Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2014	2014_284545_0014	O-000454-14	Resident Quality Inspection

Licensee/Titulaire de permis

RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO
14 York St, CORNWALL, ON, K6J-5T2

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

ST JOSEPH'S CONTINUING CARE CENTRE
14 YORK STREET, CORNWALL, ON, K6J-5T2

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

ANGELE ALBERT-RITCHIE (545), AMANDA NIXON (148), 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): May 26, 27, 28, 29, 30, June 2, 3, 4 and 5, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Director of Support Services, Manager Information System (IS) and Decision Support, Environmental Services Supervisor (ESS), Health, Safety and Education Coordinator, Patient/Resident Relations Advisor, Community Engagement Officer, Registered Dietitian, Food Services Manager, Food Services Supervisor, Back-up RAI Coordinator, Resident Care Assistant, two Recreation Programmers, Pharmacist, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Resident Care Assistants (RCA), one Dietary Aide, one OT/PT Assistant, President of the Residents' Council and several family members and several residents.

During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed medication storage areas, observed resident care, observed meal services, observed medication administration, reviewed resident health records, reviewed relevant home policies such as: Urinary Continence Care (Policy Number 11-a-195), Least Restraint - Long-Term Care and Complex Continuing Care (Policy Number 11-a-178), Skin Care (Policy Number 11-a-148) and reviewed Residents' Council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.15 (1) (a) and (b), whereby the licensee did not ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In accordance with the Director's (A) memo dated August 21, 2012, the Ministry expects homes to use the best practice document titled Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, in their home. The document describes Zone 7, as the area between the headboard or footboard and the end of the mattress, as a potential entrapment zone for the head. The document indicates that a mattress of the improper size can lead to enlarged gaps at several zones of entrapment thus creating potential entrapment hazards. The end user should test any mattress for compatibility with the bed prior to use to ensure the bed and mattress combination meets the recommendations of this guidance.

During the inspection, Inspector #148, #546 and #545 observed six beds with confirmed use of bed rails, in which the mattress did not fit the size of the bed frame. An additional ten beds were observed, in which bed rails were attached to the bed frame and available for use, where the mattress was observed to not fit the size of the bed frame. In all cases, a space existed between the mattress and foot board (Zone 7), observations confirmed the measurement of the space to range from 3 to 7.5 inches.

On June 4, 2014, Inspector #148 observed room #2255 in the company of the Director of Support Services and Environmental Services Supervisor, a room previously identified by an inspector as having a bed system in which the mattress did not fit the bed frame. In the presence of both managers it was confirmed that the mattress did not correctly fit the bed frame, whereby a space existed between the footboard and mattress. Inspector #148 measured the space between the mattress and footboard to be a total of 7.5 inches. It was speculated by both managers that the bed frame, the length of which is adjustable, may have at one point been extended to accommodate a taller resident and that the bed frame had not been readjusted for the current length of the mattress.

On June 4, 2014, the Director of Support Services provided the home's file related to the bed system evaluation that occurred in 2013. He reported that in 2013 the home

conducted an evaluation of 6 randomly selected bed systems and that not all bed systems in the home were evaluated. The 6 bed systems that were evaluated did not include any of the bed systems observed by the Inspectors. It was further reported that the bed system evaluation included zones 1-4 and that zones 5-7 were not included in the evaluation. Documentation contained in the file indicates that a separate assessment was completed by the home's OT/PT Assistant of selected bed systems, in which she found 3 bed systems whereby the length of the mattress did not fit the bed frame. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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).

~~**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**~~ error JM for MOH June 13/14

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)(a), whereby the licensee failed to ensure that the written plan of care for each resident sets out the planned care for the resident.

An identified resident was observed throughout the inspection with a tilt of approximately 30-45 degrees applied when seated in a wheelchair. The health care record was reviewed and the plan of care did not include the use of a tilt on the wheelchair. Staff providing care to the resident were interviewed and it was reported that when the resident is seated in his/her wheelchair, a tilt is applied.

On June 3, 2014, Inspector #148 interviewed the OT/PT Assistant who described that the use of the tilt on An identified resident wheelchair is to relieve pressure due to skin wound on the buttock and to assist with positioning as the resident can no longer position themselves. She further noted that the Occupational Therapist had prescribed the tilt for the described purposes and that the tilt has been used for an extended period of time. The OT/PT Assistant further indicated that the inclusion of a resident's need for a tilt application in the plan of care is not the home's current practice.

The written plan of care does not set out the planned care for Resident #005 as it relates to the application of a tilt on the wheelchair for pressure relief. [s. 6. (1) (a)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (2), whereby the licensee failed to 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.

On May 26, 2014, Inspector #148 observed 4 identified residents to be provided puree meals on a sectional plate on the Quinn House. Upon further observation and interview with staff members it was determined that each of the four residents required total feeding assistance.

The health care records were reviewed and it was confirmed that all four residents require total feeding assistance. In addition, 3 of the 4 identified residents were coded for the use of adaptive feeding aids within the most recent Minimum Data Set (MDS) Assessment. The plan of care for Resident #005 indicated the use of adaptive eating aids to support fluid intake, there was no indication of the use of a sectional plate. The plan of care for Resident #007 indicated the use of adaptive eating aids, but was unspecific as to the use.

Inspector #148 interviewed the Registered Dietitian (RD), Food Services Manager (FSM) and Food Services Supervisor (FSS) related to the use of sectional plates for residents requiring total feeding assistance. It was reported to the Inspector that the use of sectional plates was implemented on the Quinn House for the plating of all puree meals to inhibit staff members from stirring the texture modified food items together.

The use of adaptive feeding aids, specifically the use of sectional plates on the Quinn House unit, were implemented for all residents on a puree texture and not based on an assessment of each residents need and preferences.

On May 26, 2014, an identified resident was also observed with thickened fluids in a two handled cup with sippy lid. During the observation, Inspector #148 observed the resident to be fed all food and fluid. The Inspector observed the lids to be removed from the two handled cups and the resident was fed the thickened fluids by spoon. The resident's heath care record and reports from staff providing feeding assistance indicated that the resident requires total feeding assistance.

During the interview of June 2, 2014 with the RD, FSM and FSS it was further reported that the assessment and care planning for the use of adaptive feeding aids is the responsibility of the nursing department with the assistance of the OT/PT Assistant. A later interview with the Registered nursing staff on Quinn House, related to adaptive feeding aids indicated that assessment of such aids are the responsibility of the dietary department. Inspector #148 interviewed the OT/PT Assistant who indicated that to date she has not been responsible for the assessment of adaptive feeding aids on the Quinn House unit.

A review of an identified resident's health care record demonstrated that the use of the two handled cup with sippy lid is not based on an assessment of the resident's needs and preferences. [s. 6. (2)]

3. The health care record of Resident #116 was reviewed as it relates to mood and behaviours. The plan of care for Resident #116 indicates the resident is resistive to care and has a depressed state. Two Minimum Data Set (MDS) Assessments dated February and May 2014 indicate the resident wanders daily and is sad and anxious.

On June 3, 2014, Inspector #148 interviewed RCA staff member #S234 reported that the resident wanders the unit, noting that wandering will occur mostly during the evening and night time hours as the resident becomes confused about the time of day. When asked how the home manages the resident's behaviour, staff member #S234, reported that the resident safely wanders the secure unit and that the wandering is sometimes triggered by the resident believing someone has touched or stolen her personal items.

The monthly RCA Flow Sheets were reviewed, which indicated the resident is occasionally resistive to care, wanders on most dates (time of day varies) and is sad/anxious most days.

A review of the Medication Administration Record indicates that the resident is provided regular and PRN antidepressant. Over the course of one month the PRN antidepressant was administered three times, once of which was administered for increased wandering during the night.

The plan of care for Resident #116 is not based on an assessment of the resident and the needs of the residents, specifically as it relates to wandering. [s. 6. (2)]

4. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(7), whereby the licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care.

An identified resident was observed on May 30, 2014 in the dining room. The resident was observed with lap belt hanging off the sides of the chair, the lap belt was observed not to be applied. After the meal service, as the resident was leaving the dining room she stated to a RCA that the belt was not on. The RCA then approached the resident and applied the lap belt.

Inspector #148 spoke with Registered Nursing staff member #S209, who stated that the wheelchair and lap belt are in place due to a recent fall with injury. Staff member #S209 confirmed that Resident #002 is to have the lap belt applied when seated in the wheelchair to prevent the resident from attempting to get out of the chair and to prevent falls.

Resident #002's plan of care indicates that a belt will be used when the resident is seated in the wheelchair to prevent injury. There is a physician's order for the lap belt for safety.

Inspector #148 interviewed the resident and found that the resident was not able to physically or cognitively remove the lap belt.

Resident #002 did not have the care set out in the plan of care related to the application of a lap belt provided to the resident as specified in the plan. [s. 6. (7)]

5. The current plan of care for Resident #119 is dated as effective on a specific date in May 2014 and it is located directly in front of the RCAs' flow sheets, documenting the care provided to Resident #119. The plan of care indicates the following for Resident #119:

- remind to toilet regularly, cue to where bathroom is and provide skin care to prevent skin breakdown
- to be toileted every two hours. Wears incontinent products which are changed as needed. Skin care given after each incontinence episode to prevent skin breakdown - starting on a specific date in October 2012, every day AM and PM
- requires staff to assist to and from the bathroom related to resident cognitive impairment and physical impairments (undated).

Inspector #546 observed Resident #119 seated in front of a specific window on May 28 (from 12:45pm to 2:45pm), May 29 (from 09:30am - 11:45am) and May 30 (from 09:00am to 11:10am). During these times, Resident #119 was not toileted and was not moved from where the resident was seated.

RPN #S201 indicated that Resident #119 should have been toileted every 2 hours as directed in the plan of care but that the toileting was indeed not provided as specified in the care plan dated a specific date in May 2014. RN #S208 and several RCAs reported not being aware that Resident #119 was to be toileted every two hours as specified in the plan of care. [s. 6. (7)]

6. During the course of the RQI, Resident #114 was observed in a wheelchair with a front closure seat belt throughout the day, near the nursing station, by the window and/or in the TV room with music playing close by. Resident #114 was heard screaming each day during the inspection. Inspector #545 did not observe Resident #114 participating in any group or one-on-one activity during the course of this inspection.

In an interview with Recreation Programmer #S223, it was indicated that Resident #114 received one-on-one visits and strolls on the unit once to twice weekly for a period of approximately 3 to 5 minutes at a time when staff was not busy with recreation programs. Staff member #S223 indicated that Resident #114 was unable to participate in group activities due to resident's inability to be in crowds and frequent screaming episodes. It was indicated that Snoozelan was trialed about one year ago but that resident was unable to remain in the room and became very agitated. Staff member #S223 indicated that Resident #114's family hired a person in the past to take him out for strolls in the park 4 to 5 times a week and that Resident #114 responded positively to these short outings.

In an interview with RCA #S226 on June 4, 2014 it was indicated that Resident #114

craved attention and liked it when staff stroll him around on the unit. Staff member #S226 indicated that Resident #114 liked it when staff touched her/his arm and talked to her/him. He indicated that Resident #114 use to enjoy music and to have her/his head rubbed but didn't seem to enjoy these anymore.

In a review of the plan of care dated a specific date in May 2014, it was indicated that recreation staff were to offer one-on-one visits to Resident #114 to achieve maximum therapeutic benefit twice weekly, take Resident #114 outside for a walk in wheelchair once per week, to turn on the TV or the music in the resident's room to provide sensory stimulation every day and to invite family members to activity functions.

In a review of the Recreation Therapy Involvement report for the months of March, April and May 2014 it was indicated:
•May 2014: 2 strolls; one of them outside
•April 2014: 4 strolls and 1 one-one-one visit
•March 2014: 1 stroll [s. 6. (7)]

7. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (10) (b) whereby the plan of care was reviewed and revised when the resident's care needs changed.

Resident #119 sustained a fall on a specific date in May 2014 as a result of attempting to self-toilet; during the early morning hours of a specific date in May 2014, the resident complained of a sore arm and the RCA noticed swelling of the resident's wrist, the RN assessed the resident and the resident was transferred to hospital for a diagnostic evaluation. The resident returned to the home later the same day with a full arm cast with a fractured limb.

The current plan of care for Resident #119 did not identify the specific fracture nor provide clear and specific interventions in the care of this resident post-fracture, including extensive assistance of 2-person for her activities of daily living, transfers, including toileting.

The plan of care was amended 3 days post-fracture in relation to pain.

Following a conversation with #S208 on June 3, 2014, the plan of care was amended by the case manager in relation to the change to a 2 persons' transfer when assisting Resident #119 out of bed into the resident's wheelchair. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' plans of care are based on resident care needs and preferences and that resident care is provided as set out in the plans of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 15 (2) (c) in that the home did not ensure that the home's furnishings were maintained in a safe condition and in a good state of repair.

Inspector #545 observed 9 tables and 14 chairs in the McNeil House dining room on the second floor on June 3, 2014. All wooden legs of chairs and wooden tables edges were scuffed up and the wood finish was worn, exposing porous surface of wood. Inspector #546 observed all chairs and tables in the two dining rooms on the third floor and noted same condition as were noted on the second floor dining rooms.

On June 4, 2014 Dietary Aid #S232 indicated that the chairs and tables in the second floor dining room were brought from the old facility at least 6 years ago. Staff member #S232 indicated that the chairs and tables had been looking well used for a while and that they had never been sanded and re-varnished.

On June 4, 2014, during an interview with the Environmental Services Supervisor (ESS), he indicated that the dining room furniture of the Quinn House on the first floor was replaced in 2011, and that he was hoping to have the dining room furniture in the other four dining rooms on the second and third floors replaced once funding became available. He indicated on June 5, 2014 that he had no plans to sand and re-varnish any of the chairs and tables of the dining rooms due to labor cost, as it would cost him less to replace the actual furniture.

In an interview with the Director of Support Services on June 5, 2014 he indicated that he had drafted a project charter that he would be presenting at a Leadership meeting in January 2015 to request replacement of all dining room furniture on the second and third floors.

In a review of the Five Year Capital Plan (2012-2017) provided by the Director of Support Services, there was no documentation reflecting a plan to replace all dining room furniture on the second and third floors. A draft project charter initiated by the Director of Support Services was reviewed. It indicated under the section "Description": To replace all dining room furniture of the second floor with a projected start date of April 2015. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's furnishings such as chairs and tables on the 2nd and 3rd floor dining rooms are maintained in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 44 in that the home did not ensure that supplies were readily available to meet the nursing and personal care needs of Resident #079.

As per the "LTCH Required Goods, Equipment, Supplies and Services Policy" dated July 1, 2010 the licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA. Under section 2.1.5 Personal Hygiene and Grooming Supplies and Equipment, the licensee must provide the following Personal hygiene and grooming supplies and equipment including, such as (c) Denture supplies including cleaning tablets.

Inspector #545 observed several denture cleaning tablets stored in Resident #079's drawer in her/his bathroom during an observation on June 4, 2014. Resident #079 indicated that her/his family purchased denture cleaning tablets so that Resident would soak her/his upper partial each night. Resident #079 indicated that the home never supplied the denture cleaning tablets.

During interviews with registered staff members #S231 and #S225 they indicated that the home did not supply denture cleaning tablets. RPN #S225 indicated that they contacted Residents' families when their supply of denture cleaning tablets became low. RPN #S231 checked the locked Medication Room, the Clean Utility Room and the Storage Room on the 2nd floor to verify presence of denture cleaning tablets but could not find any.

During an interview with the Director of Care on June 5, 2014 she indicated that she was not aware that the home had to ensure that denture cleaning tablets needed to be readily available to meet the nursing and personal care needs of residents. Later that day, the DOC indicated that she had put in an order for denture cleaning tablets. [s. 44.]

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 supplies such as denture cleaning tablets are readily available at the home to meet the nursing and personal care needs of Resident #079 and other residents who have dentures, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.50 (2) (b) (i) in that the home did not ensure that residents who were exhibiting altered skin integrity, including skin breakdown, skin tears or wounds, received 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.

As per the home's Skin Care Policy Number 11-a-148 under the section "Procedure", item 2.2 indicates that the Registered Nurse/Registered Practical Nurse will conduct a complete Skin Assessment Record on each resident on admission, quarterly, when

there is a change in health status or when there is indication of skin breakdown (Appendix A). Item 2.4 indicates that RN/RPN will assess weekly any resident who exhibits skin breakdown and/or wounds in collaboration with the dietitian and document this assessment in the resident's Wound Management Flow Sheet (Appendix B).

Resident #114 has a condition affecting body movement and muscle coordination with severe cognitive impairments, an artery disease, a skin condition caused by immune dysfunction and a fungal foot infection.

In a review of Resident #114's Medication Administration Record (June 2014), it was indicated that staff applied a prescribed creams daily and another twice daily to the afflicted areas.

During the course of the Stage 1 and Stage 2 of this Resident Quality Inspection, Inspector #545 observed Resident #114 with altered skin integrity to some of his limbs.

During an interview with RCA #S226 on June 4, 2014, it was indicated that Resident #114 had altered skin integrity and that treatment and interventions were provided daily.

RPN #S225 indicated on June 4, 2014 that the home expects registered staff to complete a skin assessment on a quarterly basis for all residents that exhibit altered skin integrity. In reviewing Resident #114's health record, RPN #S225 confirmed that a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment was not done in the last quarter, she indicated that the last one completed was on a specific date in January 2014.

During an interview with the DOC on June 5, 2014 she indicated that Resident #114 was at moderate to high risk for skin breakdown due to abrasions to her/his body. The DOC indicated that registered staff should have, according to the home's Skin Care Policy Number 11-a-148, assessed Resident #114's skin on a weekly basis and documented their observations on the Wound Management Flow Sheet (Appendix B). The DOC indicated that the registered staff were expected to complete the Skin Assessment Record (Appendix A) quarterly, and the Wound Management Flow Sheet (Appendix B) weekly for Resident #114. [s. 50. (2) (b) (i)]

2. The licensee has failed to comply with O.Reg 79/10 s. 50 (2) (b) (ii) in that the home did not ensure that a resident who had been exhibiting altered skin integrity, including skin breakdown, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

On May 27, 2014 Inspector #545 observed Resident #037 with altered skin integrity.

During an interview with RCA #S213 it was indicated that Resident #037 frequently scratched the lesion and removed the scab and that Resident #037 was often observed with dried up blood under her/his nails.

On May 30, 2014 during an interview with Resident #037, Inspector #545 observed resident rub her/her eyes several times as well as touch the inside of her/his nose with own fingers then scratch the dried up lesion.

During an interview with RPN #S202 it was indicated that no treatment or interventions were prescribed for the Resident #037's altered skin integrity.

RN #S212 confirmed that Resident #037's has had lesions for several years, and that no treatment and interventions were presently in place to prevent infection of the wound. RN #S212 indicated that if Resident #037 was picking at the scabbed lesion then it would have been the responsibility of the RPN on the floor to report it, so that interventions could have been put in place such as applying a skin color band-aid on the lesion to protect it and to prevent infection.

During an interview with the DOC on June 5, 2014 she indicated that Resident #037 was admitted to the home with altered skin integrity that developed into a lesion more recently. The DOC indicated that registered staff should have contacted the physician and received orders for a treatment to prevent Resident #037 from touching and removing the scab off.

In a review of the plan of care dated a specific day in April 2014, documentation of treatment and interventions were not found.

As such, the home did not ensure that Resident #037 who was exhibiting altered skin integrity such as a facial lesion, received immediate treatment and interventions to prevent infection. [s. 50. (2) (b) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #037 who was exhibiting altered skin integrity, including skin breakdown, 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 and receives immediate treatment and interventions to prevent infection, as required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 57 (2) in that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

In a review of Residents' Council minutes for the months of March, April and May 2014 it was documented that residents discussed several issues, such as:

March 11, 2014:
-"soup can be cold"
-"soiled linen/garbage covers are still being left open on one unit, leaving a foul odor in the hallway"

April 8, 2014:
-"food can by spicy and sometimes not very hot"
-"plates being taken away too soon, as well as tables being cleaned in front of residents while they are still sitting at the dining room table"

May 13, 2014:
-"the food being cold remains an ongoing issue"
-"commode being left in the hallway, as well as some of the garbage not being closed causing odors"

During an interview with the President of the Residents' Council, it was indicated that the licensee did not respond in writing when Residents' Council brought forward concerns or recommendations. The President indicated that issues were addressed verbally.

During an interview with the Executive Director on June 3, 2014 she indicated that it had not been her practice to respond in writing to Residents' Council concerns or recommendations. [s. 57. (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 the licensee respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 59 (7) (b) in that the licensee did not convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council.

In a review of the "Council News" sent March 2014, it was indicated that "any member interested in forming a Family Council can contact the Executive Director for further information". The Executive Director provided in that letter - her first and last name and extension number.

During an interview with the Executive Director on June 2, 2014 she indicated that the home sent out with the billing information a letter called: "Council News" once per year to inform residents' families to contact her if anyone was interested in forming a Family Council. The Executive Director indicated that the home had not convened semi-annual meetings in the past year to advice residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (3) in that the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the President of the Residents' Council, it was indicated that in the role of President or as a Resident in the home for the past 18 months, the

Resident Council has not been asked to provide advice in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with Recreation Programmer #S223 on June 3, 2014, it was indicated that between the period of January 2013 and April 2014 when she/he was assigned to assist the Residents' Council, she/he was not aware that the home seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. Staff member #S223 indicated that the only time the survey was discussed at a Residents' Council meeting was at the February 11, 2014 meeting where the Social Worker informed Residents' Council that the satisfaction survey had been sent out by mail to family members, and they were asked to complete it and bring it back to the home as the survey would help better the needs of the family and residents.

During an interview with the Resident and Patient Relations Advisor on June 3, 2014, it was indicated that the satisfaction survey was revised about one year ago and that the Residents' Council was not consulted in developing or carrying it out, or acting on its results.

During an interview with the Executive Director on June 3, 2014 she indicated that she was involved in the review of the satisfaction survey in 2009 and that yearly the survey was being tweaked. She indicated that she did not seek advice from the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (4) (a) in that the licensee did not make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

During an interview with the President of the Residents' Council, it was indicated that the results of the satisfaction survey were not presented to the Residents' Council.

Recreation Programmer #S223, the Resident and Patient Relations Advisor and the Executive Director indicated that they did not make available to the Residents' Council the results of the 2013 satisfaction survey in order to seek the advice of the Council about the survey.

Recreation Programmer #S223 who was assigned the responsibility to assist the

Residents' Council indicated that on February 11, 2014, the Social Worker informed the Residents' Council that the satisfaction survey was mailed out to families and that is was important to complete it as the survey would help better the needs of the family and residents. Staff member #S223 indicated that no other information about the satisfaction survey was discussed at Residents' Council meetings between January 2013 and April 2014.

On June 5, 2014 during an interview with the Executive Director, she provided Inspector #545 with a spreadsheet of individual survey results completed in 2013 and 2014 and confirmed that these results were not shared with the Residents' Council. [s. 85. (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 the licensee seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #9: 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 comply with O.Reg 79/10 s.110 (7) 6 in that the licensee did not ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee did not ensure that the following were documented: all assessment, reassessment and monitoring, including the resident's response.

The home's Least Restraint - Long-Term Care and Complex continuing Care Policy Number 11-a-178, revised March 9, 2011, indicates under the section "Procedure", item 2.5 that the Registered Nurse shall reassess and document the resident's need for restraint before application and every eight (8) hours thereafter by completing the Restraint Assessment and Reassessment Record (Appendix F).

Resident #114 had a physician order for a specific front closure locked seat-belt when in wheelchair for positioning. On June 4, 2014, when asked by Inspector #545 and RPN #S225, if the resident could remove the front closure restraint, Resident #114 was unresponsive and made no attempt in removing the restraint.

In a review of the Restraint Observation Record (Policy Number 11-a-178, Appendix G) for a period of 12 days in May/June 2014, there was no documentation indicating that an evaluation of Resident's #114's condition being reassessed and the effectiveness of the restraining by a registered nursing staff was made at least every eight hours.

During an interview with RPN #S225, she indicated that the RCA monitored the restraint every hour and signed the Restraint Observation Record. She indicated that it was her responsibility to monitor and sign to validate that RCA monitored Resident #114's front closure locked restraint when Resident #114 was in her/his wheelchair. RPN #S225 indicated that she/he did not sign the Restraint Observation Record because she/he ran out of time.

During an interview with the Director of Care, she indicated that registered staff were required according to their Least Restraint Policy Number: 11-a-178, revised March 9, 2011, to assess and document the need of a restraint at least once per shift for all residents with a restraint. The DOC indicated that the front closure locked restraint for Resident #114 should have been assessed and documented by registered staff on the Residents' Restraint Observation Records. The DOC indicated that items 2.1 to 2.6 under section "Procedure" of the policy should indicate RN and RPN and that the policy needed to be updated to include "RPN". [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 for every use of a physical device to restrain Resident #114, under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee ensures that the following are documented: all assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 229 (10) 1., whereby the licensee failed to ensure that each resident admitted to the home is screened for tuberculosis (TB) within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Inspector #148 spoke with the home's Health and Safety and Education Coordinator who confirmed that at this time the home continues to implement the 2 Step Mantoux testing for TB screening of resident's newly admitted to the home.

Resident #008 was admitted to the home on a specified date. The health care record for Resident #008 was reviewed and it was determined that the step 2 of the 2 Step Mantoux test was administered twenty-four days after the resident was admitted to the home. The Charge Registered Nurse Staff member #S228, who is responsible for the implementation of TB screening in the home, confirmed that there was no evidence to suggest that Resident #008 had previous TB screening 90 days prior to admission.

Resident #009 was admitted to the home on a specified date. The health care record for Resident #009 was reviewed and it was determined that the step 2 of the 2 Step Mantoux test was administered twenty-six days after the resident was admitted to the home. Staff member #S212, confirmed that there was no evidence to suggest that Resident #009 had previous TB screening 90 days prior to admission.

Resident #010 was admitted to the home on a specified date. The health care record for Resident #010 was reviewed and it was determined that the step 2 of the 2 Step Mantoux test was administered fifteen days after the resident was admitted to the home. Staff member #S128, confirmed that there was no evidence to suggest that Resident #010 had previous TB screening 90 days prior to admission.

During an interview with Staff member #S212, it was reported to Inspector #148 that delays in the provision of the Mantoux testing are related to the inappropriate temperatures of the fridge which stores the supplies for the Mantoux testing. Staff member #S212 noted that temperatures have note been adequately maintained and supplies have needed to be discarded and the time it takes to acquiring new supply may be a contributing factor as to why the TB testing for the identified residents were not within 14 days of admission. [s. 229. (10) 1.]

2. The licensee failed to comply with O.Reg. 79/10, s.299 (10) 3, whereby the licensee did not ensure that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with publicly funded immunization schedules posted on the Ministry website.

Resident #008 was admitted to the home on a specified date. The health care record of Resident #008 was reviewed and there was no documentation to support that the resident had been offered tetanus and diphtheria in accordance with publicly funded immunization schedules. A form titled Consent for Vaccines, with implementation date of March 2007 and signed by the residents substitute decision maker and Charge

Registered Nurse Staff member #S228, did not include a consent for tetanus and diphtheria.

During an interview with Staff member #S212, who is responsible for the implementation of vaccines and immunizations in the home, it was reported that the form used to obtain consent from the SDM of Resident #008 was the incorrect form. The form does not include tetanus and diphtheria and staff member #S212 reported that this resident would not have been offered either vaccine.

Inspector reviewed the consent forms for Resident #009 and #010, both of whom had a consent form titled Consent to Vaccines, with implementation date of February 2012, which indicates that both tetanus and diphtheria were offered to the residents. [s. 229. (10) 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 residents admitted to the home are screened for tuberculosis within 14 days of admission unless the resident has already been screened 90 days prior to admission, in addition the home will offer tetanus and diphtheria to all residents in accordance with the publicly funded immunization schedules, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.5, whereby the licensee did not ensure that the home is a safe and secure environment for its residents as it relates to doors leading to the outside of the home.

In accordance with O.Regulation 79/10 s. 9 (1), all doors leading to stairwells and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not

have access to must be kept closed and locked, equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm that allows calls to be canceled only at the point of activation and, is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

On May 28, 2014, Inspector #148 observed the doors of the long term care home that lead to stairwells or the outside of the home. On the main floor of the home there are three exits leading to the outside and a forth exit leading to the Complex Continuing Care (CCC) Unit (outside of the home). Exit #1 leads to the outdoors and First Street, it is located near the administration wing between office doors #1165 and #1167 and includes two sets of double doors. Exit #2 is a single door leading to the outdoors and First Street, it is located at the end of the home's administration wing and is numbered 1193. Exit #3 known as the main entrance is two sets of double doors, which leads to the outdoors and York Street, it is located near the reception and security desk. Exit #4 is a single set of double doors leading to the CCC Unit, defined as outside of the home.

Each of the four exits were observed for compliance with O.Regulation 79/10 s.9. Each of the four exits are kept closed and locked and are equipped with a door access control system that is kept on at all times. Exit #1 and #3 were held open for a minimum of 3 minutes; no audible alarm sounded, there was no indication that the door triggered a signal to the resident-staff communication system nor was there any indication that triggered a signal to the audio visual enunciator at the nearest nursing station. Exit #4 was held open for a minimum of 3 minutes; no audible alarm sound. It was confirmed that the door triggered a signal to the audio visual enunciator at the nursing station in the CCC unit. The signal for Exit #4 did not trigger the home's resident-staff communication system nor was there evidence to support that this door was connected to the enunciator at the home's nearest nursing station. Exit #2, door 1193 was found to have an audible alarm and was connected to the audio visual enuciator at the home's nearest nursing station (located on Quinn House).

It was reported by both the Director of Support Services and the Executive Director that the Lead of Information Technology was responsible for the implementation of the door alarms and communication system. Inspector #148 interviewed the Director of Support Services and Lead of Information Technology. During the interview the following was reported to the Inspector; Exit #1 has limited access through security

access cards only and there is no alarm at this door; Exit #3 is the main entrance of the home and that at this time the door alarm is turned off; and Exit #4 leading to the CC unit has no audible alarm at the door and is connected to the CC unit audio visual enunciator.

On May 29, 2014 the Executive Director reported to Inspector #148 that after discussion with both the Director of Support Services and the Lead of Information Technology, about the door alarms identified, she indicated that in fact all of the doors leading to the outside of the home are equipped with audible door alarms and that the alarm is connected to the audio visual enunciator that is connected the Quinn House nursing station (nearest nursing station). The Administrator indicated that Exit #1, #3 and #4 have a delay of 5 minutes (300 seconds) at which time an audible door alarm would sound and the signal would be sent to the enunciator at the Quinn House nursing station, with the exception of Exit #4 which is sent to the enunciator at the CCC unit nursing station. She further noted that the Lead of Information technology has adjusted the time set on each door alarm.

On May 30, 2014, Inspector #148 spoke with the Lead of Information Technology who indicated that the door alarms for Exit #1, #3 and #4 have been modified to ensure the audio alarm sounds after 90-120 seconds, the door alarms are connected to the nearest nursing station (Quinn House). Inspector #148 requested clarification on his report on May 29, 2014, that the door alarm for Exit #1 had been turned off, that Exit #3 and #4 do not have audible alarms. He explained that he had effectively turned off the audible door alarms for each of those exits, by implementing a 5 minute delay.

Although Exit #1 and #3 are equipped with an audible door alarm and is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door, the home implemented measures that effectively turned off the audible alarm and connection to the enunciator creating an unsecured environment. [s. 5.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), whereby the licensee did not ensure that the plan, policy, protocol, procedure, strategy or system related to the continence care program was complied with.

In accordance with O. Reg. 79/10 s. 30 (1) 1. and O. Reg. 79/10 s.48 (1) 3., the licensee is required to have a continence care program to promote continence and to ensure that residents are clean, dry and comfortable. The continence care management program is to include a written description of the program that includes goals, objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

In accordance with O. Reg 79/10 s. 51 (1) and (2).,
(1) The continence care and bowel management program must, at a minimum, provide for the following:
1. Treatments and interventions to promote continence.
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.
3. Toileting programs, including protocols for bowel management.
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.
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.

and (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore

function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence.

The home's policy Number 11-a-195 was last updated February 22, 2012. The policy indicates that each resident will receive continence care according to their assessed needs with consideration to the following factors: frequency and individual patterns of toileting, fluid intake, method(s) of toileting / environmental barriers; functional abilities, safety, medications, cognitive ability and awareness of the urge to void, presence of infection, potential for continence promotion, overall health status, and resident's preference.

The Director of Care confirmed on June 5, 2014 that Policy 11-a-195 does not contain the required elements specified in accordance with O. Reg. 79/10 s. 30 (1) 1. and O. Reg. 79/10 s.48 (1) 3 and O. Reg 79/10 s. 51 (1) and (2). The following required elements were identified by the DOC as not being included in the home's Urinary Continence Care, Policy Number 11-a-195:

O.Reg 79/10 s. 51 (1):
-Treatments and interventions to promote continence
-Toileting programs, including protocols for bowel management
-Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.
-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 (2):
-each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
-each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
-each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time .

In a record review for Resident #119 it was indicated that the resident was admitted on a specified date in January 2014. Despite progress notes indicating the resident had some form of bladder incontinence at admission and that the Triage Questionnaire for Continence Assessment (Appendix A) was filled, the Continence Assessment Form (Appendix B) was not completed as per the Home's Urinary Continence Care - Nursing policy 11-a-195.

Charge RN #S208 on June 3 2014, confirmed that no continence assessments were completed on Resident #119 because the resident wears incontinence products and there would be no reason to verify the incontinence history as the resident has moderate cognitive impairment and may not be able to accurately report.

The DOC also confirmed on June 5 2014 that not all staff are completing the assessments, voiding records and ongoing assessments, despite her annual teaching to registered and direct care staff. [s. 8. (1) (a),s. 8. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 33. (1) that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Upon review of Resident #119's flow sheets completed by RCAs between December and May 2014, the resident was not bathed or showered at the minimum of twice weekly for a total of 9 times. There is no documentation to indicate that the resident refused or was away or that it was contraindicated by a medical condition. During an interview with RPN #S201, she/he indicated not being able to recall the reasons or causative factors in lack of bathing on the specified dates.

The DOC indicated during an interview that she was not aware of the reasons why Resident #119 had not been bathed on the specified dates. [s. 33. (1)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.33 (3), whereby the licensee did not ensure that a Personal Assistive Service Device (PASD) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

Resident #074 was observed on May 30 and June 2, 2014, to have a table top applied to wheelchair while resident was seated in the dining room for the lunch meal service. The table top was observed to be removed at the end of meal service.

Inspection #148 spoke with Registered Nursing staff member #S217 who reported that the table top is used at meals only, the resident will occasionally feed self and to promote this activity of daily living the table top is applied. Inspector spoke with the resident and determined that the resident was not able to cognitively or physically remove the table top. This was confirmed by staff member #S217. Inspector #148 spoke with the home's OT/PT Assistant who confirmed that the table top for this resident is used as a PASD at meal time to assist the resident to feed herself.

The health care record for Resident #074 was reviewed and the use of the PASD, as described above, was not found to be included in the plan of care. [s. 33. (3)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 56 (2) in that the licensee did not ensure that all members of the Residents' Council were residents of the long-term care home.

During an interview with the President of the Residents' Council, it was indicated that family members were invited and attended the Residents' Council meetings. The President indicated that some family members attended the meeting with a Resident but others attended alone as the resident they represented were not well enough to attend the meetings.

During interviews with Recreation Programmers #S220 and #S223 on June 3, 2014, they indicated that at least two family members attended Residents' Council meetings by themselves, without being accompanied by a resident of the home.

The Resident and Patient Relations Advisor indicated that one family member who's spouse resided in the home actively represented that home area at the Residents' Council meetings, and that she/he attended the meetings without her/his spouse who was a resident of the home.

In a review of the Residents' Council minutes for the past 5 months, it was indicated that family members attended the meetings:
-May 13, 2014: 2 family members and 8 residents
-April 8, 2014: 6 family members and 11 residents
-March 11, 2014: 6 family members and 9 residents
-February 11, 2014: 4 family members and 8 residents
-January 14, 2014: 4 family members and 6 residents

In an interview with Recreation Programmer #S223 on June 3, 2014, it was indicated that approximately one year ago, following a Residents' Council meeting, a family member asked if family members could meet for a short meeting post Residents' Council meetings so that family could voice their own concerns. Staff member #S223 indicated that to save time and prevent staff scheduling conflicts, it was decided that family members would continue to be invited to the Residents' Council meetings and have an opportunity to voice their concerns at the round table, after Residents had their opportunity to speak.

In an interview with the Executive Director on June 3, 2014 she indicated that she was aware that family members attended the Residents' Council meetings, alone or with a resident of the home. She indicated that she would offer to speak at a future Residents' Council meeting to inform the family members that the home would provide assistance to establish a Family Council. [s. 56. (2)]

WN #16: 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 failed to comply with O.Reg 79/10, s.73(1) 10, whereby the licensee did not ensure proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

A review of the health care record for an identified resident indicates the resident is at high nutritional risk with a chewing problem, requiring texture modification (puree texture) and feeding assistance.

An identified resident was observed on May 30, 2014, to be seated in a wheelchair with a tilt of approximately 45 degrees applied. Additionally, the resident was positioned with a hyper-extension of neck and head resting on the wheelchair head rest. The resident requires total feeding assistance and was being fed by Activation staff member #S221, who was seated on an adjustable stool. The staff member had not lowered the stool to an appropriate level, whereby the top of the resident's head was at the staff members shoulder level.

The OT/PT Assistant reported to Inspector #148 that the resident requires the application of a tilt to the wheelchair for the purposes of pressure relief due to a skin wound on the buttock and to assist with positioning. The OT/PT Assistant reported that the tilt should not be applied at the meal time as the tilt may be an unsafe position for the resident when eating and drinking.

An identified resident was not provided with safe positioning at the meal observed on May 30, 2014. [s. 73. (1) 10.]

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

Issued on this 13th day of June, 2014

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

Angèle Albert Ritchie #545
Amanda Nixon #148
Susan Wendt #546

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANGELE ALBERT-RITCHIE (545), AMANDA NIXON (148), SUSAN WENDT (546)
Inspection No. / No de l'inspection :	2014_284545_0014
Log No. / Registre no:	O-000454-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 13, 2014
Licensee / Titulaire de permis :	RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO 14 York St, CORNWALL, ON, K6J-5T2
LTC Home / Foyer de SLD :	ST JOSEPH'S CONTINUING CARE CENTRE 14 YORK STREET, CORNWALL, ON, K6J-5T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BONNIE RUEST

To RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices to minimize the risk to the resident and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg 79/10, s.15 (1) (a) and (b), whereby the licensee did not ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In accordance with the Director's (A) memo dated August 21, 2012, the Ministry expects homes to use the best practice document titled Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, in their home. The document describes Zone 7, as the area between the headboard or footboard and the end of the mattress, as a potential entrapment zone for the head. The document indicates that a mattress of the improper size can lead to enlarged gaps at several zones of entrapment thus creating potential entrapment hazards. The end user should test any mattress for compatibility

with the bed prior to use to ensure the bed and mattress combination meets the recommendations of this guidance.

During the inspection Inspector #148, #546 and #545 observed six beds with confirmed use of bed rails, in which the mattress did not fit the size of the bed frame. An additional ten beds were observed, in which bed rails attached to the bed frame and available for use, where the mattress was observed to not fit the size of the bed frame. In all cases, a space existed between the mattress and foot board (Zone 7), observations confirmed the measurement of the space to range from 3 to 7.5 inches.

On June 4, 2014, Inspector #148 observed room #2255 in the company of the Director of Support Services and Environmental Services Manager, a room previously identified as having a bed system in which the mattress did not fit the bed frame. In the presence of both managers it was confirmed that the mattress did not correctly fit the bed frame, whereby a space existed between the footboard and mattress. Inspector #148 measured the space between the mattress and footboard to be a total of 7.5 inches. It was speculated by both managers that the bed frame, the length of which is adjustable, may have at one point been extended to accommodate a taller resident and that the bed frame had not been readjusted for the current length of the mattress.

On June 4, 2014, Inspector #148 interviewed the Director of Support Service and Environmental Services Manager. The Director of Support Services provided the home's file related to the bed system evaluation that occurred in 2013. He reported that in 2013 the home conducted an evaluation of 6 randomly selected bed systems and that not all bed systems in the home were evaluated. The 6 bed systems that were evaluated did not include any of the bed systems observed by the Inspectors. It was further reported that the bed system evaluation included zones 1-4 and that zones 5-7 were not included in the evaluation. Documentation contained in the file indicates that a separate assessment was completed by the home's OT/PT Assistant of selected bed systems, in which she found 3 bed systems whereby the length of the mattress did not fit the bed frame.
(148)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 25, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 13th day of June, 2014

Signature of Inspector / Signature de l'inspecteur : Angèle Albert Ritchie

Name of Inspector / Nom de l'inspecteur : Angele Albert-Ritchie

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