Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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 24, 2014	2014_323130_0021	H-001371-14	Resident Quality Inspection

Licensee/Titulaire de permis

SHALOM MANOR LONG TERM CARE HOME
12 Bartlett Avenue GRIMSBY ON L3M 4N5

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

SHALOM MANOR LONG TERM CARE HOME
12 BARTLETT AVENUE GRIMSBY ON L3M 4N5

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

GILLIAN TRACEY (130), KELLY HAYES (583), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 14, 15, 16, 17, 20, 21, 22, 2014

Please Note: the following critical incident inspections were conducted simultaneously with this RQI. H-000304-14,H-000371014, H-001324-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Manager of Dietary Services, Food Service Supervisor (FSS), Manager of Environmental Services, Registered Staff, personal support workers (PSWs), President of Residents' Council, President of Family Council, residents and families.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognized the resident’s individuality and respected the resident’s dignity.

A) On an identified date in 2014, resident #110 reported they had received rough treatment from a PSW during care on a specified in 2014. The resident did not receive injury as a result of the rough care; however, the PSW was terminated as a result of the manner in which they rendered care to the resident. The ADOC, DOC and ED confirmed the resident was not treated with courtesy, respect and dignity. (Inspector #130) [s. 3. (1) 1.]

2. The licensee has failed to ensure that residents, including resident #200, had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs.

A) On an identified date in 2014, resident #200 complained of a severe headache and received a narcotic for their pain. Staff obtained the resident's blood pressure (BP) and also removed the resident's medicated patch, which has a common side effect of causing headaches. Staff documented at this time that they would continue to monitor the resident. Hours later resident #200 received another analgesic for pain; however, the resident was not reassessed until a number of hours later. At an identified time on a specified date in 2014, resident #200 was given a medication with specific monitoring parameters ordered by the physician. A review of the resident's clinical record indicated that the resident had not been monitored or reassessed as ordered by the physician. It was confirmed by the DOC during an interview that the resident should have been monitored and the physician notified. Resident #200 was not cared for in a manner consistent with their needs.(Inspector #508) [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is treated with courtesy, respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity and to ensure that residents are properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 has 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 with and complement each other.

A) Resident #105's care plan identified the resident's bladder function as totally incontinent and their bowel function as continent. A review of the Minimum Data Set (MDS) coding for resident #105's bladder and bowel function on an identified date in 2014, identified that the resident was frequently incontinent for bladder and usually continent for bowel. The MDS coding for a specified month in 2014, indicated that the resident was totally incontinent of bladder and occasionally incontinent of bowel. The MDS assessment also indicated that there had been no change in the resident's continence status over the three month period in 2014. It was confirmed by the Assistant Director of Care that the assessments were not integrated, consistent with or complemented each other. (Inspector #508)

B) According to the clinical record of resident #108, on a specified date in 2014, the resident developed a staged ulcer to an identified area. On another date in 2014, Registered Staff documented that the resident was in bed due to the affected area. Later the same month, Registered Staff documented that the open area was worsening. During the same month, Registered Staff documented their assessment of the open area and identified the affected area as a different location. On at least four occasions during the same month, the affected area was identified to be at different locations. The ADOC confirmed the the location of the affected area and verified that Registered staff did not collaborate in their assessments of the resident. (Inspector #130)

C) Resident #105 had a fall on an identified date in 2014. A review of the resident's clinical record indicated that falls assessments were completed after this fall and quarterly on two separate dates. All of these assessments had indicated that the resident did not have a history of falls; however, resident #105 had fallen on two identified dates prior to the assessments. It was confirmed by the Director of Care during an interview on that the assessments did not accurately reflect the resident's fall history and that they were not integrated, consistent with and did not complement each other. (Inspector #508)

D) A review of the plan of care for resident #400 showed that the nutrition risk assessment completed on an identified date in 2014 indicated resident #400 had stable dysphagia and the quarterly nutrition assessment completed indicated that resident #400 had no swallowing issues. In an interview with the Dietary Manager it was confirmed that the assessments were not integrated, consistent with and did not compliment each other. (Inspector #583) [s. 6. (4) (a)]

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.

A) On an identified date in 2014, resident #100 was observed in the shower room unattended with a full sling attached to a mechanical lift; seated on the commode chair asleep. When inspector #583 entered the shower room the door was pulled three quarters closed and the curtain was pulled across inside and resident #100 was not visible to staff. A review of the plan of care indicated that resident #100 had severe cognitive impairment and physical limitations and required total assistance for transfers and toileting with two staff members. Registered and non registered staff were immediately summoned by the inspector and it was confirmed that resident #100 was left unsafely and was not being care for with two staff members as directed in the resident's plan of care. In an interview with the Chief Executive Officer, it was confirmed that the home's expectation was that resident #100 should not have been left unattended in a mechanical lift. Care was not provided as specified in the plan. (Inspector #583) [s. 6. (7)]

3. The licensee has failed to ensure that the resident 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.

A) The written plan of care for resident #102, indicated the resident had skin breakdown to two identified areas and a history of ulcers. A Treatment Administration Record (TAR), indicated that a specific intervention was no longer being used as the resident had no issues to the affected areas. The MDS Significant Change Assessments completed on a specified date in 2014, indicated the resident did not have any skin impairment. Registered Staff interviewed, confirmed the resident did not have any skin breakdown and confirmed the written plan of care was not updated when the resident's condition had changed. (Inspector 130)

B) Resident # 102 had a quarterly nutritional assessment completed on a specified date in 2013; the next quarter nutritional assessment was not completed until mid 2014. The Dietary Services Manager confirmed the resident was not assessed at least every six months as required. (Inspector #130) [s. 6. (10) (b)]

4. The licensee has failed to ensure that the resident's plan of care, including resident #107's, was reviewed and revised when the care set out in the plan had not been

effective.

A) Resident #107's plan of care had identified the resident as a high risk for falls and interventions had been revised on a specified date in 2014, due to fall. A review of the resident's clinical records indicated that the resident had 11 falls after that date. A review of the resident's clinical records indicated that the resident's plan of care had not been reviewed and revised after the first fall in 2014, despite the resident falling 11 times. It was confirmed by Registered Staff that the resident's plan of care had not been reviewed and revised when the care set out in the plan had not been effective. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 with and complement each other; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that
the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change and when the care set out in the plan has not been effective, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's Skin And Wound Care Program, OO-02-05-02, indicted that staff were to "conduct a head-to-toe assessment b) With a significant change in condition and e) Immediately prior to coding the Minimum Data Set (MDS) and upon return from hospital admission.

A) According to the clinical record of resident #102, MDS Significant Change In Status Assessments were completed on four identified dates in 2014. The DOC confirmed there were no head-toe-assessments completed immediately prior to the MDS coding on these dates. (Inspector #130)

B) Resident #108 had a Quarterly MDS Assessment completed on a specified date in 2014 and MDS Significant Change in Status assessments completed later in the year. Staff interviewed and the record confirmed head-toe-assessments were not completed immediately prior to these assessment periods. (Inspector #130)

C) Resident #110 was transferred to the hospital on a specified date in 2013 and returned to the home sometime later the same year. Staff interviewed confirmed a head to toe was not completed upon return from hospital as per the policy. (Inspector #130)

D) Resident #107 was transferred and admitted to the hospital on an identified date in 2014, for four days, due to a decline in their condition. A review of resident #107's clinical record indicated that a head to toe assessment had not been completed when the resident returned from the hospital. An interview with the Director of Care confirmed that a head to toe assessment had not been completed and that the Skin and Wound policy had not been complied with. (Inspector #508)

The home's Falls Prevention and Management Program, #00-02-05-01, directed registered staff to complete a fall risk assessment and a head to toe assessment after a resident had fallen.

A) Resident #107 was identified as a high risk for falls due their diagnosis and a history of falling. A review of the resident's clinical record indicated that over a three month period in 2014, resident #107 fell 13 times. Registered Staff did not complete a fall risk

assessment after 10 of the 13 falls, and did not complete a head to toe assessment after any of the 13 falls. It was confirmed by the Director of Care that the Falls Prevention and Management policy was not complied with.(Inspector #508) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

A) It was identified on a specified date in 2014, that resident call bells in rooms #217 and #313 were not functioning. It was confirmed by Registered Staff on second floor and the Maintenance Supervisor that these call bells identified by the inspectors were not functioning and had to be repaired. (Inspector #508) [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, staff and visitors at all times, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A) The home's Preventing, Reporting and Eliminating Abuse/Neglect of Residents Policy, OO-02-18-01 indicated: A. ZERO TOLERANCE OF ABUSE/NEGLECT 8. A person who has reasonable ground to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the related information to the Director 9. Every alleged, suspected or confirmed incident of Abuse/Neglect will be investigated. D. INVESTIGATION PROCEDURE: 15. An employee or party that has witnessed or has knowledge of an incident involving Abuse /Neglect will immediately report it to their supervisor/manager/charge nurse/designee and/or Chief Executive Officer; 20. The DOC/designee ensures that all information regarding the Abuse/Neglect allegation and investigation is documented.

A) On an identified date in 2014, resident #110 reported to staff #2 that they had received rough treatment from staff #1, during care on a specified date 2014. Staff #3, who was witness to the alleged abuse confirmed in an interview that they did not report the incident. During the home's internal investigation, other staff were interviewed and reported past incidents of alleged abuse, such as yelling and failure to render care when requested to residents #110, #001 and #002. Staff interviews and written statements from staff #3, #4 and staff #5 confirmed they did not report these incidents of alleged abuse to their immediate supervisor nor the Director. The DOC was unable to produce a written record of the home's internal investigation regarding the incident first reported. The DOC confirmed the home did not initiate an investigation regarding the unreported incidents involving residents #001 and #002, brought forward by staff #3, #4 and #5. The ED confirmed the home's policy: Preventing, Reporting and Eliminating Abuse/Neglect of Residents Policy, OO-02-18-01, was not complied with. (Inspector #130) [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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff were using all equipment, including assistive aids in the home in accordance with the manufacturers' instructions.

A) It was observed on a specified date in 2014, in the third floor tub room that the chair lift that staff use to bathe residents did not have the required lap belt used to secure residents. According to the manufacturers' instructions, residents were to be secured using the lap belt while in the chair lift. It was identified during further inspections of the tub rooms on other units, that the none of the chair lifts in use had the required lap belts. It was confirmed by the ED that staff were not using the chair lifts in accordance with the manufacturers' instructions. (Inspector #508)

B) On an identified date in 2014, resident #111 was observed sitting in their wheel chair with a restraining device applied. A review of the plan of care indicated that resident #111 required the device for personal safety. Inspector #583 could fit more than a closed fist between the resident and the device. Inspector #583 requested Registered staff observe the resident and it was confirmed that resident #111 could not unfasten the device and that the device was not properly applied. In an interview with the ADOC it was confirmed that the device was not used in accordance with the manufacturers' instruction. (Inspector #583) [s. 23.]

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 staff are using all equipment, including assistive aids in the home in accordance with the manufacturers' instructions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home, (a) completed a nutritional assessment for all residents whenever there was a significant change in a resident’s health condition.

A) According to the clinical record, resident #102 had MDS Significant Change In Status Assessments completed on two identified dates in 2014. The resident was not assessed by the Registered Dietitian over a seven month period from 2013 to 2014. The Dietary Services Manager confirmed the resident should have been assessed on at least two occasions during this time period when Significant Change In Status Assessments were completed. (Inspector #130) [s. 26. (4) (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 a registered dietitian who is a member of the staff of the home, (a) completes a nutritional assessment for all residents whenever there is a significant change in a resident’s health condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

A) A review of the plan of care for resident #201, indicated they had a an a specific diagnosis. A review of the physician's orders over a three month period in 2014, showed that resident #201 had an order for a medication which required specific monitoring. A review of the medication administration record for a specific time period in 2014, confirmed the medication was not documented as being provided as directed by the physician, on at least two occasions during this time period. This information was confirmed by the Registered staff. (Inspector #583) [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a continence care and bowel management program to promote continence and to ensure that residents are clean, dry, and comfortable had been developed and implemented.

A) It was identified during this inspection that resident's #101 and #105 had not received a continence assessment upon admission or when the residents had changes in their level of continence. Resident #101 was coded in the MDS as being incontinent of bladder during at least three occasions in 2014. The resident's bladder incontinence worsened during the second assessment period 2014. A review of the resident's clinical record indicated that resident #101 had not been assessed upon admission or when there were changes in their continence. Resident #105 was coded in MDS as being incontinent of bladder on at least four assessments completed in 2014. The resident's bladder incontinence worsened during the third assessment. A review of the resident's clinical record indicated that the resident had not been assessed upon admission or when there were changes in their continence. Registered Staff confirmed during an interview that they do not conduct continence assessments. During an interview with the DOC and ADOC, they had indicated that resident's were not receiving continence assessments as the Continence Care and Bowel Management Program had not been developed and implemented. (Inspector #508) [s. 48. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a continence care and bowel management program to promote continence and to ensure that residents are clean, dry, and comfortable is developed and implemented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home.

A) On an identified date in 2014, Registered staff identified that resident #102 had skin breakdown to two identified areas, which required treatment. According to the clinical record, the resident was at risk due to their diagnosis and identified to be at high nutritional risk. The RD had not assessed the resident for an identified time period. The interventions to the nutritional plan of care had not been revised since 2013. This information was confirmed by the Dietary Services Manager. (Inspector #130)

B) It was identified on a specified date in 2014, that resident #108 had a Skin breakdown to an identified area. Progress notes recorded by Registered staff on two months later indicated the area had worsened. By the third month the area had again worsened. Staff confirmed the resident was not assessed by the RD during this time period. (Inspector #130) [s. 50. (2) (b) (iii)]

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

A) It was identified in progress note on an identified date in 2014, that resident #102 had skin breakdown to a specified area, which required treatment. One area was assessed on six occasions during a specified month in 2014, the second area was not assessed over a one month period. The DOC confirmed that skin assessments were not completed weekly as required. (Inspector #130) [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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home and to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate instrument specifically design for this purpose.

A) Resident #105 had a fall on an identified date in 2014, and reported pain to a specified area, to Registered Staff during a post-fall assessment. The resident complained of pain again on two occasions the same day. The resident complained of pain on at least four identified dates after the fall, and received analgesics to alleviate their pain.
A review of resident #105's clinical record indicated that the resident had not been assessed for pain at any time using a clinically appropriate instrument. An interview with the Director of Care, confirmed that staff had not assessed resident #105's pain using a clinically appropriate instrument designed for that purpose. (Inspector #508)

B) Resident #200 had on-going complaints of pain to specified areas. A review of the resident's clinical record indicated that the resident was assessed for pain after a fall on an identified date in 2014, and on a later date in 2014, for a quarterly review. The resident received a 'when necessary' (PRN) analgesic to manage their pain. The quarterly pain assessment completed on a specified date in 2014, indicated that the resident had moderate pain, daily. The PRN analgesic that the resident was taking to manage their pain had been increased during the same MDS assessment period and it was identified that the previous analgesic order was not effective. The resident continued to complain of pain and received their PRN analgesic 15 times over a two week period in 2014, at which time the resident passed away. It was confirmed during an interview with the DOC that the resident's pain had not been relieved by the initial interventions and resident #200 had not been assessed after the fall in 2014, using a clinically appropriate assessment instrument specifically designed for pain. (Inspector #508) [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning
Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home;
O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle was approved by a registered dietitian who was a member of the staff of the home.

A) It was observed on October 20, 2014, that the home transitioned from the spring and summer menu to the fall and winter menu. In an interview with the Dietary Manager on October 20, 2014, it was confirmed that the new fall winter three week cycle menu was not reviewed and approved by the RD in the home. (Inspector #583) [s. 71. (1) (e)]

2. The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council. The Dietary Manager confirmed that the new fall and winter three week cycle menus had not been reviewed by the Residents' Council. (Inspector #130) [s. 71. (1) (f)]

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's menu cycle is approved by a registered dietitian who is a member of the staff of the home and to ensure that the menu cycle is reviewed by the Residents' Council, to be implemented voluntarily.

WN #13: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an annual resident satisfaction evaluation of continence care products was done in consultation with residents, substitute decision-makers (SDM's), and direct care staff.

A) During this inspection it was identified that the home did not provide residents, substitute decision-makers, and direct care staff the opportunity to evaluate the continence care products that were provided to the residents. During an interview with the ED on October 16, 2014, the ED indicated that they provide residents and Substitute Decision Makers (SDM's)a satisfaction survey on an annual basis. A review of the Resident Satisfaction Survey indicated that the survey only included a question asking to rate the accessibility to continence products and did not include questions about the resident's satisfaction of continent products. The ED confirmed that they do not provide an annual satisfaction survey to evaluate the continence care products to resident's, SDM's and staff. (Inspector #508) [s. 51. (1) 5.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service had included communication of the seven-day menu to residents.

A) It was observed on October 20, 2014, at the beginning of meal service, outside the dining room on first floor, that a resident reviewing both the daily and the seven-day menus, identified discrepancies between the two menus. A review of the menus indicated that the seven-day menu posted outside the dining room had not been updated from the "week three" menu to the current "week one" menu. An interview with the FSS on October 20, 2014, confirmed that there were discrepancies between the two menus posted and that the seven-day menu posted on this unit had not been changed to the current menu being offered to residents. (Inspector #508) [s. 73. (1) 1.]

WN #15: 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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was notified when an incident occurred that caused injury to resident #201 for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

A) Resident #201 sustained a serious injury following a fall on a specified date in 2014. The resident was transferred to hospital and required surgery. Prior to the fall, the resident required minimal staff assistance and ambulated independently with the use of a walker. The resident was re-admitted to the home after their surgery, and required extensive assistance with eating, bed mobility, hygiene and transferring. The DOC confirmed that the Critical Incident Report was not submitted until after their readmission and should have been submitted no later than one business day after the incident. (Inspector #508) [s. 107. (3) 4.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

A) It was identified on October 22, 2014, at 1035 hours, on the Orchards Unit, that discontinued controlled substances were stored in the locked medication room in a single-locked cupboard. During an interview with the Registered Staff on Orchards, it was identified that all of the discontinued controlled substances for all five units in the home were stored in the Orchards medication room. It was also identified that the emergency stock box stored in this medication room contained controlled substances. It was confirmed by the ADOC that controlled substances were not stored in a double locked stationary cupboard in a locked area as required. (Inspector #508) [s. 129. (1) (b)]

Issued on this 8th day of December, 2014

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

Original report signed by the inspector.