he/she didn't receive a bath as per the bathing schedule on six identified days in 2015.

Review of the flow sheets for two identified months in 2015, revealed that resident #013 did not receive a bath on the identified dates.

The acting DOC confirmed that the resident did not receive a bath twice a week as per the written plan of care. [s. 33. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

Review of the clinical record for resident #4 indicated no dental screen documentation was found for 2014. Family/SDM had given consent to the home for the resident to be seen for annual dental assessment.

On February 27, 2015, the home provided to the inspector a list of residents who were seen by Direct Dentistry in 2014 but resident #4 was not on the list.

Resident interview indicated the resident had not seen a dentist lately.

Interview with the resident and staff who is responsible for getting consent for dental assessment, and clinical record review were unable to provide evidence of offering an annual dental assessment for the resident. [s. 34. (1) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, 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.

Review of the clinical records indicated an identified date in 2014 resident #6 was seen by the foot nurse and it was documented that the resident had wound on one of the toes; the site was cleansed, new bandage was applied; and staff was advised.

On an identified date in 2014, the resident was started on antibiotic for one week, and according to the monthly infection statistic record that was presented by the skin care coordinator and collected by IPAC lead, the antibiotic was given for skin infection.

Review of the treatment administration record indicated the resident's wounds were treated on identified dates in 2014.

Review of the Skin and Wound Assessment policy, RCSM-G-210, resident care services, reviewed November 18 2014, indicated each resident will be assessed for risk of skin breakdown using the 7 day observation RAI-MDS assessment and a "complete skin assessment" form completed by a member of the registered nursing staff, for all of the following circumstances: upon admission (as part of the development of the plan of care), when there is a significant change in the resident's health status that affects skin integrity (skin assessed quarterly with RAI assessment).

Interview with the skin care coordinator indicated that the home used to have a paper form for skin assessment but since the implementation of electronic documentation the paper form lapsed. He/she stated that all skin problems should be assessed and documented in skin and wound note. The skin care coordinator was not able to present a copy of the "complete skin assessment" form.

Review of the clinical record and interview with the registered nursing staff and the skin care coordinator confirmed that there was no skin assessment performed using the "complete skin assessment" form for the resident #6's wounds. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, skin tears or wounds has been assessed by a registered

dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Review of the clinical record for resident #6 indicated there was no assessment performed by the registered dietitian (RD) for the skin problems the resident had and were treated on identified dates in 2014.

Interview with the clinical nurse manager confirmed that a referral to RD is usually sent only if the resident has stage 2 or more advanced pressure ulcer.

Interview with the RAI coordinator confirmed RD was not notified of the resident #6's skin problems. [s. 50. (2) (b) (iii)]

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

Review of the clinical record and interview with registered nursing staff indicated resident #6 was treated on identified dates in 2014, for skin problems, skin tear and wounds.

Interview with clinical nurse manager and review of clinical record confirmed that the resident's skin tears and wounds were not assessed at least weekly. [s. 50. (2) (b) (iv)]

WN #13: 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,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was provided with a range of continence care products based on their individual assessed needs.

Review of the written plan of care for resident #10 indicated the resident is using a pull-up and pad for incontinence. The incontinent product list on the 2nd floor North identified the resident uses pads. Interview with the clinical nurse manager indicated the resident to use pads. Interview with the resident confirmed resident utilizes pull-ups and pad's for incontinence on a daily bases.

Review of the clinical record and interview with the clinical nurse manager confirmed that resident #10 was not provided with a continence product that was based on his/her individual assessed needs. [s. 51. (2) (h) (i)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at meals.

Observation performed on February 18, 2015, at 12:00 p.m. indicated that the posted weekly menu did not match what residents were served for lunch. The weekly menu indicated that "Honey Garlic Pork on a Bun" would be served and instead residents received "Assorted Deli Sandwiches".

Interview with the food service manager (FSM) confirmed that the planned menu item was not offered because it was not available. [s. 71. (4)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The home has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

Observation performed on February 23, 2015, at 11:37 a.m., revealed that on one of the units, a housekeeping cart was left unattended for five minutes outside the nursing station as the inspector carried out resident observations. It was noted that the housekeeper was not in the area. The support service staff who was coming out from replenishing the laundry verified the cart was left unattended with the following items accessible on it:
Floor scrapper
Swish glass cleaner
Yellow bucket full of soapy liquid

The maintenance manager arrived and stated that the yellow bucket consisted of a floor cleaner called "Netura". He/she confirmed that the housekeeping cart was left unattended with cleaning chemicals accessible on it and arranged to be removed immediately. [s. 91.]

WN #16: 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 has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Interview with identified registered staff on one of the floors revealed that topical creams are stored in a treatment cart that is stored in the equipment room. When the equipment room was visited by the inspector and RPN, RPN stated that PSW staff have keys to access the room. The RPN indicated that the treatment cart with topical creams does not have a lock installed in order to be locked and it is usually kept unlocked in the equipment room where all PSWs have access. An identified PSW was asked if he/she had a key to the equipment room and he/she demonstrated that he/she was able to open the door with his/her keys.

During resident observation it was noted the housekeeper on the second floor entered the equipment room. When inspector asked the housekeeping manager he/she stated the housekeeper may have a key to the equipment room.

Observation and interview with acting DOC and RPN confirmed that the treatment cart was not locked and was accessible to other than registered nursing staff. [s. 130. 2.]

WN #17: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Review of the clinical records for residents #2, 3, 6, 9 and 10 indicated the residents have not received tetanus and diphtheria immunization.

Interview with the clinical nurse manager confirmed that tetanus and diphtheria immunization is offered only to newly admitted residents since last year, but not to previously admitted residents. [s. 229. (10) 3.]

Issued on this 20th day of April, 2015

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

Original report signed by the inspector.