Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 4, 2016	2016_258519_0008	019603-16	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

SAUGEEN VALLEY NURSING CENTER
465 DUBLIN STREET MOUNT FOREST ON N0G 2L3

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

SHERRI GROULX (519), NANCY SINCLAIR (537), NUZHAT UDDIN (532), SHARON PERRY (155)

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 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 2016

The following Critical Incident, Complaint, and Followup inspections were completed within this Resident Quality Inspection (RQI):

Critical Incidents: #030291-15 (1002-000022-15) related to alleged incompetent

treatment of a resident, #019217-16 (1002-000003-16) related to a fall, #027032-15 (1002-000020-15) related to alleged abuse, #013111-16 (1002-000004-16) related to alleged abuse, #004772-16 (1002-000001-16) related to medication administration, #016147-16 (1002-000005-16) related to alleged abuse.

Complaints: # 025803-15 (IL-40686-LO) related to staff certification, #034258-15 (IL-41722-LO) related to alleged abuse, #000070-16 (IL-42356-LO) related to pest control, #005812-16 (IL-43253-LO) related to medication administration, # 010517-16 (IL-44132-LO, I.L-44113-LO) related to dining service, # 011482-16 (IL-44165-LO) related to medication administration, # 014843-16 (IL-44651-LO) related to resident rights.

Followup to Compliance Order # 001 from Inspection # 2015_325568_0029 related to bed rails.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Director of Support Services, the Director of Therapeutic Programs, the Maintenance Manager, the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Co-ordinator, the Registered Dietitian, the Cook, three Dietary staff, Housekeeping staff, two Registered Nurses, seven Registered Practical Nurses, twenty two Personal Support Workers, the Family Council Representative, four family members, and residents.

The Inspectors toured the home, observed meal service, medication passes, medication storage area and care provided to residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedures, observed recreational programming, staff interaction with residents and general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
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
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **8 VPC(s)**
- **7 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_325568_0029	519

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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other.

A resident was coded in the Minimum Data Set (MDS) quarterly review assessment as being bed-fast. A review of the resident's progress notes did not reveal that the resident was bed-fast during the seven day observation period of the MDS quarterly review assessment.

A Personal Support Worker (PSW) stated that they could not remember the resident being kept in bed as the resident had an assistive device for mobility.

During this inspection the resident was observed sitting in the assistive device during the day.

During an interview at a select date and time, the Director of Care (DOC) stated that the

resident should not have been coded bed-fast as she reviewed the documentation in Point of Care (POC) and it revealed that the resident was not bed-fast during the observation period recorded. [s. 6. (4) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other.

Record review done on a select date, revealed that a resident was coded in the Minimum Data Set (MDS) quarterly review assessment and in the MDS significant change in status assessment, as being bed-fast. A review of the resident's documentation done in Point of Care (POC) and progress notes in Point Click Care (PCC), for the period of time associated with the documentation, revealed that the resident required assistance of two staff and used an assistive device for mobility.

During an interview on a select date and time, with the Registered Practical Nurse (RPN)/ Resident Assessment Inventory (RAI) Coordinator, they stated that the resident should not have been coded as being bed-fast in the MDS assessment.

During an interview with the Director of Care (DOC), she stated that the resident was not bed-fast during the date associated with the assessment, but had had a rapid decline in condition where the resident went from walking to needing to use an assistive device; but was not bed-fast.

The licensee failed to ensure that staff and others involved in the different aspects of care for the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A resident's plan of care stated that the resident was to receive personal care before and after each meal.

On two different dates and times, it was observed that the resident was sitting in a lounge with their eyes closed and remained sitting in the lounge in the same spot until the staff assisted them to the dining room. The resident was not provided personal care

during these observations.

On three different dates and times, after a meal, it was noted that the resident was assisted back to a resident care area from the dining area and was placed in the same lounge, where the resident remained sitting. No assistance with personal care from staff was provided to the resident after the meal.

On a select date and time, a Personal Support Worker (PSW) stated that the staff on their select shift do not have time to provide this personal care to the residents. They indicated that due to resident directed care and the different times residents would require assistance, it took away from the time that they would have to provide the personal care to the residents. She confirmed that the resident was supposed to be provided this personal care as per plan of care.

On a select date, the Director of Care (DOC) stated the expectation was for staff to check the resident at least once during those hours. She acknowledged that the individual resident directed care had created different challenges for the staff, and stated that they were still working on fixing these issues. The DOC stated that the personal care set out in the plan of care for the resident was not provided as specified in the plan of care. [s. 6. (7)]

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

The plan of care for a resident stated that staff were to ensure that the resident had an assistive device placed every morning.

During the Stage One staff interview on a select date and time, it was stated by the Registered Staff that the resident was to have an assistive device placed by the Personal Support Worker (PSW) every day.

During observations made on two different dates and at different times it was revealed that the resident did not have the assistive device placed by the PSWs each morning.

On a select date, this concern was mentioned to the Director of Care (DOC) and she stated that the the assistive device would not stay in place, however, the expectation was that staff put it on. The DOC was informed that the assistive device was not being placed on as per the plan of care. The different observations made by the inspector

were communicated with the DOC.

On a select date and time, further observation revealed that the resident did not have the assistive device placed on as per the plan of care. [s. 6. (7)]

5. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

According to the documentation in the progress notes a resident was injured on a select date. The injury required treatment at the hospital.

Upon review of the resident's care plan it stated that staff were to ensure that the resident was dressed properly in order to prevent injury.

During an interview with a Personal Support Worker (PSW) on a select date and time, it was stated that the resident was not wearing proper attire when the incident occurred as they had just had their bath.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when the resident was not wearing appropriate attire and sustained an injury. [s. 6. (7)]

6. The licensee failed to ensure that the resident was reassessed and the plan of care was 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 resident had a pressure wound on admission. This pressure wound healed on a select date, but they developed another pressure wound on a later date. According to the care plan a positioning aide was to be worn while the resident was in bed to assist with off loading pressure to the affected area.

According to an interview with the resident on a select date, it was stated that they did not use the positioning aide at night in bed to take the pressure off of the affected area.

According to an interview with a Personal Support Worker (PSW) on a select date and time, it was stated that they do not apply a positioning aide to the resident when in bed.

The licensee failed to ensure that the resident was reassessed and the plan of care

reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

7. The licensee failed to ensure that the resident was reassessed and the plan of care was 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.

The plan of care for a resident stated that the resident would notify staff when they needed personal care and staff was then to provide personal care.

Observations made on two dates, four days apart, it was observed that the resident was sitting in a lounge with their eyes closed and they remained sitting in the lounge in the same spot until the staff assisted them to the dining room.

On three different dates, one hour after a selected meal, it was noted that the resident was assisted back to a select care area from the dining area and was placed in the same lounge. The resident sat there and no assistance with personal care was provided. The resident was not observed to notify staff during any of these times.

On a select date, the Director of Care (DOC) stated that the resident's cognition had declined and she believed that the resident would no longer be able to indicate to staff when personal care was needed. The DOC checked the plan of care and stated that it was last updated in 2014. She confirmed that the plan of care was not reviewed and revised when the resident 's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

8. The licensee failed to ensure that the resident was reassessed and the plan of care was 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.

The plan of care for a resident stated that staff were to ensure that the resident had access to their personal assistive device daily.

During observations made on two different dates, at different times, it was observed that the resident was not wearing the assistive device.

During an interview on a select date and time, a Personal Support Worker (PSW) stated that the resident no longer needed the assistive device. The PSW informed the inspector

that the resident had not needed the assistive device for over six months.

During an interview on a select date, the Director of Care (DOC) stated that the resident did not need the assistive device. The DOC reviewed the plan of care and acknowledged that it was not revised when the resident stopped using the assistive device. She stated that the plan of care should have been updated when the residents needs changed. [s. 6. (10) (b)]

9. The licensee failed to 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.

Upon review of a resident's care plan, it stated that the resident would continue to self ambulate using a wheelchair on and off the unit over the next quarter.

During an interview with a PSW on a select date and time, it was stated that the resident was not able to ambulate using a wheelchair and required the full assistance of staff to move from one location to another in their wheelchair.

The licensee failed to 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. [s. 6. (10) (b)]

10. The licensee failed to ensure that the resident was reassessed that the plan of care was 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.

Observations done of a resident during this inspection revealed that a resident sat in a wheelchair, rested in bed, and was transported to meals in the wheelchair.

Record review revealed that the resident had areas of altered skin integrity on an MDS assessment date. These areas were noted to be healed a month later. The plan of care indicated that the resident had a potential for altered skin integrity because of a specific activity that the resident did.

A Personal Support Worker (PSW) stated that the specific activity was no longer an activity the resident had done for two or more months.

The Director of Care (DOC) stated that during the MDS assessment month the resident had a major change in their cognition and was no longer participating in the specific activity.

The licensee failed to ensure that the plan of care was revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 1. to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other and, 2. to 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, to be implemented voluntarily.

WN #2: 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 failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the Act and the Regulation, "neglect' means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health,

safety or well-being of one or more residents.

Observations done on a select date revealed that two residents did not get offered lunch.
Observations done on a select date revealed that two residents did not get offered supper.
Observations done on another select date revealed that two residents did not get offered lunch.
Observations done on another select date revealed that two residents did not get offered lunch.

During this inspection a resident stated that they were told that if they did not go to the dining room for their meal then they would not get a meal. The resident stated that they were not comfortable eating around others.

During this inspection a resident stated that they were told that as of a certain date they would no longer be offered a meal in their room unless they were ill. The resident stated that they had not had certain meals for the past two to three weeks.

During this inspection a Registered Practical Nurse (RPN) stated that the direction from management was that if residents do not feel well they can have a tray otherwise residents were to go down to the dining rooms. Three Personal Support Workers (PSW) stated that they had been instructed that unless residents were sick they were not to offer them a tray as they were not to eat in their rooms. If they refused to go to the dining room then they were refusing their meal. They were told trays were too much work for the kitchen staff. A PSW also stated that fluids were not even offered to residents who refused to go to the dining room for meals. They stated that residents had to wait until the snack cart came around to get fluids.

The inspector reviewed the communication to all staff on the point click care dashboard. There was a note written by the Director of Support Services that revealed that she had explained to a resident they were making a choice not to come to the dining room for their meals, and that this had been explained to them, and that they understood the process. However, if the resident wanted a sandwich, they would be need to be reminded that this sandwich would come up with the bedtime snack cart, not on a tray at suppertime. If the resident wanted a meal then they would be happy to give them one when they came to the dining room.

Upon review of communication to all staff on the point click care dashboard a note was

revealed that was written by the Director of Care (DOC). The DOC stated that cognitively well residents were to be given the choice at mealtime to either go to the dining area to eat or to stay in room/on floor and not eat, that the choice was to eat or not to eat; not where the food was served. Residents who were ill (fever, colds, nausea, vomiting, diarrhea, etc) would receive trays. Residents on antibiotics were not considered ill unless they were in isolation or were obviously feeling ill. Urinary tract infections or wound infections did not exempt residents from going to the dining rooms for meals. Diabetics who were capable of making their own choices were to be allowed to skip a meal without receiving a tray. It was stated that having diabetes was not necessarily a reason to receive a tray if they were refusing to go to the dining room; Registered staff would adjust insulin doses accordingly. It was stated that fluids, including water, should still be offered from the snack cart if the resident did not attend the dining room for their meal.

On a select date, the Director of Support Services shared that if the residents were ill (vomiting, diarrhea, fever, migraines), palliative or had disruptive behaviours then they could receive a tray. If the reason was just that the resident did not want to go down to the dining room they could not have a tray.

The inspector discussed with the Director of Support Services the observations and that both residents had not been offered a lunch or supper meal during that period of time. The Director of Support Services shared that meals were offered in the dining room but the residents chose not to come to the dining room.

On a select date at a certain meal, two residents did not get offered a meal as they did not go to the dining room. The Administrator shared that meals were offered in the dining room. If the residents chose not to come to the dining room they were refusing their meal.

During a record review for a resident the records showed that the resident ate breakfast daily, refused lunches, and only consumed one supper meal over a 22 day period.

The resident's weight on a select date was recorded. A loss of 4.6 kilograms (kg) in two months was noted.

During a record review for a resident the records showed that the resident ate breakfast most days, rarely ate lunch, and rarely ate supper.

The licensee neglected two residents when they failed to assess the individual needs of those residents related to their ability or desire to attend the dining room when the residents were absent for 86-97% of lunch and dinner meals in a 22 day period. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to 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.

The home's policy with subject of Tray Service stated that the resident's criteria for eligibility for tray service included:
-Illness/outbreak procedures
-Totally bedridden
-Palliative care
-Behavioural issues awaiting appropriate assessment that may cause disruption in the dining room
-Resident's request for a specific occasion (eg. eating with visitors in an approved area within the Home).

Residents who refused to come to their assigned dining room who did not meet the criteria above would:
a) Be encouraged to come to the assigned dining room. If refusing find out why? (ie pain).
b) If clinically indicated a tray would be provided.
c) If not clinically indicated, they would be offered nutritional snacks from the snack cart following meal refusals.
The issuing authority for the home's policy was the Nutrition Manager.

The Act states that every licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. The long-term care home is to identify any risks related to nutrition care and dietary services and hydration, and implement interventions to mitigate and manage those risks.
The Act states that every licensee of a long-term care home shall ensure that each resident is offered a minimum of three meals a day.

On a select date, three residents were not offered a lunch meal as they did not go to their assigned dining rooms.
On a select date, four residents were not offered a supper meal as they did not go to their assigned dining rooms.
On a select date, four residents were not offered a lunch meal as they did not go to their assigned dining rooms.
On a select date, two residents were not offered a lunch meal as they did not go to their assigned dining rooms.
The residents listed above did not refuse to eat their meal.

The licensee failed to ensure that the tray service policy was in compliance with the Act as it did not include risks related to nutrition care and hydration or interventions to manage the risks if residents chose not to come to the dining room. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home used SmartMeds' Pharmacy and followed their pharmacy policy and procedure manual, narcotic and controlled drug count and ward count policy.

The policy stated that when a narcotic medication is administered, the nurse must document the following information on the form: date, time, quantity administered, quantity remaining and the nurse's initials.

On a select date, a Registered Practical Nurse (RPN) was observed signing the resident's narcotic/controlled drug count/ward count after completing the medication pass in the main dining room.

On a select date and time, the inspector approached the RPN and asked for the narcotic/controlled drug/ward count sheets for review. The RPN shared that they had not signed off yet for any of the narcotics/controlled drugs that they had administered since starting their shift.

The Director of Care (DOC) shared that the resident's narcotic/controlled drug count/ward count was to be completed when the medication was administered.

The licensee failed to ensure that the Narcotic and Controlled Drug Count and Ward Count policy was complied with. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

On review of the Minimum Data Set (MDS) information, a resident was coded as a three with bowel control (frequently incontinent two to three times a week) and a three with bladder control (tended to be incontinent daily but with some control present).

The quarterly MDS coded a resident as a two for both bowel and bladder, meaning occasionally incontinent of bowel once a week and incontinent of bladder two or more times a week, but not daily.

The home's policy titled "Continence Care and Bowel Management Program", stated under procedure that each resident was to be assessed using the bladder and bowel continence assessment tool within 24 hours of admission, and quarterly as a secondary assessment, if the urinary incontinence Resident Assessment Protocol (RAP) was triggered or if constipation had been identified.

During an interview on a select date and time, the Director of Care (DOC) stated that an assessment under the assessment tab in Point Click Care (PCC) should have been completed if there was a change in the continence status and upon admission.

The assessment tab was reviewed in PCC and it was noted that a continence care and

bowel assessment was not completed for the resident for the change in continence for a four month period. Upon further review of the clinical record it was found that there was not a continence care and bowel assessment completed upon admission.

A Registered Practical Nurse (RPN) stated that there was not an assessment completed for the resident in the chart and it was confirmed with the Assistant Director of Care (ADOC). [s. 51. (2) (a)]

2. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

On review of the Minimum Data Set (MDS) information, a resident was coded as being frequently incontinent of both bowel (two to three times a week) and bladder (tended to be incontinent daily), but with some control present. The resident's urinary continence was identified as changed as compared to their status of 90 days prior and the change in urinary continence was identified as deteriorated.

The quarterly MDS, indicated that a resident was usually continent of bowel (less than weekly) and bladder (having incontinent episodes once a week or less).

During an interview on a select date and time, the Director of Care (DOC) stated that an assessment under the assessment tab in Point Click Care (PCC) should have been completed if there was a change in the continence status and upon admission.

The assessment tab was reviewed in PCC and it was noted that a continence care and bowel assessment was not completed for the resident for the change in continence for a four month period. Upon further review of the clinical record it was found that there was not a continence care and bowel assessment completed upon admission.

This was confirmed with a Registered Nurse (RN) who reviewed the resident's chart with the inspector and stated that the assessment should have been completed however, it was not done. [s. 51. (2) (a)]

3. The licensee failed to ensure that that the resident who was incontinent received an

assessment that included identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A resident had an Admission Continence Assessment done on a select date. This assessment indicated that the resident was continent of bladder and bowel. The resident's Minimum Data Set (MDS) quarterly assessment done on a specific date, indicated that the resident was frequently incontinent of bowel and bladder and the urinary incontinence resident assessment protocol (RAP)was triggered. The resident's MDS significant change in status assessment done on a specific date indicated that the resident was incontinent of bowel and frequently incontinent of bladder and the urinary incontinence RAP was triggered. The resident's MDS quarterly review assessment done on a select date indicated that the resident was incontinent of bowel and incontinent of bladder and the urinary incontinence RAP was triggered.

A Personal Support Worker (PSW) stated that the resident had had a change in the last few months and was no longer toileted as the resident no longer recognized the need.

Review of the home's policy titled "Continence Care and Bowel Management Program", stated that the registered staff would assess each resident, using the Bladder and Bowel Continence Assessment Tool (Appendix A), quarterly (as a secondary assessment) if the "Urinary Incontinence" RAP was triggered or if constipation had been identified.

Record review revealed that the Bladder and Bowel Continence Assessment had not been done for a resident since the year 2011.

The Director of Care (DOC) stated that a Bladder and Bowel Continence Assessment should have been done as the resident had a major change in cognition.

The licensee failed to ensure that the resident had an assessment conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when their condition changed. [s. 51. (2) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were offered a minimum of three meals daily.

On a select date, during dining observation, it was noted that a number of residents were not in the dining rooms.

A resident was observed in their room at a select time around the lunch meal. Approximately one hour later the resident was still in bed and indicated that they did not get lunch. A Personal Support Worker (PSW) stated that they thought the resident went to the dining room but in fact did not, and did not receive a tray.

A resident was observed in their room at a certain time around the lunch meal. The resident stated that they were told that if they don't go to the dining room then they do not get offered a meal.

A resident was observed in their room, at a certain time, and they were in bed. The resident stated that they were told that they do not get a meal if they do not go to the dining room.

On a select date a Registered Practical Nurse (RPN) stated that the two residents did not get a tray for lunch because they did not go down to the dining room. The RPN said that the direction from management was that residents who do not feel well can have a tray otherwise residents are to go down to the dining rooms.

On a select date, a Cook stated that there some trays prepared for some residents but

not for the three residents indicated.

On a select date, observations made during the supper meal revealed that four residents were not offered a meal as they did not go to the dining rooms.

A resident stated that they had not been feeling well the last couple of days but said they were going down for supper as they would not feed them on the floor anymore; not even at a table in the lounge.

Two residents were in their room. A resident stated that they often miss one of the meals however, on this day, they had slept through another meal. The inspector asked if they were offered the next meal, however they indicated that they did not get a meal and that their family had purchased snacks for them to eat later.

Two Dietary Aides stated that no trays for the meal were sent up to the four residents.

On a select date, at a meal, four residents were observed to be in their rooms and were not offered a meal. A PSW stated that they had been instructed that unless residents were sick they were not to offer them a tray, as they were not to eat in their rooms.

On a select date, the Director of Support Services stated that only if the residents are ill (vomiting, diarrhea, fever, migraines), palliative or had disruptive behaviours could they receive a tray. If the reason was just that the resident did not want to go down to the dining room they could not have a tray.

The inspector discussed with the Director of Support Services the observations and that neither of the two residents had been offered a lunch or supper meal during that period of time. The Director of Support Services shared that meals were offered in the dining room but the residents chose not to come to the dining room.

On a select date, at a meal, two residents did not get offered a meal as they did not go to the dining room. The Administrator shared that meals were offered in the dining room. If the residents chose not to come to the dining room they were refusing their meal.

The licensee failed to offer seven residents three meals a day. [s. 71. (3) (a)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

A review done by the inspector of a resident's narcotic record for a select medication revealed that there were discrepancies between the narcotic record and the doses recorded for the resident in their medication administration record (MAR) on a select date.

A review done by the inspector of another resident's narcotic record for a select medication, revealed that there were discrepancies between the narcotic record and the doses recorded for the resident in their MAR on eight different dates.

A review done by the inspector of another resident's narcotic record for a select medication, revealed that there were discrepancies between the narcotic record and the doses recorded for the resident in their MAR on two different dates.

A review done by the inspector of another resident's narcotic record for a select medication, revealed that there were discrepancies between the narcotic record and the dose recorded for the resident on one date.

The Director of Care (DOC) stated that the home did not complete a monthly audit of the daily count sheets of controlled substances to determine if there were any discrepancies. The DOC and the Administrator stated they were not aware of the discrepancies listed above until shown by the inspector. [s. 130. 3.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug.

On a select date, a resident was ordered a medication for a clinical condition. Review of the resident's progress notes did not reveal that they had the medication delivered at any time on the select date. There was no documentation in the resident's progress notes that they received any medication for the clinical condition until several hours later. A review of the progress notes revealed that the medication was effective but five minutes later the progress notes indicated that more of the medication was given by the RPN for the clinical condition. There was no documentation in the progress notes indicating how the resident was responding to the medication or as to why they needed more medication at that time. The resident was then given the medication again two separate times by the RPN, however there was no documentation of any assessment of the resident to indicate how they were responding to the medication or as to the reasons why they needed more medication.

On a select date, the resident's progress notes, medication administration records (MAR), and individual narcotic records were reviewed with the Administrator and the

Director of Care (DOC). They stated that there were discrepancies in the documentation and that there should have been assessments noted in the progress notes regarding the clinical condition and the resident's condition throughout the shift to show that there was monitoring of the resident.

Review of another resident's MAR and the resident's narcotic controlled drug record was done for a prescribed medication for a clinical condition.

According to the narcotic record the medication was signed out for the resident by the RPN on eight dates at various times.

Review of the MAR for these dates was done and there was no documentation that the resident got the medication on the dates at the stated times. Review of the progress notes did not reveal any assessment of the resident needing the medication at these times or to the effectiveness of the medications if given.

The Administrator and the DOC shared that the medications were to be documented in the MAR and there should have been an assessment in the progress notes indicating the need, and then monitoring and documentation indicating the effectiveness, of the medication given to the resident.

A review of another resident's MAR and the resident's narcotic controlled drug record was done for a prescribed medication for a clinical condition.

According to the narcotic record for two dates at two different times, the medication was signed out for the resident by the RPN. A review of the resident's MAR and progress notes was done and there was no documentation that the resident was assessed for needing the medication at these times, that the medication was administered, or that there was any effectiveness to the medication.

A review of another resident's MAR and resident's narcotic controlled drug record was done for the prescribed medication for a clinical condition.

According to the narcotic record on a select date and time, the medication was signed out for the resident by the RPN. Review of the resident's MAR and progress notes was done and there was no documentation that the resident was assessed for needing the medication at the stated time, that the medication was administered, or that there was any effectiveness to the medication.

The Administrator and the DOC stated that the medications were to be documented in the MAR and there should have been an assessment in the progress notes indicating the need, and then monitoring and documentation indicating the effectiveness, of the medication given to resident. [s. 134. (a)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents at all times.

Observation on a select date and time of the call bell in the washroom of two residents revealed that the call bell apparatus on the wall was not equipped with a string or cord in order for the call bell to be easily activated. A Registered Practical Nurse (RPN) verified that the pull cord for the call bell was missing and that there should be a pull cord in order for the residents to be able to activate the call bell.

The Assistant Director of Care (ADOC) stated that all call bell apparatus should have a pull cord present for the call bell to be easily activated. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

The home's policy titled, " Abuse – Resident Abuse and Neglect", stated under procedure that if a staff member or volunteer became aware of potential or actual abuse, by a staff member, volunteer family member or co-worker, the following steps must be taken: to safeguard the resident immediately and notify the charge Nurse.

Record review revealed that on a select date and time, a resident was assisted into bed by two Personal Support Workers (PSWs). A third PSW was picking up clothes and tidying up in the room. The resident was cognitively impaired.

During an interview with a PSW it was reported that during care for the resident, another co-worker PSW was agitating the resident. The resident was disturbed by the staff member's behaviour towards them. A PSW was witnessed by two other PSWs being verbally and physically abusive to the resident. The nurse in charge had come in the room shortly after the incident but did not witness it, and the incident was not reported to the nurse by the staff members that witnessed the incident.

This incident was not reported until the next morning.

In an interview with the PSW who witnessed the incident it was confirmed that she did not report the incident, and acknowledged that the incident was reported by another PSW the next day.

The Administrator acknowledged that when the two staff members witnessed the alleged abuse by the co-worker PSW, the incident should have been reported immediately, as per policy, however, it was not. She stated that both of the PSWs had the annual education on abuse and neglect and were aware of reporting protocols.

The home's policy was not complied with when staff members neglected to safeguard the resident immediately and notify the charge nurse. [s. 20. (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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated:
(i) Abuse of a resident by anyone.

On a select date, a resident reported that approximately two months prior a staff member had been rude and vulgar towards them. The resident stated that they had reported this to the Director of Care (DOC).

On a select date, the resident stated that about two months ago a Personal Support Worker (PSW) asked the resident what they were complaining about. The resident

started to explain what they were upset about. The PSW made inappropriate comments to the resident.

The resident stated that they had told the Administrator about it but was not sure anything was going to be done, so they wrote the concern down and gave it to the Director of Care (DOC).

The record review revealed that the resident was cognitively intact.

On a select date, the Director of Care (DOC) stated that the resident had given her a list with a number of concerns on it, but did not recall the comments that were used. The inspector asked to see the list that the resident had provided to her. The first item on the list was the inappropriate comments that the resident had described. This was told to the Administrator and they did not believe that any action would be taken. The DOC stated that they did not see or recognize one of the comments, as that word was not in their vocabulary. The DOC stated she had written the PSW's name next to the comment as they had met with the resident to find out who made the comment. The DOC stated that they had no investigation notes indicating that they had investigated this incident. The DOC stated that they did speak with the PSW and that the PSW reported that they may have said it that comment to the resident.

During an interview on a select date , the PSW denied that they had said the inappropriate comments.

On a select date, the Administrator stated that they were not sure if the Director of Care (DOC) had met with the PSW. The Administrator was not aware that the DOC had received this concern in writing. The Administrator was not able to provide any risk management reports showing that this incident had been investigated. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who could not brush their own teeth received physical assistance or cueing.

During an interview with a family member on a select date, the family member complained that the resident, who was not able to do a certain activity of daily living (ADL), did not receive physical assistance from staff and the only time the resident had assistance with this ADL was when the family came in to visit the resident.

The plan of care was reviewed and it stated that the resident was totally dependent on staff for the stated ADL, and that the ADL was to be done three times a day as per the Power of Attorney (POA).

Observations on two different dates, four days apart, it was revealed that the resident was assisted back to the resident care area from the dining area and was placed in the lounge. No ADLs were observed to be provided to the resident.

During an interview on a select date and time, a Personal Support Worker (PSW) saw that the ADL was needed and that it had not been done as per the plan of care. The PSW stated that physical assistance was not provided to the resident for the ADL. It was observed by the inspector that the PSW then went into the resident's room to perform the ADL. [s. 34. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who cannot brush their own teeth receive physical assistance or cueing, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The skin and wound nursing assessments for selected dates for a resident, identified there were three areas of altered skin integrity on three separate areas of the body. These three areas had had initial wound assessments done but there was no evidence of weekly skin and wound assessments.

The home's policy titled, "Skin and Wound Care Program", stated that a wound assessment was the first step in wound management. Any wound, including suspected deep tissue injury stages I to IV, and unstageable pressure ulcers, were to have initial wound assessments completed and then a weekly follow up on the Wound Assessment tab on Point Click Care (PCC).

During a review of the Treatment Assessment Record (TAR) for a select date, it was noted that there were no treatments or assessments completed for the three areas of altered skin integrity.

During an interview on a select date, a Registered Practical Nurse (RPN) stated that the resident had a chronic medical condition and had wounds that would not heal, however, the treatments were completed by the Registered Nurses (RNs) and not the RPNs.

The Director of Care (DOC) stated that the assessments that were not documented were not done. She stated that the resident had chronic wounds that would not heal, however, the expectation was to have the areas of altered skin integrity reassessed at least weekly by a member of the Registered Nursing staff and it was not done. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance.

During this inspection, a Registered Practical Nurse (RPN) stated that some missing narcotic medication had been reported to the Director of Care (DOC) on a date earlier in 2016 but they were not sure if there had been any action taken, or if the medications had been located.

During an interview with the Administrator and the DOC on a select date, they were both asked if there had been any concerns brought forward to their attention regarding narcotic discrepancies. They both answered, no.

During an interview with the Administrator and the DOC on a select date, while reviewing some narcotic/ward count sheets, the Administrator and the DOC were asked if there had been any concerns brought forward to their attention regarding any discrepancies in the narcotic/ward counts or any reports of missing narcotics. They both replied, no.

On a select date, a RPN shared that the missing narcotic medication was prescribed for specific resident. The inspector advised the Administrator that it had been reported that this specific resident had narcotic medication missing.

On a select date, the Administrator indicted that they had been aware that the resident had narcotic medication missing since a date earlier in 2016 but thought they had been found.

On a select date, the DOC stated that on an earlier date in 2016, the resident had sixteen narcotic tablets missing that had not been found. The DOC had the resident's Narcotic/Controlled Drug Count/Ward Count sheet but did not have the medications. The DOC shared that they did not mention this when asked about discrepancies or missing narcotics as they were still not convinced that they were missing. The inspector asked if they had the narcotic tablets for the resident. The DOC stated, no.

The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance. [s. 107. (3)]

2. The licensee failed to inform the Director of the outcome or current status of an

individual who was involved in a medication incident in respect of which a resident was taken to hospital.

As per a Critical Incident Report, on a select date, a resident was administered another resident's medications. The resident went to the hospital for treatment and then returned to the home. As per the CIS, submitted the next day after the resident returned to the home, the outcome/current status of the individual involved stated that the resident had returned to normal self, physically and cognitively, and was in good spirits. The CIS indicated that the resident had some symptoms of illness that evening but then went to bed and had no further symptoms. The CIS indicated that neither the resident or their spouse had lodged any complaints concerning the incident.

The progress notes reviewed on six select dates after the incorrect medication administration indicated the resident was exhibiting signs and symptoms of physical illness and distress and had to be reassessed at the hospital.

During this inspection three PSWs shared that when the resident returned from hospital after being given the wrong medications, that the resident was not themselves for a few weeks. They reported that the resident was very unsteady and could no longer walk without assistance or come to the dining room for meals.

The RPN shared that when the resident returned from hospital the resident was not very good and could no longer walk without assistance.

Progress notes were reviewed with the Director of Care (DOC). The initial CIS for the resident, on a select date, indicted that the resident had returned to his normal self, physically and cognitively. When the DOC was asked why the CIS indicated this, they shared that they had not reviewed all the progress notes for the resident.

The licensee failed to inform the Director of the outcome/current status of the individual involved in the critical incident. [s. 107. (4) 3. v.]

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 1. to ensure that the Director is informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance

2. to ensure that the Director is informed of the outcome or current status of an individual who was involved in a medication incident in respect of which a resident was taken to hospital, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response in writing was given within 10 days of receiving Family Council advice related to concerns or recommendations.

The Family Council (FC) meeting minutes were reviewed by the Inspector . It was noted that the meeting minutes on a date in 2015 had a list of written concerns that were to be addressed by the Administrator. The response letter, referring to the concerns, from the Administrator was written four months later.

During an interview with the Administrator on a select date and time, it was stated that she did respond to the written concerns four months after they were received from Family Council. She stated that they only meet quarterly so she felt that this was sufficient. She voiced understanding that this response time was longer than the required ten day response under the Legislation.

On review of Family Council meeting minutes dated early in 2016, it was noted that FC were requesting a written response to their current concerns. The Administrator provided a written response for the Inspector to review which was dated two weeks later, which was not present in the FC meeting minute binder when reviewed by the inspector initially.

The licensee failed to ensure that a response in writing was given within 10 days of receiving Family Council advice related to concerns or recommendations when a written response was not provided by the Administrator for four months after the 2015 concerns and fourteen days after the 2016 concerns. [s. 60. (2)]

WN #15: 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. (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 failed to ensure that the results of the satisfaction survey were documented and made available to the Residents' Council in order to seek the advice of the Council about the survey.

On a select date and time, the President of Resident Council stated that the home did not make the results of the satisfaction survey available to seek the advice from the Resident Council.

During an interview on a select date and time, the Director of Therapeutic Programs stated that the Family Council and Resident Council were two separate councils and the satisfaction surveys were specific to each council. Therefore, Resident satisfaction survey results were only shared with the Resident Council and Family satisfaction surveys results were only shared with the Family Council. She confirmed that the satisfaction survey results from both the Family and Resident Council were not made available in order to seek advice. [s. 85. (4) (a)]

2. The licensee failed to ensure that the licensee documented and made available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

The Family Council meeting minutes were reviewed and the minutes stated that the family satisfaction survey results were shared in the meeting.

Upon interview with the Family Council Representative on a select date, it was stated that the satisfaction survey results were not shared with the Family Council (FC). She stated that she had been a member on FC for four years and could not recall ever seeing the results of the satisfaction survey.

Upon interview with the Director of Therapeutic Programs on a select date, it was stated that the home had two surveys they did; one separate for families and one separate for residents. She stated that the resident survey was completed by residents who had a Cognitive Performance Scale (CPS) of 0 -2, and that she would assist them with the survey if they requested. She stated that there was a separate family survey and that the families were given the survey during the annual care conference for their family member. The results of the family survey were only shared with FC and the results of the resident survey were shared with Resident Council (RC).

The Act states that the licensee shall ensure that the results of the survey are documented and made available to the Residents' Council and the Family Council to seek their advice.

The licensee failed to ensure that the licensee documented and made available to the Family Council the results of both family and resident satisfaction surveys in order to seek the advice of the Council about the surveys. [s. 85. (4) (a)]

Issued on this 17th day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHERRI GROULX (519), NANCY SINCLAIR (537), NUZHAT UDDIN (532), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2016_258519_0008
Log No. / Registre no:	019603-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 4, 2016
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	SAUGEEN VALLEY NURSING CENTER 465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATE MACLEAN

To SHARON FARMS & ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that resident # 025 receives their personal care, as per the plan of care and that resident # 014 has an assistive device placed daily, as per the plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

According to the documentation in the progress notes a resident was injured on a select date. The injury required treatment at the hospital.

Upon review of the resident's care plan it stated that staff were to ensure that the resident was dressed properly in order to prevent injury.

During an interview with a Personal Support Worker (PSW) on a select date and time, it was stated that the resident was not wearing proper attire when the incident occurred as they had just had their bath.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when the resident was not wearing appropriate attire and sustained an injury. [s. 6. (7)]

(519)

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for a resident stated that staff were to ensure that the resident had an assistive device placed every morning.

During the Stage One staff interview on a select date and time, it was stated by the Registered Staff that the resident was to have an assistive device placed by the Personal Support Worker (PSW) every day.

During observations made on two different dates and at different times it was revealed that the resident did not have the assistive device placed by the PSWs each morning.

On a select date, this concern was mentioned to the Director of Care (DOC) and she stated that the the assistive device would not stay in place, however, the expectation was that staff put it on. The DOC was informed that the assistive device was not being placed on as per the plan of care. The different observations made by the inspector were communicated with the DOC.

On a select date and time, further observation revealed that the resident did not have the assistive device placed on as per the plan of care. [s. 6. (7)]

(532)

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A resident's plan of care stated that the resident was to receive personal care before and after each meal.

On two different dates and times, it was observed that the resident was sitting in a lounge with their eyes closed and remained sitting in the lounge in the same spot until the staff assisted them to the dining room. The resident was not provided personal care during these observations.

On three different dates and times, after a meal, it was noted that the resident was assisted back to a resident care area from the dining area and was placed in the same lounge, where the resident remained sitting. No assistance with personal care from staff was provided to the resident after the meal.

On a select date and time, a Personal Support Worker (PSW) stated that the staff on their select shift do not have time to provide this personal care to the residents. They indicated that due to resident directed care and the different times residents would require assistance, it took away from the time that they would have to provide the personal care to the residents. She confirmed that the resident was supposed to be provided this personal care as per plan of care.

On a select date, the Director of Care (DOC) stated the expectation was for staff to check the resident at least once during those hours. She acknowledged that the individual resident directed care had created different challenges for the staff, and stated that they were still working on fixing these issues. The DOC stated that the personal care set out in the plan of care for the resident was not provided as specified in the plan of care. [s. 6. (7)]

The scope of this issue was a pattern (2). The severity was actual harm (3) as one resident suffered harm when the plan of care was not followed, and the home was issued a Voluntary Plan of Correction (VPC) on October 7, 2015 (3).

(532)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure resident's dietary needs are not neglected. The licensee will ensure a nutrition assessment of residents # 009 and # 043 are completed regarding their dietary requirements, abilities and preferences to ensure adequate nutritional meal choices are offered on an on-going basis.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the Act and the Regulation, "neglect' means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Observations done on a select date revealed that two residents did not get offered lunch.
Observations done on a select date revealed that two residents did not get offered supper.
Observations done on another select date revealed that two residents did not get offered lunch.
Observations done on another select date revealed that two residents did not get offered lunch.

During this inspection a resident stated that they were told that if they did not go to the dining room for their meal then they would not get a meal. The resident stated that they were not comfortable eating around others.

During this inspection a resident stated that they were told that as of a certain date they would no longer be offered a meal in their room unless they were ill. The resident stated that they had not had certain meals for the past two to three weeks.

During this inspection a Registered Practical Nurse (RPN) stated that the direction from management was that if residents do not feel well they can have a tray otherwise residents were to go down to the dining rooms. Three Personal Support Workers (PSW) stated that they had been instructed that unless residents were sick they were not to offer them a tray as they were not to eat in their rooms. If they refused to go to the dining room then they were refusing their meal. They were told trays were too much work for the kitchen staff. A PSW also stated that fluids were not even offered to residents who refused to go to the dining room for meals. They stated that residents had to wait until the snack cart came around to get fluids.

The inspector reviewed the communication to all staff on the point click care dashboard. There was a note written by the Director of Support Services that revealed that she had explained to a resident they were making a choice not to come to the dining room for their meals, and that this had been explained to them, and that they understood the process. However, if the resident wanted a sandwich, they would be need to be reminded that this sandwich would come up with the bedtime snack cart, not on a tray at suppertime. If the resident wanted a meal then they would be happy to give them one when they came to the dining room.

Upon review of communication to all staff on the point click care dashboard a note was revealed that was written by the Director of Care (DOC). The DOC stated that cognitively well residents were to be given the choice at mealtime to either go to the dining area to eat or to stay in room/on floor and not eat, that the choice was to eat or not to eat; not where the food was served. Residents who were ill (fever, colds, nausea, vomiting, diarrhea, etc) would receive trays. Residents on antibiotics were not considered ill unless they were in isolation or were obviously feeling ill. Urinary tract infections or wound infections did not exempt residents from going to the dining rooms for meals. Diabetics who were capable of making their own choices were to be allowed to skip a meal without receiving a tray. It was stated that having diabetes was not necessarily a reason to receive a tray if they were refusing to go to the dining room; Registered staff would adjust insulin doses accordingly. It was stated that fluids, including water,

should still be offered from the snack cart if the resident did not attend the dining room for their meal.

On a select date, the Director of Support Services shared that if the residents were ill (vomiting, diarrhea, fever, migraines), palliative or had disruptive behaviours then they could receive a tray. If the reason was just that the resident did not want to go down to the dining room they could not have a tray.

The inspector discussed with the Director of Support Services the observations and that both residents had not been offered a lunch or supper meal during that period of time. The Director of Support Services shared that meals were offered in the dining room but the residents chose not to come to the dining room.

On a select date at a certain meal, two residents did not get offered a meal as they did not go to the dining room. The Administrator shared that meals were offered in the dining room. If the residents chose not to come to the dining room they were refusing their meal.

During a record review for a resident the records showed that the resident ate breakfast daily, refused lunches, and only consumed one supper meal over a 22 day period.

The resident's weight on a select date was recorded. A loss of 4.6 kilograms (kg) in two months was noted.

During a record review for a resident the records showed that the resident ate breakfast most days, rarely ate lunch, and rarely ate supper.

The licensee neglected two residents when they failed to assess the individual needs of those residents related to their ability or desire to attend the dining room when the residents were absent for 86-97% of lunch and dinner meals in a 22 day period. [s. 19. (1)]

The scope of this issue was a pattern (2), and the severity was determined to be actual harm (3). The compliance history revealed a related non- compliance issued as a Voluntary Plan of Correction (VPC) on June 2, 2014 (3).

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2016

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's tray policy includes interventions to address situations when residents are choosing not to come to the dining room on an on-going basis. The policy should include what monitoring will be done to ensure the daily nutrition needs of all residents are met.

Grounds / Motifs :

1. The licensee failed to 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.

The home's policy with subject of Tray Service stated that the resident's criteria for eligibility for tray service included:
-Illness/outbreak procedures
-Totally bedridden
-Palliative care
-Behavioural issues awaiting appropriate assessment that may cause disruption in the dining room
-Resident's request for a specific occasion (eg. eating with visitors in an approved area within the Home).

Residents who refused to come to their assigned dining room who did not meet the criteria above would:

a) Be encouraged to come to the assigned dining room. If refusing find out why? (ie pain).
b) If clinically indicated a tray would be provided.
c) If not clinically indicated, they would be offered nutritional snacks from the snack cart following meal refusals.
The issuing authority for the home's policy was the Nutrition Manager.

The Act states that every licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. The long-term care home is to identify any risks related to nutrition care and dietary services and hydration, and implement interventions to mitigate and manage those risks.
The Act states that every licensee of a long-term care home shall ensure that each resident is offered a minimum of three meals a day.

On a select date, three residents were not offered a lunch meal as they did not go to their assigned dining rooms.
On a select date, four residents were not offered a supper meal as they did not go to their assigned dining rooms.
On a select date, four residents were not offered a lunch meal as they did not go to their assigned dining rooms.
On a select date, two residents were not offered a lunch meal as they did not go to their assigned dining rooms.
The residents listed above did not refuse to eat their meal.

The licensee failed to ensure that the tray service policy was in compliance with the Act as it did not include risks related to nutrition care and hydration or interventions to manage the risks if residents chose not to come to the dining room.

The scope of this issue was a pattern (2), and the severity was a potential for harm (2). This was issued as a VPC on July 9, 2015 (3).

(155)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that resident # 027, resident # 025, and any other resident who has a change in continence status has a continence assessment completed, using a clinically appropriate assessment instrument.

Grounds / Motifs :

1. The licensee failed to ensure that that the resident who was incontinent received an assessment that included identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A resident had an Admission Continence Assessment done on a select date. This assessment indicated that the resident was continent of bladder and bowel. The resident's Minimum Data Set (MDS) quarterly assessment done on a specific date, indicated that the resident was frequently incontinent of bowel and bladder and the urinary incontinence resident assessment protocol (RAP)was triggered. The resident's MDS significant change in status assessment done on a specific date indicated that the resident was incontinent of bowel and frequently incontinent of bladder and the urinary incontinence RAP was triggered. The resident's MDS quarterly review assessment done on a select date indicated that the resident was incontinent of bowel and incontinent of bladder and the urinary incontinence RAP was triggered.

A Personal Support Worker (PSW) stated that the resident had had a change in the last few months and was no longer toileted as the resident no longer recognized the need.

Review of the home's policy titled "Continence Care and Bowel Management Program", stated that the registered staff would assess each resident, using the Bladder and Bowel Continence Assessment Tool (Appendix A), quarterly (as a secondary assessment) if the "Urinary Incontinence" RAP was triggered or if constipation had been identified.

Record review revealed that the Bladder and Bowel Continence Assessment had not been done for a resident since the year 2011.

The Director of Care (DOC) stated that a Bladder and Bowel Continence Assessment should have been done as the resident had a major change in

cognition.

The licensee failed to ensure that the resident had an assessment conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when their condition changed. [s. 51. (2) (a)]

(155)

2. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

On review of the Minimum Data Set (MDS) information, a resident was coded as being frequently incontinent of both bowel (two to three times a week) and bladder (tended to be incontinent daily), but with some control present. The resident's urinary continence was identified as changed as compared to their status of 90 days prior and the change in urinary continence was identified as deteriorated.

The quarterly MDS, indicated that a resident was usually continent of bowel (less than weekly) and bladder (having incontinent episodes once a week or less).

During an interview on a select date and time, the Director of Care (DOC) stated that an assessment under the assessment tab in Point Click Care (PCC) should have been completed if there was a change in the continence status and upon admission.

The assessment tab was reviewed in PCC and it was noted that a continence care and bowel assessment was not completed for the resident for the change in continence for a four month period. Upon further review of the clinical record it was found that there was not a continence care and bowel assessment completed upon admission.

This was confirmed with a Registered Nurse (RN) who reviewed the resident's chart with the inspector and stated that the assessment should have been completed however, it was not done. [s. 51. (2) (a)]

(532)

3. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

On review of the Minimum Data Set (MDS) information, a resident was coded as a three with bowel control (frequently incontinent two to three times a week) and a three with bladder control (tended to be incontinent daily but with some control present).

The quarterly MDS coded a resident as a two for both bowel and bladder, meaning occasionally incontinent of bowel once a week and incontinent of bladder two or more times a week, but not daily.

The home's policy titled "Continence Care and Bowel Management Program", stated under procedure that each resident was to be assessed using the bladder

and bowel continence assessment tool within 24 hours of admission, and quarterly as a secondary assessment, if the urinary incontinence Resident Assessment Protocol (RAP) was triggered or if constipation had been identified.

During an interview on a select date and time, the Director of Care (DOC) stated that an assessment under the assessment tab in Point Click Care (PCC) should have been completed if there was a change in the continence status and upon admission.

The assessment tab was reviewed in PCC and it was noted that a continence care and bowel assessment was not completed for the resident for the change in continence for a four month period. Upon further review of the clinical record it was found that there was not a continence care and bowel assessment completed upon admission.

A Registered Practical Nurse (RPN) stated that there was not an assessment completed for the resident in the chart and it was confirmed with the Assistant Director of Care (ADOC). [s. 51. (2) (a)]

The scope of this issue was widespread (3) with three out of three residents reviewed affected and the severity was a potential for harm (2). The home had a history of unrelated non-compliance (2).

(532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that all residents in the home are offered three meals a day.

Grounds / Motifs :

1. The licensee failed to ensure that residents were offered a minimum of three meals daily.

On a select date, during dining observation, it was noted that a number of residents were not in the dining rooms.

A resident was observed in their room at a select time around the lunch meal. Approximately one hour later the resident was still in bed and indicated that they did not get lunch. A Personal Support Worker (PSW) stated that they thought the resident went to the dining room but in fact did not, and did not receive a tray.

A resident was observed in their room at a certain time around the lunch meal. The resident stated that they were told that if they don't go to the dining room then they do not get offered a meal.

A resident was observed in their room, at a certain time, and they were in bed. The resident stated that they were told that they do not get a meal if they do not go to the dining room.

On a select date a Registered Practical Nurse (RPN) stated that the two residents did not get a tray for lunch because they did not go down to the dining room. The RPN said that the direction from management was that residents who do not feel well can have a tray otherwise residents are to go down to the dining rooms.

On a select date, a Cook stated that there some trays prepared for some residents but not for the three residents indicated.

On a select date, observations made during the supper meal revealed that four residents were not offered a meal as they did not go to the dining rooms.

A resident stated that they had not been feeling well the last couple of days but said they were going down for supper as they would not feed them on the floor anymore; not even at a table in the lounge.

Two residents were in their room. A resident stated that they often miss one of the meals however, on this day, they had slept through another meal. The inspector asked if they were offered the next meal, however they indicated that they did not get a meal and that their family had purchased snacks for them to eat later.

Two Dietary Aides stated that no trays for the meal were sent up to the four residents.

On a select date, at a meal, four residents were observed to be in their rooms and were not offered a meal. A PSW stated that they had been instructed that unless residents were sick they were not to offer them a tray, as they were not to eat in their rooms.

On a select date, the Director of Support Services stated that only if the residents are ill (vomiting, diarrhea, fever, migraines), palliative or had disruptive behaviours could they receive a tray. If the reason was just that the resident did not want to go down to the dining room they could not have a tray.

The inspector discussed with the Director of Support Services the observations and that neither of the two residents had been offered a lunch or supper meal during that period of time. The Director of Support Services shared that meals were offered in the dining room but the residents chose not to come to the dining

room.

On a select date, at a meal, two residents did not get offered a meal as they did not go to the dining room. The Administrator shared that meals were offered in the dining room. If the residents chose not to come to the dining room they were refusing their meal.

The licensee failed to offer seven residents three meals a day. [s. 71. (3) (a)]

The scope of this issue was a pattern (2), and the severity was a potential for harm (2). The home had a history of unrelated non-compliance (2).

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2016

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 130. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Order / Ordre :

The licensee shall ensure that a monthly audit of the daily count sheets for narcotics and controlled substances is done in order to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered. These audits are to be documented and reviewed monthly with no less than the Director of Care and Administrator in attendance.

Grounds / Motifs :

1. The licensee failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

A review done by the inspector of a resident's narcotic record for a select medication revealed that there were discrepancies between the narcotic record and the doses recorded for the resident in their medication administration record (MAR) on a select date.

A review done by the inspector of another resident's narcotic record for a select medication, revealed that there were discrepancies between the narcotic record and the doses recorded for the resident in their MAR on eight different dates.

A review done by the inspector of another resident's narcotic record for a select medication, revealed that there were discrepancies between the narcotic record and the doses recorded for the resident in their MAR on two different dates.

A review done by the inspector of another resident's narcotic record for a select medication, revealed that there were discrepancies between the narcotic record and the dose recorded for the resident on one date.

The Director of Care (DOC) stated that the home did not complete a monthly audit of the daily count sheets of controlled substances to determine if there were any discrepancies. The DOC and the Administrator stated they were not aware of the discrepancies listed above until shown by the inspector. [s. 130. 3.]

The scope of this issue was widespread (3) and the severity was a potential for actual harm (2). The home had a history of unrelated non-compliance (2).

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2016

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall ensure that all residents taking narcotics or controlled substances have documented assessments of the effectiveness of the drug and the resident's response after each dose to determine the necessity of additional doses.

Grounds / Motifs :

1. The licensee failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug.

On a select date, a resident was ordered a medication for a clinical condition. Review of the resident's progress notes did not reveal that they had the medication delivered at any time on the select date. There was no documentation in the resident's progress notes that they received any medication for the clinical condition until several hours later. A review of the progress notes revealed that the medication was effective but five minutes later the progress notes indicated that more of the medication was given by the RPN for the clinical condition. There was no documentation in the progress notes

indicating how the resident was responding to the medication or as to why they needed more medication at that time. The resident was then given the medication again two separate times by the RPN, however there was no documentation of any assessment of the resident to indicate how they were responding to the medication or as to the reasons why they needed more medication.

On a select date, the resident's progress notes, medication administration records (MAR), and individual narcotic records were reviewed with the Administrator and the Director of Care (DOC). They stated that there were discrepancies in the documentation and that there should have been assessments noted in the progress notes regarding the clinical condition and the resident's condition throughout the shift to show that there was monitoring of the resident.

Review of another resident's MAR and the resident's narcotic controlled drug record was done for a prescribed medication for a clinical condition.

According to the narcotic record the medication was signed out for the resident by the RPN on eight dates at various times.

Review of the MAR for these dates was done and there was no documentation that the resident got the medication on the dates at the stated times. Review of the progress notes did not reveal any assessment of the resident needing the medication at these times or to the effectiveness of the medications if given.

The Administrator and the DOC shared that the medications were to be documented in the MAR and there should have been an assessment in the progress notes indicating the need, and then monitoring and documentation indicating the effectiveness, of the medication given to the resident.

A review of another resident's MAR and the resident's narcotic controlled drug record was done for a prescribed medication for a clinical condition.

According to the narcotic record for two dates at two different times, the medication was signed out for the resident by the RPN. A review of the resident's MAR and progress notes was done and there was no documentation that the resident was assessed for needing the medication at these times, that the medication was administered, or that there was any effectiveness to the

medication.

A review of another resident's MAR and resident's narcotic controlled drug record was done for the prescribed medication for a clinical condition.

According to the narcotic record on a select date and time, the medication was signed out for the resident by the RPN. Review of the resident's MAR and progress notes was done and there was no documentation that the resident was assessed for needing the medication at the stated time, that the medication was administered, or that there was any effectiveness to the medication.

The Administrator and the DOC stated that the medications were to be documented in the MAR and there should have been an assessment in the progress notes indicating the need, and then monitoring and documentation indicating the effectiveness, of the medication given to resident. [s. 134. (a)]

The scope of this issue was a pattern (2), and the severity was the potential for actual harm (2). The home had a history of unrelated non-compliance (2).

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 4th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Groulx

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