Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2014	2014_226192_0037	L-001478-14	Resident Quality Inspection

Licensee/Titulaire de permis

RETIREMENT HOME SPECIALISTS INCORPORATED
120 Conception Bay Highway Suite 110, Villa Nova Plaza Conception Bay South ON A1W 3A6

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

MORRISTON PARK NURSING HOME
7363 CALFASS ROAD R. R. #2 PUSLINCH ON N0B 2J0

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

DEBORA SAVILLE (192), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)

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 31, November 3, 4, 5, 6, 2014

This home has an outstanding compliance order related to staffing that was not inspected during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Food Services Supervisor, Office Manager, Pharmacist, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

13 WN(s)
7 VPC(s)
1 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. 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, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #003 was identified to have altered skin integrity in 2014 when a wound was identified on the resident. Record review and interview confirmed that weekly wound assessments were not initiated. The next assessment of the wound was documented to have occurred three weeks later in 2014. Record review and interview confirm that weekly wound assessments were not completed on two specified dates in 2014 prior to the wound being identified as healed.

Resident #003 was identified to have a wound in 2014. Interview with the Registered Practical Nurse responsible for wounds confirmed that the wound remained. Record review and interview confirmed that weekly wound assessments were not completed for four specified weeks in 2014.

Resident #003 was identified to have altered skin integrity in 2014. No assessments

were completed between the time altered skin integrity was identified and the next assessment two and a half months later. Interview with the RPN responsible for wound care confirmed that altered skin integrity remains a concern for the resident and treatments are being received.

The licensee failed to ensure that resident #003 received weekly wound assessments when they demonstrated altered skin integrity. [s. 50. (2) (b) (iv)]

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

Resident # 005 was admitted to the home in 2014 with altered skin integrity. The resident developed two additional areas of altered skin integrity.

Upon review of the Point Click Care documentation it was noted that Skin and Wound assessments were done but not weekly by a member of the Registered Nursing staff.

The altered skin integrity present at admission was not assessed again for a two month period when the Enterostomal Therapist assessed it. The specified weekly skin and wound assessments were missing from the documentation.

Altered skin integrity identified in July 2014 was not assessed weekly on specified dates according to the documentation.

Altered skin integrity identified in September 2014 was not assessed weekly on specified dates according to the documentation.

The licensee failed to ensure that Resident # 005, with multiple sites of altered skin integrity, had weekly Skin and Wound Assessments done. [s. 50. (2) (b) (iv)]

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

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

Findings/Faits saillants :

1. The licensee of a long term care home failed to ensure that there was a written plan of care for each resident that sets out the planned care for the residents.

Resident #010 was observed on specified dates in 2014, to be tilted in a wheelchair.

Interview with the RAI Coordinator confirmed that a tilt wheelchair which was being used as a Personal Assistance Services Device (PASD) without limiting or inhibiting the resident's freedom of movement.

A review of the clinical health record and confirmation from the RAI Coordinator confirmed that the plan of care for the resident did not include the use of the PASD. [s. 6. (1) (a)]

2. 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.

The plan of care for resident #003 indicated under Personal Hygiene that the resident required extensive assistance from staff. That staff are to encourage participation in their personal hygiene.

The Kardex available to Personal Support Workers through Point of Care (POC) indicated that the resident required constant supervision with physical assistance each shift.

Resident #003 was observed to be ungroomed in 2014. The Point of Care (POC) documentation indicated that the resident had received assistance with grooming. There is no indication that the resident refused grooming in POC documentation or the progress notes.

Interview with the Administrator/Director of Care confirmed that the homes expectation would be for the resident to receive personal hygiene daily and that if the resident had refused, the refusal would be documented in POC and communicated to registered staff.

The plan of care for resident #003 failed to set out clear direction to staff and other who provide direct care to the resident in relation to shaving. [s. 6. (1) (c)]

3. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

A) The plan of care for a specified resident indicated that dentures are to be worn for all meals and that staff are to ensure that dentures are in the resident's mouth and cleaned after meals.

Interview with the resident and observation confirmed that dentures are not worn at any time.

Interview with the Registered Practical Nurse confirmed that the resident no longer wears their dentures and that the plan of care had not been reviewed and revised with a change in the resident's oral care needs.

B) The plan of care for resident #004 indicated that the resident was on a prompted toileting program and staff were to check for wetness every two hours, and record in Point of Care if the resident's incontinence product was wet, or if the resident had voided into the toilet.

Resident #004 was admitted to the home in 2014 and had specified needs at the time of admission. A toileting routine was established based on the continence assessment and

three day voiding record. The resident sustained a change in condition and interventions were again changed.

Interview with a Registered Practical Nurse confirmed that the plan of care had not been revised with a change in the resident's continence care needs.

C) The plan of care for resident #004 indicated under Falls specific identified interventions related to falls.

Observation failed to identify use of all identified interventions. Interview and observation with a Registered Practical Nurse identified that the resident no longer had specified interventions in place.

The licensee failed to ensure that the plan of care was revised when the care needs for resident #004 changed. [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 ensuring that the plan of care sets out the planned care for the resident, sets out clear directions to staff and others who provide direct care to the resident and that the resident is 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, to be implemented voluntarily.

WN #3: 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 had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During Stage 1 of the inspection it was observed that Resident #005 had bed rails in the up position and they were laying on a specified surface.

Upon interview with the Administrator/Director of Care it was stated that every time a surface is replaced on a resident's bed a ten point inspection of the bed for entrapment zones takes place. The Administrator/Director of Care stated that the bed was assessed with a tool to simulate a resident in the bed, but that Resident #005's safety in the bed had not been assessed.

A paper copy of "Restraints: Bed Rail Safety Check", completed in 2014, was reviewed. It was noted by the Inspector, the Office Manager, and the Administrator/Director of Care that only the bed assessment did not accurately identify the bed rails in use by the resident.

Interview with the Administrator/Director of Care confirmed that the safety of Resident #005 with bed rails in the up position, and a specified surface, was not assessed. [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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres (cm).

On October 31, 2014 it was observed that the window in a specified room opened greater than 15 cm.

On November 3, 2014 it was observed that the windows in specified rooms opened greater than 15 cm.

Non-compliance related to windows that open greater than 15 cm. was previously issued in July 2013. Interview with the Director of Care/Administrator confirmed that at that time, chains were applied to the windows.

Chains were observed to be present on the windows but did not prohibit the windows from being opened greater than 15 cm. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #5: 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 the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #005 was noted to have a medical device present.

According to Point Click Care documentation Resident #005 relied on a specified medical device. The plan of care for the resident was changed, but not tolerated well and the medical device was reapplied.

Interview with the Registered Practical Nurse (RPN) confirmed that Resident #005 did not have a Urinary Continence Assessment done when the resident's condition changed.

Upon interview with the Administrator/Director of Care she confirmed that it was the home's expectation that a urinary continence assessment would have been completed as the resident was incontinent and their bladder condition changed. [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 the 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 is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During observation of the medication room on November 6, 2014 it was noted that narcotic and controlled substances that had been considered discarded were accessible to anyone entering the medication room and were not stored in a double locked stationary cupboard in the locked medication room.

The home had recently gone to using a locked cupboard for the disposal of discarded narcotics and controlled substances. The locked cupboard was observed to be laying on its side on a shelf in the medication room. Staff were to place discarded medications with their count sheets into the opening of the locked box where they would not be accessible until destroyed in the presence of the Pharmacist. On November 6, 2014 it was noted that several medication cards were readily accessible in the opening of the locked box. The inspector was able to withdraw cards containing Ativan, codeine and Tylenol #3 in addition to other discarded medications from the opening of the box.

Interview with the Registered Nurse, Administrator/Director of Care, Registered Practical Nurse and Pharmacist confirmed that narcotic and controlled substances are intended to be placed into the locked box and that gravity would be necessary for the substances to fall securely into the box where they would not be accessible. Interview confirmed that narcotics and controlled substances placed in the opening to the box would be accessible and were not stored securely. [s. 129. (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive training in fall prevention and management.

Record review and interview with the Registered Practical Nurse responsible for training confirmed that 52% of the direct care staff of the home have completed training in fall prevention and management in 2014.

Interview with the Registered Practical Nurse responsible for training on November 6, 2014 at 1410 hours identified that in 2013 only 18% of direct care staff participated in training in fall prevention and management. [s. 221. (1) 1.]

2. The licensee has failed to ensure that direct care staff are provided training in skin and wound care.

Interview with the Registered Practical Nurse responsible for training in the home

identified that the home uses Surge electronic training which included Skin and Wound Care Program for Clinical Staff.

Interview with the RPN confirmed that training on skin and wound care was conducted in September 2014 and that only 50 percent of the direct care staff of the home participated in the training and that the home is unable to confirm that all direct care staff participated in training in skin and wound care in 2013. [s. 221. (1) 2.]

3. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually.

Interview with the Registered Practical Nurse responsible for education within the home identified that the home uses Surge Learning. In 2014 training related to abuse including recognition and prevention of abuse, Whistle Blower Protection, Mandatory Reporting, and Resident Rights was scheduled for January and February 2014. As of November 6, 2014, 51 to 53 percent of the staff have participated in this training.

Interview with the Registered Practical Nurse responsible for training and the Administrator/Director of Care confirmed that participation in Surge learning for 2013 was low and that not all staff participated in training offered. Records from Surge Learning indicated that 59% of the staff participated in training related to abuse recognition and prevention in 2013.

The licensee failed to ensure that all staff who provide direct care to residents, receive training related to falls prevention and management, skin and wound care, and abuse recognition and prevention annually. [s. 221. (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 direct care staff are provided training in falls prevention and management, skin and wound care, and abuse recognition and prevention, to be implemented voluntarily.

WN #8: 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) In November 2014 a resident who has an indwelling catheter was observed to be laying in bed. The resident's catheter drainage bag was observed to be laying on the floor beside the bed.

In 2014 the resident was again observed to laying in bed with the catheter drainage bag laying on the floor beside the bed.

In November 2014 another resident who has an indwelling catheter was observed to be laying in bed and the catheter drainage bag was observed to be laying on the floor at the foot of the bed.

Interview with the Registered Practical Nurse confirmed that catheter bags laying on the floor could increase the resident's risk of infection.

Review of the home's policy titled "Care of a Resident with an Indwelling Catheter", policy Section 3 - NRSG 03-02-02, dated as revised February 2014 stated that the drainage bag is to be secured to the bed or the wheelchair in such a way that the bag never touches the floor; with an identified outcome to be the prevention of urinary tract infections.

B) During observations on October 31, 2014 and November 3, 2014 by inspectors #192 and #165 the following unlabeled personal items were observed in shared bathrooms:

i) Unlabeled urinal observed on floor in bathroom
ii) In a specified bathroom two of three denture cup were not labeled.

iii) In a specified bathroom unlabeled denture cup on shelf in bathroom
iv) In a a specified bathroom unlabeled toothbrush observed on shelf in shared bathroom

It is noted that on November 5, 2014 an audit was conducted of all bathrooms. In a specified bathroom, which is a shared bathroom, an unlabeled denture cup was observed.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program ensuring that catheter drainage bags are secured off the floor and that all personal care items are labeled.

C) During observation of medication administration the Registered Practical Nurse (RPN) was observed to pour and administer medication to five residents without completing hand hygiene. The staff member was observed to touch hard surfaces, such as the computer mouse and medication cart and received dirty water cups from each of the residents following administration of the medication.

Interview with the RPN confirmed that while they had not had resident contact, they had touched other surfaces which may not be clean prior to preparing and administering oral medications to residents of the home. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During observation on October 31, 2014 and November 3, 2014 it was noted that four of eleven rooms, corridors and common areas had baseboards that were loose, missing or pulling away from the wall. Five of eleven rooms were noted to have drywall damage with raw drywall and metal corner bead exposed. The manager responsible for Maintenance and Housekeeping confirmed the damage to walls and loose baseboard on November 6, 2014 at 1530 hours.

On November 6, 2014 it was observed that the commode over the toilet in the bathroom in a specified room had a cracked seat that would prohibit cleaning of the commode and created a potential pinch hazard for residents. Damage to the commode was confirmed by the manager responsible for Maintenance and Housekeeping.

On November 6, 2014 it was observed in the presence of the manager responsible for Maintenance and Housekeeping that the wooden rail between the lounge and dining room has a rough wooden surface and the finish has worn off the wood. There is a potential for splinters from contact with the rough wooden surface.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive fingernail care, including the cutting of fingernails.

Resident #001 was observed to have long, dirty finger nails. A Personal Support Worker confirmed that the resident's nails remained long and dirty indicating that the resident is bathed on specified days and nail care would be provided at that time.

Record review confirmed by the Registered Practical Nurse (RPN) on November 6, 2014 indicated that the resident had been bathed as scheduled and nail care provided. Observation of the resident, confirmed by the RPN identified that the nails on the residents right hand remained long and dirty. The RPN confirmed that the resident had received morning care.

The home's policy titled Morning Care, policy number 04-02-14 signed as reviewed April 28, 2010 indicated under 12. check fingernails - trim and clean as necessary.

The licensee failed to ensure that resident #001 received fingernail care. [s. 35. (2)]

2. The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

During Stage 1 observations made on November 3, 2014 it was noted that a specified resident had dirty fingernails. The resident is a diabetic and received routine foot care from an external provider.

Interview with a Registered Practical Nurse on November 6, 2014 identified that Registered Staff provide nail care on bath days for the residents in the home. She stated

that there is a system developed on the bath sheet for notifying the Personal Support Workers that a nurse must cut certain resident's nails, especially if they are diabetic. She brought the Inspector to the nurses station to show her the bath sheet with a line symbol beside the resident's name.

Point of Care was reviewed on November 6, 2014 at 1335 hours and it indicated that Resident #005 had their bath on November 3, 2014 on the evening shift which included the cutting and cleaning of fingernails.

Observation of the resident in the dining room identified dirty finger nails.

A review of the home's policy in the Nursing Care Manual - Routine Resident Care - Morning Care, NRSG.CARE-04-02-14, dated April 28, 2010, stated that Nursing Staff are to, daily: (12) check finger nails - trim and clean as necessary.

The licensee failed to ensure that a specified resident had clean finger nails daily. [s. 35. (2)]

WN #11: 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 is no Family Council, the licensee convenes semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council.

The Administrator/Director of Care provided a copy of the invitation to participate in Family Council posted December 2013 and confirmed that only one meeting was held annually to advice residents' families and persons of importance to residents of their right to establish a Family Council.

The licensee failed to ensure that semi-annual meetings were held to advice of the right to establish a Family Council. [s. 59. (7) (b)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Interview with the Administrator confirmed that the advise of Residents' Council was not sought in the development and carrying out of the satisfaction survey and in acting on its results. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy under section 29 of the Act addresses restraining under the common law duty when immediate action is necessary to prevent serious bodily harm to the person or others.

The home's policy, "Restraints" - Section 9, Policy #NRSG 09-04-01, dated revised April 2010, did not address the need under common law duty, section 36 of the Act for the resident's condition to be reassessed 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 15 minutes and at any other time when reassessment is necessary based on the resident's condition or circumstances. The policy also failed to include that following

application of a physical device under common law duty, the licensee shall explain to the resident or the resident's substitute decision maker the reason for the use of the physical device.

The home's policy indicated that in an emergency situation a physical restraint may be applied on the direction of a registered nurse with appropriate documentation. [s. 109. (c)]

2. The licensee has failed to ensure that the home's written policy under section 29 of the Act addresses the types of physical devices permitted to be used.

Review of the home's policy "Restraints" - Section 9, Policy # NRSG 09-04-01, dated as revised April 2010, identified that the policy did not list under prohibited devices the entire list of prohibited devices according to s.112 of the Regulations.

Under "Prohibited" in the home's policy the following prohibited devices have been excluded: vest or jacket restraints, any device with locks that can only be released by a separate device, such as a key or magnet, four point extremity restraints, any device used to restrain a resident to a commode or toilet, and any device that cannot be immediately released by staff.

Under the "Definitions of Physical Restraints" in the home's policy prohibited restraints such as jacket and vest restraints, and roller bars on wheelchairs are included.

These discrepancies between what is required in the Legislation under s.112 and what is in the home's policy makes the policy confusing for the staff in the home when referring to it for reference when a resident requires a restraint.

The policy lacks clarity on the types of physical devices permitted to be used in the home. [s. 109. (d)]

3. The licensee has failed to ensure that the home's written policy under section 29 of the Act addresses how the use of restraining will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and Regulation.

Upon review of the home's policy, "Restraints" - Section 9, Policy # NRSG 09-04-14, dated as revised April 2010, it was noted under "Quality Control" that a monthly

evaluation which included an analysis of the restraining of residents by use of a physical device as per the requirements of s.113(a) of the Legislation was not included.

The policy did not address the results of the monthly analysis to be considered in the evaluation as required by s.113(c) of the Legislation. [s. 109. (g)]

Issued on this 20th day of November, 2014

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_226192_0037
Log No. / Registre no:	L-001478-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 20, 2014
Licensee / Titulaire de permis :	RETIREMENT HOME SPECIALISTS INCORPORATED 120 Conception Bay Highway, Suite 110, Villa Nova Plaza, Conception Bay South, ON, A1W-3A6
LTC Home / Foyer de SLD :	MORRISTON PARK NURSING HOME 7363 CALFASS ROAD, R. R. #2, PUSLINCH, ON, N0B-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KAREN BOLGER

To RETIREMENT HOME SPECIALISTS INCORPORATED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that residents #003 and #005 who were exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds and any other resident exhibiting altered skin integrity, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

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

Resident # 005 was admitted to the home in 2014 with altered skin integrity. The resident developed two additional areas of altered skin integrity.

Upon review of the Point Click Care documentation it was noted that Skin and Wound assessments were done but not weekly by a member of the Registered Nursing staff.

The altered skin integrity present at admission was not assessed again for a two month period when the Enterostomal Therapist assessed it. The specified weekly skin and wound assessments were missing from the documentation.

Altered skin integrity identified in July 2014 was not assessed weekly on specified dates according to the documentation.

Altered skin integrity identified in September 2014 was not assessed weekly on specified dates according to the documentation.

The licensee failed to ensure that Resident # 005, with multiple sites of altered skin integrity, had weekly Skin and Wound Assessments done. (519)

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

Resident #003 was identified to have altered skin integrity in 2014 when a wound was identified on the resident. Record review and interview confirmed that weekly wound assessments were not initiated. The next assessment of the

wound was documented to have occurred three weeks later in 2014. Record review and interview confirm that weekly wound assessments were not completed on two specified dates in 2014 prior to the wound being identified as healed.

Resident #003 was identified to have a wound in 2014. Interview with the Registered Practical Nurse responsible for wounds confirmed that the wound remained. Record review and interview confirmed that weekly wound assessments were not completed for four specified weeks in 2014.

Resident #003 was identified to have altered skin integrity in 2014. No assessments were completed between the time altered skin integrity was identified and the next assessment two and a half months later. Interview with the RPN responsible for wound care confirmed that altered skin integrity remains a concern for the resident and treatments are being received.

The licensee failed to ensure that resident #003 received weekly wound assessments when they demonstrated altered skin integrity. (192)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 20th day of November, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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