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
Jun 6, 2014	2014_214146_0010	H-000552-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
369 Frederick Street, KITCHENER, ON, N2H-2P1

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

R. H. LAWSON EVENTIDE HOME
5050 JEPSON STREET, NIAGARA FALLS, ON, L2E-1K5

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

BARBARA NAYKALYK-HUNT (146), MICHELLE WARRENER (107), ROBIN MACKIE (511), THERESA MCMILLAN (526)

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): May 22, 23, 26, 27, 28, 29, 30, 2014

During this RQI, H-000650-14, a Critical Incident inspection was conducted and the findings are part of this RQI report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Director of Finance, Registered Dietitian (RD), Program Manager, Food Services Manager (FSM), Environmental Manager, Resident Assessment Instrument (RAI) Coordinator, Registered staff, dietary staff, housekeeping staff, Personal Support Workers, residents and family members.

During the course of the inspection, the inspector(s) toured the home; reviewed policies and procedures, meeting minutes, resident health records, dietary menus and staff files; and observed residents in their living and dining areas.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.
(A) In May 2014, resident #040 was observed to have a device applied improperly.
(B) In May 2014 resident #013 was observed to have a device applied improperly. [s. 110. (1) 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. (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 did not ensure that there was a written plan of care for each resident that set out, (c) clear directions to staff and others who provided direct care to the resident.
(A) Resident #040's care plan contained conflicting directions to staff for transferring and toiletting. This information was confirmed by the DOC.(146)
(B) Resident #035's plan of care contained unclear and confusing directions to staff. An interview with the front line PSW confirmed the written care plan did not provide clear direction to staff in relation to the use of bed rails. (511) [s. 6. (1) (c)]

2. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

(A)Resident #025's health record contained conflicting assessments related to transfers and mobility. The assessments were not collaborative as confirmed by the DOC. (511)
(B)Resident #035's plan of care contained conflicting assessments related to the use of an intervention. The registered staff member confirmed staff and others involved in the different aspects of care of the resident had not collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with and complemented each other. (511)
(C) Resident #041's chewing and swallowing assessments were not consistent with each other. (107)
(D) The coding and the RAP summary statements for resident #041 were not consistent in relation to the level of assistance the resident required for eating. (107) [s. 6. (4)]

3. The licensee did not ensure that staff involved in the different aspects of care collaborated with each other (b) in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.
(A) Resident #025's plan of care indicated a variety of mobility interventions. An interview with the PSW confirmed that each staff member provided different transfer assistance levels. The DOC confirmed that the staff had not collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. (511)
(B) Resident #044 had significant change noted and nursing and dietary had differing interventions in place to address the change.(107)
(C)Resident #044 had a change in medications and was skipping a significant amount of meals according to nursing. This information was not incorporated into the care plan by the RD.
(D)Resident #044's plan of care identified a hydration goal for a certain amount of fluids per day as determined by the RD. Staff did not use the same goals on the resident's plan of care. This information was confirmed by the health record, the RD and registered staff. (107) [s. 6. (4) (b)]

4. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when (b) the resident's care needs changed or care set out in the plan was no longer necessary.
(A) A resident's needs changed related to eating assistance. The plan of care was not

revised when there was a change in the level of assistance required for eating. The health record and the RD confirmed that the resident was not reassessed or the care plan revised when the care needs changed. (107) [s. 6. (10) (b)]

5. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when (c) care set out in the plan of care was not effective.
(A) A resident's care plan goal indicated the resident needed a certain amount of fluids daily. The RD confirmed that the plan of care was not revised when the hydration goals were not met. The resident's fluid intake was not evaluated in relation to the hydration target identified on the resident's plan of care and interventions were not revised when the plan was ineffective in relation to meeting the resident's hydration target.
(B) The Dehydration Resident Assessment Protocol (RAP) for a resident was triggered at a quarterly review and completed by nursing staff. The resident's hydration was not assessed in relation to the goals identified on the resident's plan of care and stated "care plan goals and interventions have been reviewed by the care team members and continue to be effective in preventing the RAP problem." This information was confirmed by the RAI coordinator.
(C) The Dehydration/Fluid Status RAP for a resident was triggered in May 2014 and completed by nursing staff. The RAP stated the resident's fluid intake was adequate at 1700-1800ml/day. Nursing staff confirmed the goals and interventions related to hydration were not revised at that time and were not evaluated in relation to goals identified on the resident's plan of care.
(D) The Nutrition Status RAP for a resident stated the resident's fluid intake was an average of 1670ml/day during the observation period, that the resident's requirements were 3050ml, and that the resident was likely meeting their requirement. The RD confirmed the goals and interventions related to hydration were not revised at that time and were not evaluated in relation to goals identified on the resident's plan of care. [s. 6. (10) (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,
(4) 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;
(10)the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective, 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 kept clean and sanitary and were maintained in a safe condition and in a good state of repair.
(A) In May 2014 a large brown, leather textured, chair that was located on the first floor had worn, exposed fabric noted on the armrests and back. An interview with the Environmental Manager confirmed the chair was not in a good state of repair.
(B) In May 2014, four sit to stand lifts were noted to be unclean with dirt and matter located on the base of the lifts. The removable slings and fabric belts that were secured to the lifts appeared soiled and stained. Interview with the Environmental Manager indicated the cleaning of the lifts was a nursing responsibility and not a part of the general housekeeping. Interview with a PSW confirmed the nursing staff do not clean the base of the lifts and the belts are wiped down with a cleansing wipe 'as needed'. [s. 15. (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 to ensure that the home, furnishings and equipment are kept clean and sanitary and are 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a resident was protected from abuse by the licensee or staff.
During a stage one interview, a resident indicated a staff member had mistreated the resident verbally and emotionally. This was alleged by a family member to have occurred on two additional occasions. The home conducted an internal investigation, confirmed the verbal abuse and implemented disciplinary action to the involved staff member. This information was confirmed by the DOC. [s. 19. (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 the licensee shall protect residents from abuse by anyone and shall ensure that the residents are not neglected by the licensee or the staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

During an interview a resident indicated that a staff member had mistreated the resident. The DOC confirmed that the home had reasonable grounds to suspect resident abuse may have occurred and had not reported the information to the Director. [s. 24. (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 when a person who has reasonable grounds to suspect that any of the following have occurred or may have occurred, immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, 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. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

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).

Findings/Faits saillants :

1. Not all menu items were prepared according to the planned menu and recipes.
(A) The planned menu and recipe for pork chops with citrus mustard required the pork chops to be cooked in the sauce the day they were required for production. In May 2014 the cook had baked the pork chops a day in advance, was cooling them, then would cook the chops again the next day with sauce added. The FSM stated that the cooks were instructed to prepare the food differently than the planned menu, however, the recipe was not revised for consistent preparation of the item.
(B) The recipe for zucchini for a lunch meal in May 2014 required fresh julienned zucchini with oil, white sugar, black pepper, and white vinegar to be done in a saucepan or for fresh sliced zucchini to be sliced diagonally and roasted. The zucchini that was prepared for the lunch meal was from frozen zucchini prepared in the steamer. The food prepared did not match the planned recipe. [s. 72. (2) (d)]

2. Not all foods were stored and served using methods that prevented food borne illness.
(A) Not all foods in the walk in refrigerator were labeled and dated when observed the morning of a date in May 2014. Numerous perishable items (sandwiches, mousse, sliced tomatoes, whipped cream, sandwich filling with mayonnaise) without labels and dates were observed in the refrigerator. The FSM confirmed that labeling/dating of refrigerator items was required and was not consistently being completed.
(B) Not all food temperatures were being taken or recorded prior to service to residents. The cook confirmed that the temperatures of regular textured items were taken at the end of the cooking process, however, temperatures of texture modified and cold items were not monitored prior to service to residents. Monitoring records for a week in May 2014 were incomplete for some of the regular textured items and records were not available for any of the texture modified items. Thermometers available in the kitchen had a range of 50 degrees Fahrenheit (F) to 550 degrees F. The range of the thermometers was insufficient to monitor the temperatures of cold food items. Various liquids were added to foods for the preparation of minced and pureed texture items and the items were removed from the heat prior to processing. Temperatures were not taken prior to service to ensure they had returned to appropriate service temperatures for food safety and palatability. Seven residents identified inadequate food temperatures at meals during the Stage One inspection period. The home's "Food Temperatures - 7.05.04" policy required staff to monitor and record all potentially hazardous food temperatures, including texture modified items and cold items. [s. 72. (3) (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 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that, there was a process to report and locate residents' lost clothing and personal items.

Four residents had reported missing clothing that had not been found. Record review for the four residents identified inconsistent documentation for the lost items and no documentation of follow-up with family members or residents if the items were found. Interviews with the laundry aide, the Environmental Manager and the DOC all revealed a different practice for reporting and locating resident lost clothing. The Environmental Manager confirmed that there was no documented or clear process for reporting and locating residents' lost clothing and personal items. [s. 89. (1) (a) (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, as part of the organized program of laundry services under clause 15(1)(b) of the Act, the licensee (a) develops and implements procedures to ensure that (iv) there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #8: 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. (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 did not ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must have received annual training in all the areas required under subsection 76 (7) of the Act.

A review of the home's annual 2013 and 2014 educational training documents did not include training for abuse recognition and prevention. Interview with the DOC confirmed the home's staff had not received annual training in all the areas required under subsection 76(7) of the Act. [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 to 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 have received annual training in all the areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was (a) in compliance with and was implemented in accordance with all applicable requirements under the Act.
(A) The home's Nutrition and Skin Integrity policy number 7.07.03 was last reviewed on November 14, 2012 and stated the following procedure: "A referral to the Registered Dietitian, as a member of the interdisciplinary team responsible for residents' skin integrity, is made by either Nursing staff or the Physician whenever a resident has stage II, III or IV decubitus ulcers or slow healing wounds."
Regulation 50.(2)(b)(iii) of the Act states that every licensee of a long-term care home shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 were implemented. The home's policy indicated that the registered dietitian was to receive a referral only if a resident had a stage II, III or IV decubitus ulcer or a slow healing wound. This policy does not comply with the regulation in terms of a dietitian assessing a resident if a resident were to exhibit altered skin integrity that also included skin tears or Stage I wounds. The wound care nurse (RN) and the FSM confirmed that the policy did not trigger a dietary assessment for residents who had altered skin integrity including skin tears or wounds less than stage II in severity.

(B)The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was (b) complied with.
The home did not ensure that the Infection Prevention and Control Program and policies were complied with. The homes Infection Control policy "Pre-hiring Lab Tests and Immunization" number 9.06.71 last reviewed on January 14, 2014, indicated that blood work and immunizations were required by all staff as a condition of employment at the home. The policy stated that staff were to provide results for the following lab work: Hepatitis B, Hepatitis B antigen, Varicella Titre, Rubella, and Anti Hepatitis C Virus. According to the policy, staff were also required to provide evidence that they were up to date on the following immunizations: tetanus, chicken pox if they had not had the disease, hepatitis B, mumps, measles, rubella, and polio. The Manager of Finance and the DOC verified that this policy had not been complied with by the home. (526) [s. 8. (1) (a),s. 8. (1) (b)]

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

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On a date in May 2014 it was observed that a room labeled as Housekeeping/Electrical was left unlocked and unsupervised. A note on the door read the door was to be kept locked at all times. Interview with the housekeeper confirmed the door was to be locked and was inadvertently left unlocked. (511) [s. 9. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.
(A) Three residents were observed to have skin issues that were not documented. The DOC confirmed that the skin issues should have been documented. (146)
(B) A resident's health record did not include an evaluation of the effectiveness of the resident's nutritional plan of care at the two quarterly reviews. (107) [s. 30. (2)]

WN #12: 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 did not ensure that each resident of the home received fingernail care, including the cutting of fingernails.
(A) Three residents were observed to have grime and dirt under their fingernails.

WN #13: 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 did not ensure that a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.
(A) A resident's progress notes indicated that the resident had skin and wound issues. The wound care nurse confirmed that not all residents with altered skin integrity had been referred to the RD.
(B) Skin integrity concerns were identified for another resident in the progress notes. The RD confirmed that an assessment related to the resident's skin integrity was not completed. (107) [s. 50. (2) (b) (iii)]

2. The licensee did not ensure that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, was assessed at least weekly by a member of the registered staff as clinically indicated.
(A) A resident's progress notes indicated that the resident had three separate skin and wound issues. Weekly wound assessments were not done. The wound care nurse confirmed that the weekly skin and wound assessments should have been completed. [s. 50. (2) (b) (iv)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. When the Residents' Council advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee did not, within 10 days of receiving the advice, respond to the Residents' Council in writing.
(A) According to the minutes of February 2014, resident council had concerns about cleaning and asked how often cleaning was done behind the nightstands. There was no evidence of any response in the minute binder. The current staff liaison person confirmed that a written response should be in the binder. The environmental manager stated that he had not heard of the concern prior to May 29, 2014. The staff liaison stated that in future written responses will be requested and attached to the minutes binder. The DOC confirmed that written responses within 10 days had not been occurring. The DOC confirmed that written responses within 10 days has not been occurring. (146)
(B) The Food Committee meeting minutes with the Resident Council minutes indicated specific concerns/suggestions, however, the concerns/suggestions were not responded to.
(i) At the February 3, 2014 meeting concerns/suggestions were voiced related to: hard chips with the fish and chips; menu suggestions, cold sweet potato fries; bacon was too crispy and hard to chew; toast that was too dark.
(ii) At the May 5, 2014 meeting concerns/suggestion were voiced related to: wanting softer perogies; tough pizza crust.
The FSM confirmed a written response was not provided for concerns raised at the Food Committee meetings. [s. 57. (2)]

WN #15: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The Residents' Council had not reviewed the meal and snack times. The FSM confirmed that meal and snack times were not discussed and approved as part of the Council meetings. Residents' Council and Food Committee meeting minutes did not reflect that meal and snack times were discussed with and approved by the Council. [s. 73. (1) 2.]

WN #16: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' Council and the Family Council in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).
This information was confirmed by the DOC, the Family Council chairperson and a review of Resident Council minutes and Family Council minutes. [s. 85. (3)]

2. The licensee did not ensure that, (a) the results of the survey were documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3)
This information was confirmed by the Resident Council and Family Council meeting minutes, the Family Council chairperson and the DOC. (146) [s. 85. (4) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee did not ensure, (a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it; (b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences; (c) that the results of the analysis undertaken under clause (a) are considered in the evaluation; (d) that the changes and improvements under clause (b) are promptly implemented; and (e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Interview with the DOC confirmed the home had not, at least once in every calendar year, completed an evaluation to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and determine what changes and improvements were required to prevent further occurrences. [s. 99. (b)]

WN #18: 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. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

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 did not ensure that the Infection Prevention and Control interdisciplinary team met at least quarterly.
Minutes for Infection Prevention and Control Team meetings were reviewed for March 5, 2014, September 18, 2013, April 10, 2013, and September 19 2012. The Infection Control Nurse and the DOC confirmed that the Infection Prevention and Control Team only met on the dates where meeting minutes were available and did not meet quarterly between March 5, 2014 and September 19, 2012. [s. 229. (2) (b)]

2. The licensee did not ensure that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices.
Inspection of the Infection Prevention and Control Program revealed that no annual evaluation had been conducted by the home and that the program had not been

updated. This was confirmed by the Infection Control Nurse and the DOC. [s. 229. (2) (d)]

3. The licensee did not ensure that all staff participated in the implementation of the Infection Control program.
(A)In May 2014, a staff member was observed to omit handwashing prior to or after providing an injection to a resident. The staff member continued to provide medication to other residents without handwashing. The staff confirmed that hand washing is required prior to and after providing resident care and as part of the infection prevention and control program. (511)
(B)In May 2014 during a lunch dining service, staff entering the dining room were not observed washing their hands prior to assisting residents to eat their meals or between assisting residents. A staff who was assisting a resident to eat their meal was observed to blow their nose into a tissue, wipe their brow with the same tissue, place the tissue in their pocket, then proceed to feed a resident their meal without washing their hands. In the midst of feeding a resident, another staff was observed to wipe the floor with a napkin beneath a dining table, pick up some debris and place the soiled napkin in a used cup on the resident's table, then proceed to feed the resident without washing their hands.
(C)In May 2014 one of the staff members was observed assisting a resident to walk with a physio assistant. The staff was observed to sneeze, blow their nose into a tissue, place the tissue in their pocket, assist the resident and then blow their nose again and continued assisting the resident. At no time did the staff wash their hands. The home's Infection Control policy for Hand Washing Procedure (Number 9.06.36) last reviewed on October 29, 2013 indicated that hands should be washed before initial resident/resident environment contact, before aseptic procedures, after body fluid exposure risk and after resident/resident environment contact. Staff did not wash their hands according to their infection control program. (526) [s. 229. (4)]

4. The licensee did not ensure that residents were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with publicly funded immunization schedules.
Immunization records for resident's #041, #044 and #045 were reviewed. The records did not include evidence that residents had been offered immunizations against tetanus or diphtheria in accordance with publicly funded immunization schedules. Health records for two residents did not indicate if residents were offered immunizations against pneumoccocus in accordance with publicly funded immunization schedules. The Infection Control Nurse could not verify that these

residents had been offered these immunizations. [s. 229. (10) 3.]

5. The licensee did not ensure that staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices.
Four staff files were reviewed for staff who had been hired between June 2012 and April 2014; three did not contain evidence that staff had been screened for tuberculosis upon hiring. The Manager of Finance confirmed that the home did not screen staff for tuberculosis upon hiring. The home's infection control program last reviewed in January 2014 did not include tuberculosis screening for staff. [s. 229. (10) 4.]

Issued on this 14th day of July, 2014

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

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

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) :	BARBARA NAYKALYK-HUNT (146), MICHELLE WARRENER (107), ROBIN MACKIE (511), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2014_214146_0010
Log No. / Registre no:	H-000552-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 6, 2014
Licensee / Titulaire de permis :	THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA 369 Frederick Street, KITCHENER, ON, N2H-2P1
LTC Home / Foyer de SLD :	R. H. LAWSON EVENTIDE HOME 5050 JEPSON STREET, NIAGARA FALLS, ON, L2E-1K5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RANDY RANDELL

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

To THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA, 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. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

Grounds / Motifs :

1. Previously issued November 2012 as a Compliance Order (CO) and May 2013 as a CO.
The licensee did not ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.
(A) In May 2014, resident #040 was observed to have a device applied improperly
(B) In May 2014 resident #013 was observed to have a device applied improperly (146)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

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 6th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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