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

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Performance Improvement and Compliance Branch

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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
Jun 25, 2015	2015_200148_0017	O-002090-15	Resident Quality Inspection

Licensee/Titulaire de permis

SHERWOOD PARK MANOR
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

SHERWOOD PARK MANOR
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

AMANDA NIXON (148), LISA KLUKE (547), RUZICA SUBOTIC-HOWELL (548), SUSAN WENDT (546)

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): June 8-12 and June 15-19, 2015.

The Resident Quality Inspection, included the following critical incidents; Log O-000806-14, O-001038-14, O-001005-14 and two complaints; Log O-001725-15 and O-001730-15.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Support Services Manager, Assistant Director of Care, Office Manager, Maintenance Coordinator, Resident and Family Services Manager, Physiotherapist, Physiotherapy Assistant, Dental Hygienist, Registered Nurses (RN), Registered Practical Nurses (RPN), Food Service Workers, Personal Support Workers (PSW), Housekeeping aids, residents and family members.
The Inspectors also reviewed resident health care records, resident and family council meeting minutes, staffing patterns/schedules specific to the nursing department, prepared meal menus and production sheets, material related to the home's required programs such as falls, restraints, continence and pain. In addition, the Inspectors observed the home related to maintenance, housekeeping and safety and observed resident care and staff-resident interactions, including medication administration and meal service.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **15 WN(s)**
- **5 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

The plan of care for an identified resident indicates that the resident requires two person assistance for transfer on and off the commode and total assistance for toileting. On June 10, 2015, Inspector #148 spoke with the Power of Attorney for care for the resident, who indicated that the staff are very busy and that the resident will sometimes have to wait too long for toileting. On the morning of June 17, 2015, Inspector #547 observed the resident sitting in the West hallway. The resident was speaking to PSW #S120, asking to go to the bathroom, stating "it is coming out, and I cannot hold it". PSW #S120 indicated to the resident that she needed two staff to transfer him/her to the toilet and there were no other staff available to assist at this time. Moments after, PSW #S120 indicated that she was now scheduled for her break and that the second PSW on this wing was supervising two residents in the tub room, continuing the delay of toileting assistance for the identified resident. PSW #S120 indicated that PSW float shifts are present in the home but working on the East or South wing and that the staff are not always able to contact the float to request assistance. When asked, PSW #S120 indicated that the walkie-talkie is used to contact the floats but they are not functioning properly and staff do not always carry them. PSW #S120 further indicated that between 9-11:00am, it is very difficult to provide toileting assistance to those residents that require a two person transfer related to the organization of the bathing schedule. At 10:15am, Inspector #547 was in the East/South hallway junction and observed the identified resident requesting RPN #S121 to assist him/her to the toilet, the RPN and a second staff member both indicated they were too busy to assist. The RPN called staff using the walkie-talkie but did not get a response. At 11:30am, the Inspector spoke with the resident again, who indicated that toileting assistance had been provided but was not sure at what time. [s. 8. (1) (b)]

2. On the morning of June 16, 2015, Inspector #148 spoke with PSW #S119 who indicated that her "partner" (the second PSW working on the South wing), was currently on break and for this reason could not provide transfers or toileting care to resident's requiring a two person or lift transfer. At the time of this interview, an identified resident was requesting to go to bed and was needing to be toileted, but due to the resident requiring a two person transfer, this need could not be met at this time. The Inspector noted to PSW #S119 that a second resident was in his/her bedroom in a wheelchair placed near a commode with mechanical lift in place. PSW #S119 reported that she has prepared this resident for transfer to commode so that the resident can be toileted when her partner returns. PSW #S119 further reported that once the resident in the bedroom

was on the commode she would have to stay with him/her for safety and this would further delay assistance provided to other residents. The staff member noted that there are two "float" PSWs but that they are usually providing care on the East wing as there are approximately 10 residents who require two person transfer. She noted that she would only call the float PSW if it was an emergency. When asked, PSW #S119 indicated that due to the organization of break times continence care is affected and sometimes residents need to wait too long, whereby it is too late when the staff provide toileting assistance. (148)

On June 17, 2015, Inspector #548, spoke with a resident and the resident's spouse, both of whom indicated that the resident is capable of vocalizing the need to be toileted. Both indicated that toileting is provided around 10:30-11:00am, every day. The resident's wife indicated that there are times when the resident has vocalized the need to be toileted, but that there are no staff around to provide assistance and the resident will need to use his/her brief. On June 18, 2015, PSW #S135 indicated that she toilets the resident around 10:30-11:00am each day. She indicated that this is the only time she is able to toilet the resident. PSW #S135 indicated that she would like to toilet the resident more often, however, she is not able to do so due to the competing needs of all of the residents on the unit and the fact that there are only two staff members scheduled for this unit. PSW #S135 was informed by the Inspector that the resident was care planned to be toileted before and after each meal and in the evening. PSW #S135 indicated that she makes all attempts possible to toilet the resident. On June 18, 2015, the Inspector spoke with PSW #S136 who indicated that she was not surprised that the identified resident may need, at times, to use a brief. PSW #S136 indicated that there are 24 residents on the wing and two staff members that are assigned to complete all care for residents. When asked about the plan of care for the identified resident, PSW #S136 indicated that she toilets the resident around 10:30-11:00am each day, but knew the resident was to be toileted more often. As example, PSW #S136 described that when her colleague goes on break at 1:20pm for 15 minutes she is left alone to attend to the needs of all the residents, she will attempt to lay residents in the beds and toilet them. She reported that she is not able to toilet those residents that require two people assistance until her colleague comes back from break. PSW #S136 indicated that there is supposed to be support provided from another units during breaks, however, this does not happen as they are also taking breaks on the other units. (548) [s. 8. (1) (b)]

3. Sherwood Park Manor has 107 licensed beds. On June 19, 2015, Inspector #546 met the DOC to review the staffing plan. The DOC confirmed the staffing on the day shift to include: 1 RN (with the addition of 1 RN on Thursdays for physician visits), 3 RPNs (with

the addition of 1 RPN from Monday through Friday for MDS assessments and an additional RPN on Mondays for physician visits).

The home has a total of 15 PSWs working in the following capacity: 4 PSWs, 6am to 2pm; 10 PSWs, 7am to 3pm (of which 2 PSWs work solely on the bath team); and 1 PSW, 7am to 11am.

Between the hours of 6am to 3pm, the DOC reports the routine as follows: 6am to 8am – medications are administered to residents by the RPNs and morning care is provided by the PSWs (morning care was identified as being personal hygiene services, including toileting and activities of daily living, such as bathing, dressing, grooming) and residents are assisted or transported to their respective dining rooms for meals. At 8:30am, breakfast is served, PSWs to provided assistance in the dining room (Inspectors observed breakfast to continue until after 9:30am). At 9:00am, PSWs working the 6-2pm assignment take a 20 minute break. At 9:30am, PSWs working the 7- 3pm assignment go to a 20 minute break. Between 9:00am to 12:00pm, morning care continues. At 11:25am, PSWs working the 6-2pm assignment take a 35 minute break. At 12:00pm, lunch is served to residents in their respective dining rooms (Inspectors observed lunch to continue until after 1:30pm). At 1:00pm, PSWs working the 7- 3pm assignment take a 35 minute lunch break. At 1:30pm, PSWs working the 6- 2pm assignment take a 20 minute break. At 2:00pm, PSWs working the 7-3pm assignment take a 20 minute break.

Inspector #148 provided a high level debrief on the examples above, indicating that family and residents had reported a wait time for toileting assistance that impacted on the resident's individual continence needs. The Administrator acknowledged that the home is working through issues related to the organization of personal support services in the home to better provide for resident care needs. It was noted that due to the high level of care needs in the home, it is known that morning care, including the provision of toileting, can be delayed. He acknowledged that staff are doing their very best with attempting to ensure that the toileting needs of residents are met.[148] [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 there is an organized program of personal support services for the home to meet the assessed continence needs of residents, to be implemented voluntarily.

WN #2: 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 resident-staff communication and response system, could be easily seen, accessed and used by residents, staff and visitors at all times, in resident bedrooms.

The resident-staff communication and response system was found to be located at each resident bedside, the console of which was on the wall usually near the side of the bed. A call bell cord runs from the console to the bed location and ensures easy access to the

communication system.

On June 9, 2015, Inspector #148 observed an identified resident to be resting in bed. This resident has limited range of motion of his/her arms. The call bell cord was observed to be hanging from the communication system console, the cord lying on the floor and not within reach of the resident. Inspector #148 confirmed with the resident, that the cord was not accessible to him/her.

On the same date, Inspector #602 observed an identified resident in the resident's bedroom and that no call bell cord was present. The communication system console was functional but not accessible to the resident at the time of the observation.

On June 10, 2015, Inspector #547 observed an identified resident to be resting in bed and the call bell cord was located inside the resident's bedside drawer and out of reach of the resident. Inspector #547 interviewed the resident who indicated that the call bell cord was not available most of the time and demonstrated that he/she could not reach the cord at the time of the observation.

On June 15, 2015, Inspector #547 observed an identified resident seated in a wheelchair watching television and noted that the resident did not have a call bell cord attached to the console of the communication system; the system was observed to be functional. The resident indicated that he/she could not access to communication system as the console was out of reach. The communication system was not accessible to the resident at the time of this observation.

On June 18, 2015 Inspector #547 interviewed RPN #S116 who indicated that all residents should have their call bell cord within reach when they are in their bedrooms or bathrooms which is a requirement reviewed regularly with staff in the home. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

On June 8, 2015, Inspector #548 observed that the main dining room for the home was not equipped with a resident-staff communication and response system.

On June 15, 2015, Inspector #547 further observed that the sitting areas on the West,

East and South units were also not equipped with a resident-staff communication and response system. These sitting areas were observed at times to have residents present and unattended by a staff.

On June 15, 2015m Inspector #547 interviewed the Maintenance Co-ordinator who described that the home has both an "older" section, the South end; and a "newer" section, the North end. He indicated that when the North end was build it was adequately equipped with a resident-staff communication and response system. He was aware that the identified areas in the South section were without a resident-staff communication and response system, however, was not aware that the older part of the home required a communication system, in the identified areas. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #3: 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 has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes 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 (SDM), if payment is required.

During an interview with an identified resident admitted in 2013, the resident complained of a dry and sore mouth. During an interview with an identified resident admitted in 2013, the resident indicated that he/she required a new set of dentures. An interview with the SDM of an identified resident, reported that she was unaware that the home offers any dental services.

Inspector #148 spoke again with the two identified residents, both of whom indicated they had not been been offered a dental assessment. The home has a Dental Hygienist that visits the home regularly to provide assessments within her scope of practice and preventative services such as cleaning and scaling. The Inspector spoke with the home's Dental Hygienist who indicated that she attains patients when the family approaches her in the home about a concern or when the nursing staff approach her relating to a complaint. She further indicated that she attempts to see all new residents for an initial consult, but that she is not always able to see every newly admitted resident.

Inspector #148 spoke with the home's DOC who indicated that there is no process in place to ensure that an annual dental assessment is offered to all residents, she agreed with the Hygienist description of how patients are ascertained and confirmed that there are no other services offered to residents outside of that provided by the Hygienist. [s. 34. (1) (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 each resident is offered an annual dental assessment, subject to payment being authorized by the resident or the resident's substitute decision maker, to be implemented voluntarily.

WN #4: 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,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle includes alternative choices of entrees, vegetables and desserts at lunch and dinner.

The home's currently planned regular menu was reviewed and it was found that several days throughout the menu doidnot include for choice of vegetable. Exampled by the following:
Week 1 – no vegetable choice at lunch on Monday, Friday and supper on Sunday
Week 2 – no vegetable choice at lunch on Monday, Saturday and supper on Sunday
Week 3 – no vegetable choice at lunch on Tuesday, Wednesday and Friday

It was found that the second choice vegetable was substituted in the menu for fruit, dessert type item such as ambrosia or bean salads. [s. 71. (1) (c)]

2. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

The lunch meal service was observed by Inspector #148 on Monday June 8, 2015. The planned menu included French toast, ham and berries or peanut butter sandwich with ambrosia and fudge brownie or apricot halves for dessert. The planned menu, as described, was the same for the puree texture modification. Upon review of the food items offered and available it was determined that there was no puree sandwich, puree ambrosia or apricots. Rather than apricots, mandarin oranges were available as second choice, however, no puree mandarin oranges were available. The Inspector noted the substitution was not written on the production sheets. Cook #sS113 indicated that the dietary department was short and that there was little time to prepare the needed food items. Cook #S113 agreed that there was no choice of entrée, vegetable or dessert

prepared as planned and directed by the production sheets for the puree texture modification.

The lunch meal service was observed by Inspector #148 on Tuesday June 9, 2015. The planned menu included sausage on a bun with sauerkraut and cold potato salad or macaroni and cheese with green peas and a macaroon square or fruit cocktail for dessert. The planned menu, as described, was the same for the puree texture modification. Upon review of the food items offered and available it was determined there was no puree macaroni and cheese, puree bun/bread or puree macaroon square. Cook #S112, agreed that there was no alternative choice of entrée or dessert prepared as planned and directed by the production sheets for the puree texture modification. Cook #S112 indicated that she would be pulling 3 tray purees of macaroni and cheese out from the freezer and would microwave, sending 2 down to the smaller dining room. The lunch service is scheduled to begin at 12:00pm, on this day the service began at 12:26pm, Cook #S112 was observed to begin preparation of the tray purees at 12:27pm after two residents were served a puree meal.

On both dates above the planned menu was not offered and available at the lunch meal service, impacting on the availability of choice and variety for residents on a puree texture modification. [s. 71. (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 the menu cycle includes planned alternatives for entree, vegetable and desserts and that the planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the assessment, reassessment, monitoring and resident's response are documented, as it relates to the application of restraints for two identified residents.

It was confirmed that the home uses a form titled: Restraint Positioning/Monitoring Record, to document the assessment, reassessment, application, monitoring, release and positioning of residents who use a physical device as a restraint. The form includes set times for all nursing staff to record this information on the form.

On June 12, 2015, Inspector #547 interviewed RPN #S116, who indicated that documentation for restraints are to be completed by the PSWs every hour, every shift utilizing the codes for documentation as per the Restraint Monitoring form, with their signature. Registered nursing staff should re-assess the resident's need for restraint use, and if it is applied correctly and then also sign the bottom of the Restraint Positioning/Monitoring Record.

On June 9, 2015, Inspector #547 noted that an identified resident had two full bed rails in up position while in bed. The Restraint Monitoring Record for this resident was reviewed by Inspector #547 for the dates between May 17 to June 12, 2015, whereby there were missing entries including four evening shifts and six night shifts, for the physician ordered two bed rails as restraint while in bed. Upon review of the resident's monitoring record, a pattern was supported by the resident's plan of care to indicate that the resident is typically in bed after supper in the evening and every night and that bed rails for this resident should be applied and monitored.

Inspector #547 reviewed the same resident's record with RPN #S116 who indicated that there was missing documentation for repositioning and monitoring in the June record, as

well as no signature to indicate registered nursing staff conducted assessments of the restraint for nine evening and night shifts out of eleven days.

On June 9, 2015, Inspector #547 observed an identified resident to be seated in a wheelchair with a seat belt applied; on occasion the Inspector observed the belt to be loosely applied with a span of approximately five inches between belt and resident's abdomen. The health care record for this resident was reviewed by the Inspector and indicated that the resident had an order for a seat belt with sleeve as a restraint while seated in a wheelchair. The Restraint Monitoring Record for the resident was reviewed by Inspector #547 for June 2015, whereby there were missing entries for one day shift. It was established that the resident's pattern is to have the seat belt applied daily, starting at 7:00am. In addition, RPN #S116 indicated that this resident is to be up in his/her wheelchair for supper daily with the seat belt applied, usually removed by 8-9:00pm. The monitoring record was also missing entries for seven evening shifts during the period, between June 1, 2015 and June 18, 2015 .

Upon review of the same resident's monitoring record, with RPN #S116, it was further indicated that there was no signature to indicate registered nursing staff conducted assessments of the restraint ten day shifts and sixteen evening shifts. [s. 110. (7) 6.]

2. On June 8, 2015, RPN #S109 reported that two identified resident's are not physically capable of getting out of bed on their own and both require assistance with positioning in bed. Both residents' POA's have consented to a physician's order for two bed side rails while in bed, as restraint. Both residents were observed by Inspector #548, to be in bed with both side rails up.

The first of the two residents, is routinely placed in bed at approximately 1900 to 0800 hours. Upon record review of the home's Restraint Positioning/Monitoring Record from June 4-15 2015, there is no record of the reassessment of the resident's condition and the effectiveness of the restraint, by registered nursing staff 12 out of 26 scheduled times.

The second to the two residents, is routinely placed in bed on request at approximately 2300 hours- 0800 hours. Upon record review of the home's Restraint Positioning/Monitoring Record from June 4-15 2015, there is no record of the reassessment of the resident's condition and the effectiveness of the restraint, by registered nursing staff 4 out of 11 scheduled times.

On June 16, 2015, Inspector #548 spoke with RPN #S134 who was working on the unit, in which both residents reside. When asked the RPN indicated that she was not aware that she was to reassess the resident's condition or the effectiveness of the restraint for residents. Further to this, RPN #S134 was not aware that she was to document her assessment on the monitoring record nor had she completed this during her shift. [s. 110. (7) 6.]

3. On June 18, 2015, Inspector #547 interviewed the Director of Care who confirmed that the Restraint Positioning /Monitoring Record is to be used to record assessment, reassessment, application, monitoring, release and positioning of residents who use a physical device as a restraint. This includes the reassessment by registered nursing staff. [s. 110. (7) 6.]

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 restraining of a resident by a physical device is documented, including assessment, reassessment, monitoring and responses, to be implemented voluntarily.

WN #6: 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:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

On a specified date, an identified resident had a fall that resulted in injury. The resident was sent out to hospital on the same day and returned to the home three days after. On June 10, 2015, during an interview with the Power of Attorney for care, for the resident, it was reported that shortly after the resident was returned from hospital, the resident was moved from his/her previous shared bedroom to the Serenity room; a vacant private room near the main nursing station. The POA for the resident indicated that he was not made aware of the change in room until his arrival to the home the next day. Inspector #148 spoke with RN #S105 who was present on the day the resident's room was changed. RN #S105 indicated that due to the resident's injury and confusion, it was decided it would be in the resident's best interest to move the resident to the Serenity room to ensure close observation. RN #S105 reported that family were present but that the POA for care was not in the home at the time of the move. The health care record was reviewed and there was no supporting documentation that the POA was made aware of the internal transfer immediately. [s. 3. (1) 16.]

WN #7: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

An identified resident has a diagnosis which has affected the resident's physical

functioning and ability to perform activities of daily living. The resident's ability to feed him/herself has declined as evidenced by the last two MDS assessments, the most recent of which, indicated the need for extensive assistance. The resident was observed at the meal service on June 12, 2015, whereby the resident was served hot cereal, a slice of toast and two fluids, both served in lidded cups with straws. The resident was observed to attempt to drink fluids by placing lips on the edge of the cup. The resident made no attempt to drink from the straw, seeming to not understand or see the use of the straw. It was not until a resident at the table directed the resident to use the straw and physically assist the resident with the fluid that the resident was able to consume. The resident attempted to retrieve a ½ slice of toast but in the process dropped the second half on the floor. The resident was able to consume the ½ slice independently but was not observed to attempt consumption of the hot cereal. An activation aid approached the resident at the end of the meal service, without any encouragement or assistance with intake or offer of another serving. The activity aid removed the resident from the dining room at this time. At no point during the observation was the resident approached by staff and provided any verbal or physical encouragement.

The plan of care was reviewed and indicates the resident requires set up and supervision with intermittent assistance, i.e. cut food for resident. The plan of care is not based on the most recent assessment nor the resident's current needs.

On a specified date, an identified resident had an un-witnessed fall in the resident's bedroom, with no injuries. The Post Fall Screening tool and Incident Report suggest that the resident's call bell was not within reach and/or that the resident did not use the call bell to request assistance for toileting.

Assessments including the most recent MDS assessment and most recent physiotherapy assessment, indicate that the resident's physical functioning has declined, assistance is required with toileting, side rails are in use and that the resident may practice poor judgement. Specifically within the physiotherapy assessment, the resident's risk of falls was assessed as high.

The plan of care was reviewed and does not indicate any reference to the resident's risk of falls. The plan of care is not based on the most recent assessments. (148) [s. 6. (2)]

2. The licensee has 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 an identified resident indicates the resident has a history of falls with injuries sustained and that the resident requires two bed rails while in bed as a restraint due to the risk of falls.

The health care record indicates that on a specified date during the night shift the resident fell out of bed and sustained injury. The post fall assessment completed on the same date indicates that there was no restraint, including bed rails, in place at the time of the fall. Restraint Monitoring Records along with statements within the Critical Incident Report to the Director further support that the two bed rails were not applied at the time of the fall.

On a second specified date, the same resident fell out of bed during the evening shift and sustained injury. The post fall assessment completed on the same date indicates that there was no restraint, including bed rails, in place at the time of the fall. Restraint Monitoring Records further support that the two bed rails were not applied at the time of the fall.

The care set out in the plan of care,as it relates to bed rails, was not provided to the resident. (Log O-005067-14). [s. 6. (7)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On June 17, 2015, Inspector #148 reviewed the home's doors leading to non-residential areas. The Inspector identified three doors in the home that lead to non-residential areas that were not equipped with locks. Two of the doors lead to linen closets on the North wing of the home. The closets are small spaces that are used to store linen and related continence products; the closets are large enough for one or more persons to be and there is no resident-staff communication system. The third door identified, was the door leading to the main/South nursing station. This area contains items and health care records used predominately by the nursing staff and has a locked door leading to the outside. All three areas were observed, at times, to be unsupervised. At no time during the inspection were residents observed to be in these identified areas.

Both the linen closet doors and the nursing station door are required to be equipped with a lock, and kept closed and locked when not supervised by staff. [s. 9. (1) 2.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's clamped raised toilet seats were kept in a good state of repair.

On June 9, 2015, Inspector #148 observed an identified shared resident bathroom to have a raised toilet seat with metal supports clamping to the toilet that were heavily rusted and visibly corroded.

On June 10, 2015, Inspector #547 observed an identified shared resident bathroom to have a raised toilet seat with metal supports that had brown/orange matter resembling rust on each support.

On June 15, 2015, Inspector #547 interviewed Housekeeping Aide #S114 regarding one of the the raised toilet seats, who indicated that she had removed this raised toilet seat, as required every Monday on the cleaning schedule, and washed the raised toilet seat top and bottom with the use of the home's cleaning product and cleaning brush. Staff #S114 indicated that she was unable to remove some of the brown/orange matter as it was rusted and corroded into the metal base of the clamps.

On the same date, the Inspector interviewed Housekeeping Aide #S122 regarding two raised toilet seats. He indicated that the toilet seats are washed daily, however the metal clamps are no longer washable, as they would need sanding to remove the rust that has corroded the clamps. Staff #S114 and #S122 indicated they were not aware if the identified raised toilet seats had been reported to the maintenance department.

On June 16, 2015, Inspector #547 interviewed the Maintenance Coordinator regarding the clamped raised toilet seats, he indicated that he received a report from the housekeeping staff last evening that these raised toilet seats required maintenance. Today, the Maintenance Coordinator has begun replacing these raised toilet seats with new raised toilets seats the home had in stock, and he plans to order more to replace all rusted raised toilet seats used in the home. [s. 15. (2) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision maker, if any, and any other person that either of them may direct are given an opportunity to participate fully in the conferences.

In accordance with section 27 of the Regulations, the care conference of the interdisciplinary team is held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker.

An interview by Inspector #148 with the SDM of an identified resident, who was admitted in late 2014, indicated that the SDM had not been able to attend the six week care conference. The SDM indicated that a date and time were provided to her for the conference but due to other circumstances the scheduled date and time were not acceptable to her. She does not recall the home providing an alternative date nor did any one contact her to discuss the plan of care or any other matters of importance. She is not aware if a care conference took place.

The Inspector spoke with the home's DOC who indicated that the care conference was scheduled and held in early 2015, the record of the conference indicates that no resident or family were present. The DOC indicated that the schedule for resident care conferences is set and is quite rigid, families are notified usually six weeks in advance by one of the home's administrative assistants. The DOC noted that although a later or earlier time may be accommodated that dates are rarely flexible. When asked by the Inspector, the DOC confirmed that based on the record of the conference the SDM of the identified resident was not contacted prior to or after the care conference.

The SDM of the identified resident was not given an opportunity to participate fully in the six week care conference. [s. 27. (1)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device is included in the resident's plan of care.

An identified resident was observed over the course of the inspection to be seated in a wheelchair with a table tray applied, the tray clipped in the back of the wheelchair and the resident was unable to remove the device. The health care record demonstrates that the wheelchair and table top were implemented after a fall with injury. Inspector #148 spoke with RN #106, who indicated the tray is applied to maintain the resident's safety.

The plan of care was reviewed and it was determined that there was no physician order for the use of the physical device as a restraint nor did a plan of care exist to support the use of the physical device as a restraint. [s. 31. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The following personal items were observed to be unlabelled by Inspector #148 on June 8 or 10, 2015, respectively:
In an identified shared room, a toothbrush on the bathroom counter; a second toothbrush in a white basket with writing on the bottom of basket that is illegible;
In an identified shared room, two used deodorants on a bathroom shelf and one used hair brush;
In an identified shared room, toothbrushes, mouth swabs and two bottles of mouth wash;
In an identified shared room, four used bottles of mouthwash.

On June 9, 2015, Inspector #547 observed an electric toothbrush on the bathroom counter in an identified shared room to be unlabelled. On June 10, 2015, the same inspector observed two denture cups, one of which the written name on the cup is illegible.

On June 9, 2015, Inspector #548 observed a toothbrush in an identified shared room to be unlabelled.

On June 18, 2015, Inspector #548 spoke with PSW #S107, who indicated that all personal items such as toothbrushes are to have the resident's name marked on the item with a black marker. PSW #S136 indicated that personal items such as lotions and toothbrushes should be placed in a plastic container with the residents name written on it.

On June 18, 2015, Inspector #548 spoke with the DOC who indicated that the residents personal items such as toothbrushes and combs are all to be placed in identifiable plastic container with the resident's name of it.

The home does not have a process in place to ensure that all resident personal items are labeled. [s. 37. (1)]

WN #13: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining service includes, at a minimum proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The health care record for an identified resident indicates chewing and swallowing difficulties including dysphagia, with a history of choking episodes. The resident requires physical assistance at the meals. The health care record for a second identified resident indicates chewing and swallowing difficulties including dysphagia, with a history of aspiration pneumonia. The resident requires total feeding assistance. The health care record for a third identified resident indicates chewing and swallowing difficulties including dysphagia and that due to physical limitations the resident requires assistance when eating and drinking.

At the dining observation on June 8, 2015, staff members were observed to provide feeding assistance to the three residents identified, while standing. Proper techniques including being at eye level with the resident were not practiced consistently over the course of the meal observed. [s. 73. (1) 10.]

WN #14: 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 informed within one business day of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health status.

An identified resident had a history of falls with injury. There was an identified fall on a day in 2014, whereby the resident fell and was sent to hospital for assessment. RN #S105 spoke with the hospital the same day as the fall and was informed that the resident had an injury that would substantiate a significant change in health status. This incident, resulting in hospital transfer and significant change in health status, was discovered by the Inspectors during a review of two falls that occurred after this fall. The home did not report the incident within one business day, as required
(Log O-001038-14) [s. 107. (3) 4.]

WN #15: 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 has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

On June 12, 2015, Inspector #547 observed the treatment cart located in the hallway in front of the main nursing station between the West and East wings of the home to be unlocked, and unattended by any registered nursing staff while four residents were seated near by. RPN #S128 then came around the corner from the front entrance hallway and locked the treatment cart immediately upon noticing that the cart was left unlocked. Inspector #547 inquired why the treatment cart required to be locked, and Staff #S128 indicated there are medicated ointment and creams located inside the third drawer of this cart. Staff #S128 confirmed that the home's expectation is to ensure that this treatment cart is locked when unattended by registered nursing staff. [s. 130. 1.]

2. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home.

On June 10, 2015, Inspector #547 observed Housekeeping Aide #S129 in the North wing medication room mopping the floor around the medication carts located inside this room. Staff #S129 indicated that the Registered Nursing staff opened the door for her, and that once she was done, she would close the door behind her to lock it again. No registered nursing staff accompanied the housekeeping aide, or were within view of this room during this time. It was further noted that the home's stock medication cupboard inside this room is not kept locked and is stocked with items including but not limited to, bottles of Lactulose 667mg/ml, Bronchophan expectorant 100mg/5ml, Novo-Gesic Forte 500mg tabs.

On June 16, 2015, Inspector #547 interviewed the Director of Care regarding access to the medication rooms on each unit, and the Director of Care indicated that the home's expectation is that only the registered nursing staff have keys to the medication and treatment rooms, and that if another staff member has to enter these rooms, that the registered nursing staff must remain with them until they leave the medication or treatment rooms. [s. 130. 2.]

Issued on this 25th day of June, 2015

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

Original report signed by the inspector.