Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 22, 2014	2014_267528_0026	H-000964-14	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

ANSON PLACE CARE CENTRE
85 Main Street North, Hagersville, ON, N0A-1H0

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

CYNTHIA DITOMASSO (528), CAROL POLCZ (156), JENNIFER ROBERTS (582)

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): July 28, 29, 30, 31, 2014 and August 1, 5, 6, 7, 2014

This inspection was done concurrently with Complaint Inspection Log# H-000185-14 and Follow-up Inspection Log# H-000885-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Nurse Clinician, the Quality Improvement Coordinator, the Resident Assessment Indicator (RAI) Coordinator, Food Services and Environmental Services Supervisor, Programs Manager, Registered Dietitian (RD), Physiotherapist (PT), Business Manager, registered nursing staff, personal support workers (PSW), dietary aides, maintenance, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed documents including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

On the initial day of inspection, July 28, 2014, it was noted that the steam table in the sun room dining room was turned on and was hot at approximately 11:00 hours. The steam table was accessible to residents in the room as there was not a barrier between the counter and the hot steam table. The door to the servery was found to be unlocked and the lock was noted to be broken which would allow residents further access to the hot steam table. The servery area was not a safe and secure environment for the residents.

Interview with the Food Services Supervisor (FSS) and Administrator, resulted in the immediate installation of a barrier on the counter and repair of the servery door lock, which rendered the steam table inaccessible to residents in the dining room. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

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

s. 6. (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 the plan of care set out clear directions to staff and others who provide direct care to the resident.

The care plan for resident #12 indicated that the resident had full dentures, however, in July 30, 2014, at lunchtime, it was noted that there were bottom dentures in a cup on the resident's bedside table. During an interview on July 30, 2014, the resident reported that they had only worn the top dentures for about ten years and claimed that the bottom dentures did not fit well with the top and therefore, they did not use them. Interview with direct care staff confirmed that the resident only wore one top denture and not a full set, and that this should have been included in the resident's plan of care to provide clear directions to staff. [s. 6. (1) (c)]

2. The licensee did not ensure that staff and others involved in the different aspects of

care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented eachother.

On May 9, 2014, registered staff identified a new area of skin breakdown for resident #19. The progress notes included regular documentation of skin breakdown from May 2014 to July 2014, including an RD assessment on June 26, 2014 addressing altered skin integrity. Pixalere, an electronic wound care documentation system used by the home, identified the same area of skin breakdown on June 27, 2014, followed by weekly wound assessments until July 22, 2014. The Minimum Data Set (MDS) assessment and Resident Assessment Protocols (RAPS) from July 2, 2014, however, was not consistent with the clinical health record and indicated the resident's skin was intact. Interview with registered staff confirmed that the assessments by registered staff in the progress notes and Pixalere was not consistent with the MDS and RAPS assessment from July 2014. [s. 6. (4) (a)]

3. The licensee did not ensure that the 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 changed or care set out in the plan was no longer necessary.

A. The plan of care for resident #17 indicated that the resident required supervision of one person for limited assistance related to mobility. In the document the home refers to as the care plan, under a focus of impaired mobility related to cognitive function and pain, directed staff that the resident required two persons to assist with mobility. Interview with physiotherapy confirmed that the resident no longer required two staff to assist with ambulation and the intervention was not removed from the care plan.

B. Throughout the course of the inspection, resident #17 was observed to be using oxygen as a treatment. On July 15, 2014, the physician ordered an increase in the rate of oxygen to be administered to the resident. Review of the document the home refers to as the care plan did not include the increased oxygen rate. Interview with registered staff confirmed that as of August 1, 2014, the care plan was not revised to reflect the new order.

C. On July 23, 2014, resident #10 was readmitted to the home from hospital with new skin breakdown. Review of the document the home refers to as the care plan indicated that the resident was at risk for impaired skin integrity and included a goal that the resident's "...skin will remain clear and intact without red areas over the next quarter", and it did not include any reference to the resident's new area of impaired

skin integrity. Interview with registered staff confirmed that the plan of care was not updated to include the resident's new area of skin breakdown after re-admission from hospital.

D. On July 11, 2014, a new area of skin breakdown was identified by registered nursing staff for resident #11. Review of the document the home refers to as the care plan indicated that the resident was at risk for impaired skin integrity and included a goal that the residents "skin will remain clear and intact and circulation will be maintained to prevent skin breakdown on a daily basis over the next quarter", and did not include any reference to actual altered skin integrity. Interview with registered staff confirmed that the plan of care was not updated to include the resident's current skin breakdown. [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 to ensure the following:
i. that the plan of care set out clear directions to staff and others who provide direct care to the resident
ii. 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 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 did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A. Observations conducted on July 28, 29 and August 1, and 5, 2014, revealed that the communication and response system in resident #17's room was noted to be frayed and in disrepair. An interview conducted with the Environmental Services Supervisor (ESS) on August 5, 2015, confirmed that the call bell was in disrepair and was subsequently added to the home's Maintenance Care record for repair.

B. Observations conducted on July 28, 29 and August 1, and 5, 2014 revealed that tub lifts on the east wing and west wing were noted to have worn surfaces and cracks in the padding. According to the home's policy "Preventative Maintenance" (HS J-80) last revised on May 6, 2013, staff must enter requests for maintenance or repairs for equipment by completing an electronic requisition using Maintenance Care. A review of the home's Maintenance Care record system from July 2013 did not identify that the tub lifts as requiring corrective action or repair. An interview conducted with the ESS and maintenance on August 5, 2014 confirmed that both tub lifts were in disrepair and required replacement or repair. The tub lift on the east wing was subsequently removed from use to due its current state. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

A. During the initial tour of the home on July 28, 2014, it was observed that the Auditorium, Solarium and Beauty Salon (located in the basement), accessible and used by residents, were not equipped with a resident-staff communication and response system. An interview conducted with The Administrator on July 28, 2014 confirmed that these three areas did not have call bells. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #5: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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).

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. In July 2014, resident #10 was readmitted to the home with a new area of skin break down. Review of the clinical record on July 30, 2014, did not include an assessment of the new wound by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Interview with registered staff confirmed that the new wound had not been assessed using a clinically appropriate assessment tool specifically designed for skin and wound assessment.

B. On May 9, 2014, registered staff noted a new area of skin breakdown for resident #19. Review of the plan of care did not include an assessment of the wound using a clinically appropriate assessment instrument specifically designed for skin and wound until May 25, 2014. Interview with registered staff confirmed that the wound was not assessed using a skin and wound assessment for over two weeks after being identified. [s. 50. (2) (b) (i)]

2. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

A. On July 23, 2014, resident #10 was readmitted to the home with a new area of skin breakdown. The Registered Dietitian (RD) assessed the resident the following day but did not address skin integrity. A referral was made by registered staff to the RD on July 29, 2014, related to diet texture but did not include any information about skin breakdown. Review of the plan of care on July 30, 2014, did not include an assessment by the RD within relation to the resident's new altered skin integrity. Interview with registered staff confirmed that a referral was not sent to the RD noting new area of skin breakdown and therefore the RD's assessment did not address altered skin integrity.

B. On July 11, 2014, registered staff noted a new area of skin breakdown for resident #11. On July 17 2014, the RD assessed the resident related to decreased fluid intake but did not address altered skin integrity. A referral was made by registered staff to the RD on July 23, 2014 noting the resident was not meeting fluid needs and did not include new area of skin breakdown. Review of the plan of care on July 30, 2014, did not include an assessment by the RD within relation to the resident's new altered skin integrity. Interview with registered staff confirmed that a referral was not sent to the RD noting new area of skin breakdown and therefore the RD's assessment did not address the altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. On July 11, 2014, staff noted that resident #11 had a new area of skin breakdown. On July 14, 2014 the wound was assessed by registered staff. Review of the plan of care from July 21, 2014 to July 30, 2014, did not include weekly wound assessments. Interview with registered staff confirmed that after July 14, 2014, weekly wound assessments were not completed by registered staff although the wound was still present.

B. On May 9, 2014, registered staff identified a new area of altered skin integrity for resident #19. Review of the plan of care did not include regular weekly wound assessments. Weekly wound assessments were noted in either the progress notes or Pixalere on May 25, 2014, June 8 and 27, 2014, and July 9, 16 and 22, 2014. Interview with registered staff confirmed that weekly wound assessment were not completed for two weeks in May 2014 and two weeks in June 2014. [s. 50. (2) (b) (iv)]

4. The licensee did not ensure that the resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, while asleep if clinically indicated.

The plan of care for residents #10 and #11 indicated that both residents had impaired skin integrity and required to be turned and repositioned every two hours and as needed. On August 1, 2014 at 9:00 hours, both residents were noted to be up in wheelchairs in the dining room. Residents were assisted to the hallway after breakfast and, at approximately 11:45 hours, were assisted back to the dining room for lunch. During the observation, the Inspector did not observe staff assist either resident with repositioning as specified in the plans of care. Interview with direct care staff confirmed that the residents had altered skin integrity, impaired mobility, and required assistance with turning and repositioning while in their chairs. [s. 50. (2) (d)]

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 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 was specifically designed for skin and wound assessment
ii. has been assessed by a registered dietitian who is a member of the staff of the home, and has any changes made to the plan of care related to nutrition and hydration been implemented
iii. has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
iv. the resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, while asleep if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids were prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness.

During a tour of the kitchen on August 5, 2014, the following was noted:

i. Three bins of onions were stored on the floor in the walk-in refrigerator. One of the bins was located under a pan of marinating chicken. Both the cook and FSS confirmed that this was not safe food storage and would be removed immediately.
ii. There were four pans/bowls of prepared food (homemade sauerkraut, tartar sauce) that were not labeled or dated found in the walk-in refrigerator.
iii. In the dry storage area, it was noted that there was a bag of dried beans on the floor. iv. Dirty floor mats were stored on the shelving alongside food items.
v. Cans and bottles on the shelves were found to be dirty.
vi. Dessert items were found in the dessert fridge uncovered.
vii. The fridge had rusty and dirty shelving.

Interview with the FSS confirmed that the items should be cleaned and stored safely to prevent contamination. Both a dietary aide and the FSS confirmed that the fridge should be cleaned to ensure safe food storage. [s. 72. (3) (b)]

2. The licensee failed to ensure that there was a cleaning schedule for:
   * the food production areas
   * servery areas, and
   * dishwashing areas and that staff comply with this schedule

It was noted on August 5, 2014 that there were daily cleaning schedules found in the kitchen that were signed off as being completed; however, the kitchen area was in need of a thorough cleaning. The home did not have a routinely scheduled deep clean.

The walls, floors, and shelving were found to be very dirty with food splashes and debris. The stove had caked food on the burner areas and the grill trap was full of old food and was unclean. The dry storage area had cob webs on the ceiling and the walls and shelving were in need of cleaning. Sugar, flour or beverage thickening powder was found to be spilled onto several of the bottles and cans found on the shelves.

Interview with the FSS confirmed that the kitchen area was unclean and required a deep cleaning of all the areas. [s. 72. (7) (c)]

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 the following:
i. food and fluids were prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness
ii. there was a cleaning schedule for the food production areas, servery areas, and dishwashing areas and that staff comply with this schedule, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee did not ensure that charges for food and services that a licensee is required to provide to a resident funded by the Minister under section 90 of the Act, were prohibited.

A. The plans of care for five residents, indicated that they required a pull-up type continence product which were to be provided by family. Review of the range of continence products supplied by the home did not include a pull-up product, however the supplier used by the home did have pull-up products available.

Interview with the five residents and `their SDMs currently using a pull-up type product and the following information was gathered:
i. the home had advised the families that if they wanted a pull-up type product they would have to purchase the product themselves
ii. since July 2013, all five resident/SDMs were supplying their own pull-ups and paying for them out of pocket, but families nor residents could not provide an exact date
iii. two out of five residents were using pull-ups from the same supplier used in the home
iv. two out of five residents were using pull-ups from a different supplier than used in the home, but would be willing to try a pull-up from the home's supplier

Interview with registered and direct care staff confirmed that they were using incontinence products supplied by the families. Incontinence products are funded by the MOHLTC under Nursing and Personal Support Services, and therefore are required to be provided by the licensee. [s. 245. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that charges for food and services, that a licensee is required to provide to a resident funded by the Minister under section 90 of the act, are prohibited, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

On July 31, 2014, during meal service, resident #51 was given a routine subcutaneous injection in the dining room. At 12:45 hours, staff approached the resident, lifted their shirt to expose the abdomen, and administered an injection. Four other residents were noted to be eating dessert with resident #51 at the time of the injection and therefore, staff did not provide resident #51 with privacy in a routine treatment. Interview with registered staff confirmed that subcutaneous injections are usually not given in the dining room and the resident should have been escorted to his room for privacy. [s. 3. (1) 8.]

WN #9: 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 failed to ensure that the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home policy "Post Fall Assessment Policy" indicated that a resident will be assessed every shift for the next twenty-four hours.

i. Resident #12 had a fall in November 2013, and was assessed immediately after the fall. Review of the plan of care did not include any re-assessment for the shifts following the fall.
ii. Resident #18 had a fall in November 2013, and was assessed by registered staff immediately after the fall. Review of the plan of care did not include any re-assessment for the shifts following the fall.

Interview with registered staff confirmed that the post fall re-assessments were not completed for these residents as per the home`s policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #10: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an interdisciplinary assessment of safety risks with respect to the resident.

Through observations and staff interviews, residents #12 and #17 were noted to require one bed rail raised when in bed for safety and mobility. Review of the clinical record did not include a formalized nursing assessment related to the use of bed rails and associated safety risks. Interview with registered staff confirmed that a formalized nursing assessment of safety risks related to bed rails was not completed for residents #12 or #17. [s. 26. (3) 19.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that residents are offered immunization against influenza at the appropriate time each year.

A) According to the home's policy "Admission of a Resident" (RCS B-05) last revised on July 15, 2013, the influenza vaccine (during flu season) is administered once consent is obtained from the resident/SDM and repeated every one (1) year.

A review of the clinical record for resident #53 revealed that the date of the last administered influenza immunization was December 4, 2012. Although a consent was signed by the resident's power of attorney (POA) in 2013, there were no records to indicate that the vaccine had been administered at the appropriate time in 2013. An interview with the Director of Care (DOC) confirmed that the consent was signed for resident #053, however the influenza immunization was not administered in 2013. [s. 229. (10) 2.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
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. 3. (1)	CO #002	2014_247508_0016	528

Issued on this 19th day of September, 2014

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