Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2015	2015_344586_0001	T-000096-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET COLLINGWOOD ON L9Y 4X1

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

JESSICA PALADINO (586), CYNTHIA DITOMASSO (528), LESLEY EDWARDS (506)

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): January 13, 14, 15, 16, 19, 20, 21 and 22, 2015.

This inspection was conducted concurrently with Critical Incident Inspections T-000147-14, T-000474-13, T-000351-14, T-001475-14; Complaint Inspection T-000719-14; and Follow-up Inspections T-001331-14 and T-000851-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager, Environmental Services Manager, Registered Dietitian (RD), Personal Support Services (PSS) Manager, registered nursing staff, housekeeping staff, dietary staff, Personal Support Workers (PSW's), residents and family members.

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
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

19 WN(s)
7 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2014_369153_0010	586

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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. Previously issued: CO July 2014.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing identified interventions.

In November 2014, an altercation occurred between resident #100 and resident #105, resulting in superficial injuries to one resident.

i. The Critical Incident Report documented that resident #100 was wandering in and out of residents' rooms, wandered into resident #105's room, and pushed their wheelchair. Resident #105 pushed back, started yelling, and swung at resident #100; resident #100 responded by hitting resident #105.
ii. Review of the plan of care for resident #100 revealed that the resident displayed responsive behaviours. Specific interventions to manage the resident's behaviours were documented in the plan of care.
iii. Review of the plan of care for resident #105 revealed that the resident displayed responsive behaviours, and included specific triggers for the resident.
iv. In interviews with direct care staff and registered staff on the care area, it was confirmed that two specific interventions for resident #100 were not in place as per their plan of care at the time of the altercation.
v. In an interview with registered staff, it was confirmed that resident #100 was observed wandering from room-to-room and heading towards resident #105's room. Registered staff also observed resident #105 approach their own room. At no time were the residents separated or resident #100 redirected away from resident #105 or his/her room. Staff could not verify if a specific intervention regarding resident #105's room was present as per their plan of care; however, the altercation occurred in resident #105's room.

Interventions identified to minimize the risk of altercations for resident #100 and resident #105 were not implemented. [s. 54. (b)]

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. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Throughout the course of the inspection, registered staff were observed throwing medication packages, which contained residents' names and medication regimes, in the general garbage.

i. Interview with the DOC revealed that direction from pharmacy was to add water to the garbage bags on the medication carts before discarding in the general garbage; however, the home could not provide a formalized policy or procedure to outline the process.
ii. Four registered staff on three different home areas confirmed that medication packages were discarded with the general garbage and did not identify any additional steps when discarding these packages. Medication packages were not disposed of in a manner which would protect the residents' personal health information. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #004 that set out the planned care for the resident.

A. Resident #004 used bed rails in the raised position at all times when in bed as confirmed by observation and staff interviews on January 19, 2015. Staff interviewed were aware of the use of the rails. Review of the written plan of care and kardex, which provided direction to front line staff, confirmed the use of the bed rails was not included.

B. Resident #004 experienced a fall from their bed on an identified date in December 2014. The post-fall assessment stated that the resident would benefit from using a rubber mat beside their bed. Observation and interview with a registered staff on January 19, 2015 confirmed that after the fall, the resident began using a rubber mat beside their bed. Review of the written plan of care and kardex, which provided direction to front line staff, confirmed the use of the rubber mat was not included. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to residents as specified in their plans.

A. Resident #010's plan of care directed staff to toilet the resident before and after meals. Observation by an inspector on January 15, 2015 confirmed that the resident was not toileted from 1000 hours until 1230 hours. The PSW confirmed that they did not follow the resident's plan of care to toilet the resident before lunch.

B. Resident #201's plan of care directed staff to apply the safety device seat belt when in their wheelchair. On January 15, 2015 the resident was observed in the wheelchair sliding down the chair. Two staff members needed to reposition the resident and the staff member confirmed that the resident should have had the seat belt applied. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

The plan of care for resident #005 documented the resident's preference on bathing and hairdressing. Review of Point of Care (POC) documentation revealed that the resident received a bed bath and not a tub bath 40 percent of the time. Interview with three PSW's confirmed that the resident enjoyed one-on-one time with staff during the bed baths. It was also identified that the resident no longer preferred to get their hair done by the hairdresser. Interview with registered staff confirmed that the resident had both tub baths and bed baths and that the care plan was not updated to include the resident's change in preference with both bathing and hairdressing. [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 the care set out in every resident's plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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 has failed to ensure that where bed rails were used, the resident was assessed and their bed system evaluated in accordance with evidence-bases practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A review of resident #005's written plan of care indicated that they required the use of bed rails in the raised position when in bed. On January 19, 2015 the resident was observed in bed with bed rails raised. A review of the resident's clinical health record did not include an assessment of the bed rails being used. The Nurse Manager confirmed that the home did not have a formalized assessment for the use of bed rails in place. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, every resident is assessed and their bed system evaluated in accordance with evidence-bases practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports.

The home's policy "ADM- F019: Resident Abuse", last revised July 2013, directed staff to report all incidents or complaints of abuse immediately to the Charge Registered Nurse, Administrator/DOC, or the Ministry of Health and Long Term Care (MOHLTC).

i. In an Interview with direct care staff on January 8, 2015, it was revealed that resident #106 recently reported to direct care staff that a staff member was rough during care. Direct care staff immediately told registered staff who discussed the incident with the staff members and resident involved, and determined that care was provided too fast for the resident.
ii. Interview with the DOC on January 9, 2015 identified that the DOC was not made aware of the resident's complaints and confirmed that registered staff did not report the resident's concerns or subsequent follow up discussions with staff to the Administrator or DOC, as outlined in the policy.
Staff did not comply with the home's policy related to section 24 of reporting all complaints of abuse immediately to the Charge Registered Nurse, Administrator/DOC, or MOHLTC. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's policy is followed relating to promoting zero tolerance of abuse and neglect of residents, specifically ensuring all persons aware of alleged or actual abuse or neglect of a resident immediately report it to the Director, to be implemented voluntarily.

WN #6: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

Resident #211's admission skin assessment was to be completed electronically within 24 hours of admission. A review of the clinical health record confirmed that skin assessment was not completed by the registered staff, and this was confirmed by a Nurse Manager. [s. 50. (2) (a) (i)]

2. The licensee has failed to ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were assessed by a registered dietitian who is a member of the staff of the home.

Resident #009 had a pressure area identified on an identified date in November 2014. As of January 20, 2015, there was no assessment of the resident related to the area of altered skin integrity completed by the RD in the clinical record. Interview with the Nurse Manager confirmed that an RD assessment had not been completed nor was a dietary referral located for the area of altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #009 was noted to have a pressure area on their body. The area of altered skin integrity was noted on an identified date in November 2014. Wound assessments were not consistently completed weekly after that as evidenced by the following:
i) in November, completed 2 of an expected 3 assessments;
ii) in December, completed 1 of an expected 4 assessments;
iii) in January, completed 0 of an expected 3 assessments.
The Nurse Manager confirmed that the weekly wound assessments were not completed weekly. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident receives a skin assessment by a member of the registered nursing staff within 24 hours of admission, is assessed by a registered dietitian who is a member of the staff of the home, and receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's program of nutrition care included the implementation of policies and procedures relating to weight change assessments, referrals, and documentation.

A. The home's policy "Weight Management Program" (policy number DN G-35, effective date October 2013) directed staff to reweigh any resident that had a weight loss or gain of 2.25 kg or greater, then directed the registered staff to review any significant weight changes and to complete a dietary referral to the RD. Interview with the RD on January 21, 2015 confirmed that there was a registered staff member who was responsible for reviewing all weight changes in the home monthly. This was also confirmed by that staff member. Both staff confirmed that the registered staff member would assess each of the triggered weight changes and evaluate if a referral should be sent to the RD or not. The policies, however, state all referrals of greater than 2.25 kg were to be sent to the RD, regardless of the outcome of the registered staff's assessment to determine if referrals were to be sent or not.

B. Review of resident #011's weight record revealed that the resident experienced significant weight loss of greater than 2.25 kg from November – December 2014. Review of the resident's health record revealed that a referral was not sent to the RD until 22 days after the significant weight loss was identified. Resident #011 was not assessed by the RD until 28 days later. The RD and registered staff responsible for reviewing the weights each month confirmed this. When asked when the weights were reviewed each month, the staff member stated that they are done "when [they] are able to get to them". Interview with the RD confirmed that due to the home's current process, not all significant weight changes were being referred to the RD in a timely manner.

C. Review of four resident's weight records revealed that many weight entries were being struck out by registered staff in Point Click Care (PCC) several weeks after the original weight was taken. Additionally, some of the weights being struck out were in fact reweighs.

i. Resident #309's August 2014 weight was struck out for a weight discrepancy 51 days after the original weight was taken, and after the next month's weight had already been taken and documented on an identified date in October 2014.
ii. Resident #308's August 2014 weight was struck out 50 days after the original weight was taken.
iii. Resident #003's November 2014 weight was struck out after 70 days.
iv. Resident #011's November 2014 weight was struck out after 43 days. Additionally,

both of resident #011's November 2014 weights were struck out, thereby implying the resident did not have a November 2014 weight recorded.
v. Interview with the RD confirmed that there was no documentation to support why weights were being struck out from the clinical health record, and these weights were therefore not being referred to the RD as per their policy. Furthermore, the RD confirmed that by removing weight entries, the automatically-generated weight change triggers in PCC would be affected. Therefore, resident weight discrepancies were not consistently referred to the RD for follow-up and action plans were not developed. [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's program of nutrition care includes the implementation of policies and procedures relating to nutrition care, specifically weight change assessments, referrals, and documentation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that following requirement was met with respect to the restraining of a resident by a physical device: staff apply the resident's physical device in accordance with any manufacturer's instructions.

On January 14 and 15, 2015 resident #012 was noted to be wearing a front fastening seat belt that was loose fitting and not applied according to manufacturer's guidelines as confirmed by observation and interview with front line staff. Review of the resident's physician's orders confirmed the seat belt was a restraint. According to the DOC on January 15, 2015, staff were aware, based on education that they had received, that seat belts used to restrain a resident should be tightened to the distance of approximately two finger widths. The seat belt observed on resident #012 was more than five inches from the resident's thighs which was not in accordance with the manufacturer's guidelines. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every resident's physical device is applied in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy and procedure for fall prevention was complied with.

The home's policy "Nursing and Personal Care Manual, Fall Prevention" (policy number NPC E-25, last revised August 2014) indicated that when a resident falls, the registered staff were to complete a detailed progress note post-fall.

i. During a review of resident # 300's clinical record it was noted that the resident sustained a fall on an identified date in August 2013.
ii. The resident was sent to the hospital on an identified date in August 2013 and sustained an injury.
iii. There was no progress note made by the registered staff on duty the evening of the fall until the following day.
The Nurse Manager confirmed that the staff member should have completed their documentation regarding the incident the day the fall occurred. [s. 8. (1) (b)]

WN #10: 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 was easily seen, accessed and used by resident, staff and visitors at all times.

On January 13 and 14, 2015, the bedroom call bells attached to two residents' beds in their rooms were not functioning and therefore could not be activated. Staff confirmed that the call bells were broken and could not be activated. The communication and response system was inaccessible to the residents in the room. [s. 17. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident's #009 and #211 addressed their skin condition, including altered skin integrity and foot conditions.

A. The plan of care for resident #009 did not address the resident's pressure area on the body which was identified on November 6, 2014. The Nurse Manager confirmed that this information should have been in the resident's plan of care.

B. The plan of care for resident #211 did not include the resident's altered areas of skin that were discovered on an identified date in December 2013. The resident's pressure ulcer rating scale (PURS) indicated that the resident was a moderate risk for altered skin integrity. The Nurse Manager confirmed that this information should have been in the resident's plan of care. [s. 26. (3) 15.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The home had a monthly resident verification form which PSW's were expected to sign every half hour that they visually checked the residents for safety or for their whereabouts. On January 19, 2015, the January 2015 forms for one of the units were reviewed and the following was revealed:

i. Resident #301 – there were nine shifts where the PSW's failed to document from 0600 to 1330 hours and two shifts from 2200 to 0530 hours.
ii. Resident's #302, #304, #305, #306, #307 - there were eight shifts where the PSW's failed to document from 0600 to 1330 hours and two shifts from 2200 to 0530 hours.
iii. Resident #303 – there was one shift where the nursing staff failed to document from 1400 to 2130 hours. This information was confirmed by the DOC. [s. 30. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work.

During interviews conducted on January 13 and 14, 2015, eight residents and or families indicated that there was not enough staff available to provide the care and assistance that the resident's required.

i. Review of scheduling from the past thirty days confirmed that the home was short one "Building" PSW on day shift and evening shift, seven out of fifteen days.
ii. Review of the scheduling for the past six months indicated that home areas were missing a PSW four to six shifts per month.
iii. In an interview with the DOC, it was identified that the home did not have a formalized back-up plan for personal care staffing when staff could not come to work. [s. 31. (3) (d)]

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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure alternatives to the use of a Personal Assistance Services Device (PASD) had been considered and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activities of living.

Resident #005 had side rails applied to the bed. Review of the clinical record indicated that there was no assessment completed to determine if the bed rails were being used as a PASD. The home's Nurse Manager confirmed that there was no assessment completed and no alternatives had been considered and tried to assist the resident with the routine activities of living. [s. 33. (4) 1.]

2. The licensee has failed to ensure that the use of the PASD was approved by any person provided for in the regulation.

Review of the clinical records for residents #005 indicated there were no documented approvals for the use of the bed rails as a PASD. The home's Nurse Manager confirmed that there were no approvals obtained for the use of the PASD. [s. 33. (4) 3.]

3. The licensee did not ensure that the use of the PASD was consented to by the resident or, if the resident was incapable, a substitute decision maker (SDM) of the resident with authority to give consent.

Review of the clinical record indicated that resident #005 or their SDM did not provide consent for the use of bed rails as a PASD. The home's Nurse Manager confirmed there was no consent signed from the resident or their SDM for the use of bed rails as PASD. [s. 33. (4) 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

The plan of care for resident #006 indicated that the resident was incontinent, requiring total assistance from staff. Interventions directed staff to check for wetness before and after meals, at bedtime, and on rounds at night.

i. After lunch on January 19, 2015, resident #006 was portered by day staff from the dining room room to the hallway. Within an hour the resident was then portered to the television room where they sat until evening staff brought the resident to the dining room for dinner.
ii. At no time during the resident observation from 1315 to 1700 hours was the resident assisted with incontinent care. Interview with day staff indicated that the resident was bathed between breakfast and lunch, and evening staff confirmed they were not checked for incontinence prior to dinner and would be checked after dinner when transferred to bed.
The individualized continent plan of care, to check for wetness before and after meals, was not implemented. [s. 51. (2) (b)]

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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

During dinner service on January 19, 2015, resident #102 was observed in the dining room sleeping in the wheelchair. Staff were observed telling the resident that it was dinner time and was served the entrée. The resident continued to sleep for approximately twelve minutes until a staff member, who was feeding two residents at the same table, approached resident #102 and provided encouragement to eat.

i. Review of the plan of care indicated that the resident required constant encouragement and directed staff to remain with resident during meals and provide assistance when necessary.
ii. Interview with direct care staff confirmed the resident required encouragement and sometimes physical assistance with eating. [s. 73. (1) 9.]

2. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

During the dinner meal on January 19, 2015, resident #101 was served the entrée, along with two other residents at the same table. Resident #101 was observed trying to lean forward and lift their hands to the plate for approximately ten minutes until staff provided any assistance.
i. Review of the plan of care for the resident indicated that the resident required total assistance with eating.
ii. Interview with a family member of another resident at the same table revealed that the family member often fed their mother and resident #101 because no was staff available.
iii. Interview with direct care staff confirmed the resident had to wait for assistance after their entrée was served for an extended period of time, and proceeded to assist the resident with their meal after the interview. [s. 73. (2) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

From January 13 to January 16, 2015, the wheelchairs of residents #002, #004, #005, #012, #202, #203, #204, #205, #206, #207, #208, #209 and #210 were observed to be dirty. Old food crumbs were noted on the seat of the chairs, and covering the bottom base in and around the wheels, footrests and headrests. The staff on the unit confirmed that the wheelchairs were not cleaned as per the wheelchair cleaning schedule. [s. 87. (2) (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, doublelocked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On January 15, 2015, controlled substances for destruction were noted to be stored in the medication room on each home area within a single locked box in a stationary cupboard that was unlocked. Interview with the nurse manager confirmed that all five drug destruction boxes were stored in a single-locked stationary cupboard only within the locked medication room. [s. 129. (1) (b)]

WN #19: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the home's infection prevention and control program related to labelling of personal care items.

During stage one of the inspection the following were observed:
i. On January 13, 2015, two bars of used soap were found on the shelf in the spa room in one of the home areas.
ii. On January 13, 2015, a used and unlabelled comb and a hairbrush with hair in it, along with a used and unlabelled roll on deodorant, were found in the spa room of one of the home areas.
iii. On January 14, 2015, two toothbrushes were unlabelled and both sitting on the vanity in a residents' shared bathroom.
The DOC confirmed that all personal items were to be labelled. [s. 229. (4)]

Issued on this 18th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	JESSICA PALADINO (586), CYNTHIA DITOMASSO (528), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2015_344586_0001
Log No. / Registre no:	T-000096-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 9, 2015
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF SIMCOE 1110 Highway 26, Midhurst, ON, L0L-1X0
LTC Home / Foyer de SLD :	SUNSET MANOR HOME FOR SENIOR CITIZENS 49 RAGLAN STREET, COLLINGWOOD, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TOLLEEN PARKIN

To CORPORATION OF THE COUNTY OF SIMCOE, 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)

Linked to Existing Order / Lien vers ordre existant: 2014_312503_0017, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents by implementing the identified interventions.

Grounds / Motifs :

1. Previously issued: CO July 2014.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing identified interventions.

In November 2014, an altercation occurred between resident #100 and resident #105, resulting in superficial injuries to one resident.

i. The Critical Incident Report documented that resident #100 was wandering in and out of residents' rooms, wandered into resident #105's room, and pushed their wheelchair. Resident #105 pushed back, started yelling, and swung at resident #100; resident #100 responded by hitting resident #105.
ii. Review of the plan of care for resident #100 revealed that the resident displayed responsive behaviours. Specific interventions to manage the resident's behaviours were documented in the plan of care.
iii. Review of the plan of care for resident #105 revealed that the resident displayed responsive behaviours, and included specific triggers for the resident.
iv. In interviews with direct care staff and registered staff on the care area, it was confirmed that two specific interventions for resident #100 were not in place as per their plan of care at the time of the altercation.
v. In an interview with registered staff, it was confirmed that resident #100 was observed wandering room-to-room and heading towards resident #105's room. Registered staff also observed resident #105 approach their own room. At no time were the residents separated or resident #100 redirected away from resident #105 or his/her room. Staff could not verify if a specific intervention regarding resident #105's room was present as per their plan of care; however, the altercation occurred in resident #105's room.

Interventions identified to minimize the risk of altercations for resident #100 and resident #105 were not implemented. [s. 54. (b)] (528) (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 06, 2015

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 9th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Paladino

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