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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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 15, 2016	2016_444602_0034	011657-16	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49 R R 2 PICTON ON K0K 2T0

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

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49 HALLOWELL TOWNSHIP PICTON ON K0K 2T0

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

WENDY BROWN (602), AMBER LAM (541), HEATH HEFFERNAN (622), SUSAN DONNAN (531)

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 3 - 7, 2016 and October 11 - 13, 2016

The following logs were also included in this inspection:
005555-16 alleged staff to resident abuse
020173-16 alleged resident to resident abuse
020643-16 missing resident with injury
022407-16 transfer with resident injury
028285-16 alleged staff to resident abuse
028519-16 alleged resident to resident abuse
029303-16 fall with injury and transfer to hospital

During the course of the inspection, the inspector(s) spoke with Residents, Resident and Family Council representatives, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian(s) (RD), Physiotherapist (PT), the Physiotherapy Assistant, the Cook, Dietary Aides, the Receptionist, Housekeeping and Maintenance staff, the Director of Care (DOC) and the Administrator. During the course of the inspection, the inspectors conducted a full walking tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies, as well as the home's complaint record and staffing plan.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **8 VPC(s)**
- **1 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. 21.	CO #002	2016_280541_0017	531
LTCHA, 2007 S.O. 2007, c.8 s. 31. (3)	CO #001	2016_280541_0017	531

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 O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week; in a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

The H.J. McFarland Memorial Home has 84 beds requiring that the Director of Nursing and Personal Care (DOC) works regular hours in the position of at least 35 hours per week. During the entrance conference held on October 3, 2016, at the home's Resident Quality Inspection (RQI) inspector#602 was alerted to the fact that the Administrator was working as both the Administrator and the DOC as of August 30, 2016.

In an interview on October 4, 2016 the Administrator/DOC advised that since August 30, 2016 approximately two-thirds of her time each week (28 hours) was devoted to the Administrator role and responsibilities and that the remaining one-third (12 hours) of her time was spent as the DOC. The Administrator/DOC further advised that interviews for a permanent full time DOC were underway and that an interim DOC should be in place as of October 11, 2016.

On October 11, 2016 the Administrator confirmed that RN#106 was now working in the interim DOC position at 35 hours each week; ending the home's 12 day period without a DOC working the required hours. The Administrator also indicated that interviews for a permanent DOC were still ongoing.

A compliance order is warranted given that the scope of the non compliance is widespread; effecting all residents, and there is potential for resident harm. Additionally sufficient staffing non compliances were issued in the 2015 RQI. [s. 213. (1)]

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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During a dining observation conducted on a specified date, inspector#541 noted a resident coughing on soup. The inspector noted the resident was served a regular texture soup. While the main entrée was being served the inspector overheard a staff stating the resident is puree"; the resident was then served a puree entrée.

Inspector#541 obtained the diet roster from the servery which is used by dietary aides and cooks to ensure residents receive the correct diet. On a specified date a cook indicated the diet roster contained the names of all residents who eat in the dining room and their particular diet. Inspector#541 reviewed the binder twice noting that the resident's name and diet/past diet was not listed. When asked, the cook confirmed that the residents diet texture should be noted as puree.

A PSW confirmed the resident should receive a pureed texture. The staff further advised that the pureed texture diet has been in place for two to three weeks due to a previous choking episode.

The resident's nutritional care plan was reviewed and indicated that the resident's diet order as a regular diet, chopped texture, regular fluids and pureed fruits.

The resident's progress notes were reviewed and there was no assessment that indicated when or why the resident's diet texture was changed to puree. There were no nutritional assessments for the resident noted for a 4 month period in the electronic chart or the paper copy of the chart.

The home's current Registered Dietitian started at the home a few weeks prior and confirmed that since starting, there were no dietary referrals.

The resident was not reassessed and the plan of care was not reviewed and revised when the resident's diet texture was changed from chopped to puree. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures residents are reassessed and that plans of care are reviewed and revised at least every six months and at any other time when resident care needs change or care set out in plans are no longer necessary, to be implemented voluntarily.

WN #3: 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:(b) complied with

As per O. Reg 79/10 s. 30(1)1 the home is required to have policies related to the dietary services and hydration program.

Inspector #541 requested the home's policy related to resident weight changes and the home's policy related to Registered Dietitian (RD) referrals. The acting Nutritional Manager provided the following policies:
- Policy #VIII-E-10.10 titled Referral to Dietitian and/or Director of Dietary Services
- Policy #VIII-G-20.80 titled Monitoring of Resident Weights

Page 1 of policy #VIII-E-10.10 states that registered staff will complete a referral to the

Registered Dietitian and/or the Nutritional Supervisor to communicate any assessments, follow up or interventions related to dietary and nutritional care that may be required. The RN/RPN will:
- Assess all residents for nutritional risk factors and determine if a RD referral is necessary in such cases as:
- Diet needs to be reassessed as a result of changes in health status, return from hospital, new diagnosis of dysphagia, changes in dentition, improvement in health.
- Difficulty swallowing as evidenced by coughing, choking, gurgling, regurgitation, pocketing

On October 6, 2016 a registered staff was interviewed and asked when a referral to the home's RD would be indicated. The registered staff stated that RD referrals are sent for situations including new admissions, re-admissions from hospital, swallowing issues and choking. The registered staff stated these referrals are completed on the electronic charting system.

The home's RD was interviewed on October 7, 2016; she indicated s/he had started at the home a few weeks prior and was not sure how referrals are sent. The RD staff confirmed that there have been no referrals as of the time of the interview and that the residents diet texture was recently changed from chopped to puree.

A PSW staff confirmed the resident is to receive a puree texture and has been for two to three weeks due to a previous choking episode.

Inspector#541 reviewed the electronic and paper charts for the resident and there were no referrals sent to the home's RD for this resident. The home's current RD, started at the home a few weeks prior and since that time there have been no dietary referrals for any residents.

Page 1 of policy #VIII-G-20.80 titled Monitoring of Resident Weights states that registered staff will:
- Request the PSW reweigh the resident if there is an unanticipated weight change (loss or gain) or 2 kg difference in resident's weight from the previous month.

Two different residents were noted to have significant weight changes over 2 specific months .

During an interview with a registered staff it was indicated that a re-weigh would be

reflected on the electronic charting system Point Click Care. Weight entries for both residents were reviewed on Point Click Care and there was no indication re-weighs were completed. [s. 8. (1) (a),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 the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act; and is complied with, to be implemented voluntarily.

WN #4: 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 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.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other

Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document included the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggested that the documents were "useful resources".

One of the companion documents was titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails.

On a specified date, Inspector #622 recorded observations regarding the resident beds;

1) Resident #018 – bed was observed to have a large gap between the head of the bed and the mattress in zone 7. In an interview on a specified date with a registered staff it was indicated that the mattress was old and that they would replace the mattress that same day.
2) Resident #011 - bed was observed to have two quarter rails in the up position.
3) Resident #025 – one half rail was noted in the up position
4) Resident #036 - one upper bed rail was found in the up position.

On a specified date inspector #622 received an email from the Administrator pertaining to audits of bed systems and resident assessment within the bed systems. The email indicated the last bed system audits were completed in 2013 and further indicated there were no current bed system evaluations or assessment of the following residents; #011, #018, #025, #036 within their bed systems.

In a follow up interview on a specified date the Administrator stated there was no documented audits of the bed systems or assessments of resident #'s 011, #018, #025, #036 within their bed systems as required in accordance with the best practice guidelines. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #5: 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:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

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 nutritional status, including height, weight and any risks related to nutrition care.

Resident#029's plan of care was reviewed to determine if there were any interventions in place to reflect the resident is to receive all meal courses at once. Upon review, it was noted that there was no plan of care related to nutrition for the resident. [s. 26. (3) 13.]

2. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home completed a nutritional assessment for the resident on admission and whenever there was a significant change in status in the resident's health condition.

Residents #025, #029, #036 and #037 were all admitted to the home during a specified period. None of the residents had an admission nutritional assessment completed by the home's Registered Dietitian.

Inspector#041 interviewed the acting Nutritional Manager who contacted the dietician who was employed at the home during the above noted time period. The RD informed the acting Nutritional Manager that the admission assessments were completed on paper and could be located in the residents' paper charts. Inspector #541 reviewed the paper charts for resident #025, #029, #036 and #037 and there were no nutritional assessments present. [s. 26. (4) (a),s. 26. (4) (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 plans of care are based on an interdisciplinary assessment of resident nutritional status, including height, weight and any risks related to nutrition care as well as ensure that the registered dietitian who is a member of the staff of the home completes a nutritional assessment for residents on admission and whenever there was a significant change in status resident health condition, to be implemented voluntarily.

WN #6: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During an interview regarding a resident a registered staff indicated the resident had a small pressure sore, venous sores, and a a small open area, The registered staff reviewed the treatment for the various sores and other pressure relief interventions in place.

A review of the resident's electronic records and progress notes indicated there were two assessment completed over a seven week period. The registered staff stated that skin and wound assessments were to be completed weekly on any resident with wounds and indicated that weekly skin and wound assessments were not being completed. She advised that if the weekly skin and wound assessments were being completed, they would be found in the progress notes on the electronic record. Inspector #622 together with the staff reviewed the progress notes and the assessments located in the electronic record and found that skin and wound assessments were not being completed weekly.

During an interview on October 11, 2016 regarding skin and wound assessments, DOC#106 stated that residents who have wounds should be assessed at each dressing change and weekly. The DOC together with Inspector #622 reviewed the electronic record documentation including; the Treatment Administration Record (TAR), progress notes and documentation under the assessment tab on point click care for resident #043 and confirmed that the wound assessments had not been completed weekly. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #7: 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 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 their health status

Resident#011 was noted to have several significant changes in weight. The resident's health care record was reviewed including progress notes, Resident Assessment Protocols (RAPs), assessments in point click care and the dietary section of the resident's paper chart. Between a specified period there was one nutritional assessment completed for resident#011. In this assessment the RD indicated weight loss for a specified date was not significant and no interventions were changed for resident #011. The assessment further indicates that resident#011 was now underweight. The significant weight changes during two other periods were not assessed.

Resident#012 was noted to have several significant changes in weight. Resident#012's health care record was reviewed including progress notes, RAPs, assessments in point click care and the dietary section of the resident's paper chart. During a specified month the significant weight change was assessed by the home's RD. There was no assessment of the other significant weight changes that occurred during two other specified months.

Resident#031 was noted to have several significant changes in weight. The resident's health care record was reviewed including progress notes, RAPs, assessments in point click care and the dietary section of the resident's paper chart. There are no assessments of resident#031's significant weight change that occurred during a specified period.

The home's current RD #101 was not employed by the home when the above noted residents had the significant weight changes. RD#100 is no longer an employee therefore was unable to be interviewed. [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 to 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 their health status, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

Inspector #541 was in the dining room on a specified date and noted residents #016, #021, #024, #029, #040, #045 and #046 to have their entrée and dessert at the same time.

Resident #29 was noted to have left the dining room during the meal and return a few minutes later. When resident#29 returned the entrée remained on the table and the dessert was sitting to the side. The resident left the entrée unfinished and ate the dessert.

Resident#021 is noted to be at high nutritional risk due to skin breakdown and significant weight fluctuations according to a nutritional risk assessment. Resident#021 was noted to have eaten approximately 25% of the entrée when the dessert was served. The resident was observed eating the dessert and left the majority of the entrée unfinished.

Resident#016 is noted to be at Moderate nutritional risk as per a nutritional risk assessment. The resident had a full plate of spaghetti and salad on the table while the dessert was served. The resident then indicated that s/he did not want the entrée and would eat jello instead.

Resident#046 is noted to be at high nutritional risk and was considered severely underweight as per a nutritional risk assessment. Resident#046 had not touched the entrée or soup when the dessert was served leaving the resident with all three courses on the table at once.

Inspector#541 reviewed the above noted residents' nutritional care plans and none of whom had interventions in place to reflect an assessed need or request to have all courses served at once. [s. 73. (1) 8.]

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 dining and snack service includes, at a minimum: course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

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

On October 3, 2016 inspector#622 observed the following:

A) Lilac Wing - Shower room contained the following unlabelled, used items: a bar of soap, an open bottle of lotion laying in the sink, shampoo, conditioner, and body wash bottles set on the bath chair, a well used tiny bar of soap in the shower soap holder and a brush and black comb on the shower shelf.
B) Willow Wing - tub room supply cart contained the following unlabelled, used items: Top of cart - two bins, one containing three cans of shaving cream and a lotion bottle, the other bin containing body wash, cream, lotion, and skin cleanser products

Second drawer - black hair brush
Third drawer - nine combs, two hair brushes and a bag of rollers
C) Whispering Pines - tub room supply cart contained the following unlabelled, used items:
Top of cart - bin containing two cans of shaving cream, five stick deodorants, and several nail clippers, additionally, fingernail and toenail clippers were observed beside the bin.
Third drawer - four black combs, two black brushes
The Whispering Pines shower room contained the following unlabelled, used items:
Shower area - bar of soap in the shower soap holder
Supply Cart - top of cart appeared soiled and contained a bar of soap, fingernails, hair, dust, a black comb, a hair brush, and toenail and fingernail clippers.

On October 12, 2016 inspector #622 interviewed several staff including PSW's #122 and #123 who indicated personal care items are not to be shared amongst residents. In a subsequent interview with a Registered Nurse (RN#106), it was confirmed that the home's expectation was that hair brushes, combs and nail clippers are only used for one resident and that each resident should have their personal care items stored in their rooms and taken to the tub rooms for use. RN#106 further advised there are no communal personal care items and that unlabelled and used supplies should not have been left in shower and tub rooms. The Administrator also confirmed that each resident is to have their own personal care items and communal, unlabelled personal care items are not to be used. [s. 229. (4)]

2. The licensee has failed to ensure that immunization and screening measures are in place that make certain staff is screened for tuberculosis.

Review of the LTCH Licensee Confirmation Checklist for Infection Prevention and Control completed by the home and signed by the Administrator on October 03, 2016 indicated that not all staff have been screened for tuberculosis (TB).

In an interview on October 13, 2016 the Administrator indicated that there was no process in place for screening staff for TB at this time. The Administrator explained that screening was done for previous employees but had probably fallen off. The Administrator shared that employee paper files did not contain TB screening information and that recent contact with Human Resources revealed they do not have any TB screening files on staff and that it was up to the home to perform this duty. The Administrator further indicated she had not requested TB screening from employees who had been recently hired. In an interview with reception#128 on October 13, 2016 it was

confirmed that a screen for TB on hire/as part of orientation was not yet formally in place. [s. 229. (10) 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 all staff participate in the implementation of the infection prevention and control program. O. Reg. 79/10, s. 229 (4) and (10) specifically ensuring that:
- all direct care staff understand and follow best practice guidelines for the proper cleaning, disinfection and appropriate storage of clean resident personal care items e.g. nail clippers, supplies & equipment and
- immunization and screening measures are in place and all staff, current and new, are screened for tuberculosis in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 15th day of December, 2016

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BROWN (602), AMBER LAM (541), HEATH HEFFERNAN (622), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2016_444602_0034
Log No. / Registre no:	011657-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 15, 2016
Licensee / Titulaire de permis :	COUNTY OF PRINCE EDWARD 603 Highway 49, R R 2, PICTON, ON, K0K-2T0
LTC Home / Foyer de SLD :	H.J. MCFARLAND MEMORIAL HOME R.R. #2, 603 HIGHWAY 49, HALLOWELL TOWNSHIP, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Nisbet

To COUNTY OF PRINCE EDWARD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The licensee shall ensure that home's Director of Nursing and Personal Care works regularly in that position on site at the home at least 35 hours per week.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week; in a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

The H.J. McFarland Memorial Home has 84 beds requiring that the Director of Nursing and Personal Care (DOC) works regular hours in the position of at least 35 hours per week. During the entrance conference held on October 3, 2016, at the home's Resident Quality Inspection (RQI) inspector#602 was alerted to the fact that the Administrator was working as both the Administrator and the DOC as of August 30, 2016.

In an interview on October 4, 2016 the Administrator/DOC advised that since August 30, 2016 approximately two-thirds of her time each week (28 hours) was devoted to the Administrator role and responsibilities and that the remaining one-third (12 hours) of her time was spent as the DOC. The Administrator/DOC further advised that interviews for a permanent full time DOC were underway and that an interim DOC should be in place as of October 11, 2016.

On October 11, 2016 the Administrator confirmed that RN#106 was now working in the interim DOC position at 35 hours each week, ending the home's 12 day period without a DOC working the required hours. The Administrator also indicated that interviews for a permanent DOC were still ongoing.

A compliance order is warranted given that the scope of the non compliance is widespread; effecting all residents, and there is potential for resident harm. Additionally sufficient staffing non compliances were issued in the 2015 RQI. (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 19, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 15th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Wendy Brown

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