Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 1, 2016	2016_380593_0028	013551-16	Resident Quality Inspection

Licensee/Titulaire de permis

MOHAWK COUNCIL OF AKWESASNE
P.O. Box 579 CORNWALL ON K6H 5T3

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

TSIIONKWANONHSOTE
70 Kawehnoke Apartments Road Akwesasne ON K6H 5R7

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

GILLIAN CHAMBERLIN (593), MELANIE SARRAZIN (592), MICHELLE JONES (655)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 6, 7, 11 - 14, 17-20, 2016.

In addition, three intakes were inspected during the RQI. Two follow up's log #025795-16, related to Administrator hours and log #025796-16, related to Director of Care hours, and one complaint log #027756-16, related to residents rights.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (Acting DOC), Registered Nursing Staff (RN, RPN), Dietary Staff, Activation Staff, Housekeeping Staff, Personal Support Workers (PSW), residents and family members.

The Inspector's observed the provision of care and services to residents, medication administration, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, staff training records and relevant licensee policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

13 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 212. (1)	CO #001	2016_284545_0022	593
O.Reg 79/10 s. 213. (1)	CO #002	2016_284545_0022	592

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident 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. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device, was included in the resident's plan of care only if the following was satisfied, 4. a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining and 5. the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

During the inspection, residents #010 and #015 were observed by Inspector #593 in bed with bilateral full bed rails in use.

Both residents #010 and #015 were admitted to the home in 2016. Resident #010 is cognitive however has an appointed SDM. Resident #015 is not cognitive and also has an appointed SDM.

A review of resident #010 and #015's plan of care by Inspector #593 was unable to locate any documentation related to the use of bed rails including an order from the physician or registered nurse in the extended class approving the use of the bed rails or consent by the resident or SDM.

During an interview with Inspector #593, October 13, 2016, resident #010 indicated that when they were in bed, the staff put both bedrails up so that they did not fall out of bed.

During an interview with Inspector #593, October 14, 2016, PSW #111 indicated that

resident #010 required two full bed rails when in bed for safety as they have tried to get out of bed on their own and fallen. PSW #111 further reported that this happened when the resident was first admitted and has had two full bed rails in place ever since.

During an interview with Inspector #593, October 14, 2016, RPN #108 indicated that resident #010 required two full bed rails for safety as they have tried to climb out of bed and fallen and the two full bed rails prevent them from falling out of bed. RPN #108 further reported that nursing staff make the recommendations for the use of bedrails, then the Occupational Therapist (OT) assesses the resident and then the physician writes an order which should be located in the residents chart.

During an interview with Inspector #593, on October 14, 2016, PSW #113 indicated that resident #015 required two full bed rails when in bed for safety so that the resident did not climb out or fall out of bed but was not sure. PSW #113 further reported that resident #015 has used two full bed rails since admission to the home.

During an interview with Inspector #593, on October 14, 2016, RPN #114 indicated that resident #015 required two full bed rails for safety when in bed and has used two full bed rails since admission. RPN #114 reported that two full bed rails were considered a restraint and for this reason a doctor's order would be required, as would consent from the POA.

During an interview with Inspector #593, October 17, 2016, the Acting DOC indicated that two full bed rails in use were considered a restraint and if there was a restraint in use, they were required to obtain consent by the POA, a physician's order and the restraint was to be documented in the care plan. When determining the use of bed rails as a restraint, the Acting DOC reported that upon admission, a falls risk assessment was completed for each resident and if the resident was at risk of falls, interventions were put into place and this may include the use of bedrails, however the Acting DOC added that these assessments were not up to date. [s. 31. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the use of any physical restraint for all residents includes a physicians or registered nurse in the extended class order for the restraint and that the restraining resident or substitute decision maker with authority has given consent, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #002 was admitted in 2016 with several diagnoses including cognitive impairment.

A review of resident #002's health care record was completed by Inspector #592. On a particular date, the resident was identified as having altered skin integrity to a particular area of their body. The progress notes further documented regarding the altered skin integrity and indicating that redness and swelling were also present. The physician orders were to clean the area with normal saline and apply a dressing daily.

Six days later, the physician orders were changed to daily normal saline compress and application of a prescribed medication to the area of altered skin integrity, leaving them to air.

Following the physician orders, Inspector #592 was unable to find documentation related to the stage of the pressure ulcers and the actual state of the resident's skin integrity.

On October 14, 2016, RPN #108, indicated to Inspector #592 that a weekly wound assessment was to be performed on each resident having altered skin integrity each Sunday. He further indicated that registered staff will initial the "Treatment Administration Record" (TAR) and then use a skin assessment tool in Point Click Care, the home's electronic documentation software.

On October 17, 2016, RN #102 and RPN #114 indicated to Inspector #592 that upon any skin alteration, a weekly wound assessment should be completed on residents. They both indicated to Inspector #592 that in the case of resident #002, weekly wound assessments have not been completed because the areas of altered skin integrity on the resident's body were not measurable. RPN #114 further indicated that there were no orders from the physician to complete a weekly wound assessment therefore weekly wound assessments were not completed for resident #002. RPN #114 indicated to Inspector #592 that the resident was still exhibiting altered skin integrity and was requiring daily treatments.

On October 17, 2016, the Acting DOC indicated to Inspector #592 that the home's expectation was to have a skin assessment completed weekly to all residents who are exhibiting altered skin integrity. She further indicated to Inspector #592 that since the altered skin integrity weas discovered on resident #002, that the resident should have had a weekly wound assessment completed. [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 ensuring that all residents exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: 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 failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures were 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 whirlpool, tubs, shower chairs and lift chairs.
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces

On October 19, 2016, Inspector #592 observed in the presence of the Acting DOC and the Administrator, one unlabelled spray plastic bottle containing a clear liquid located in the South tub room. The bottle did not have a manufacturers label however the bottle was labelled "tub cleaner" with a permanent marker.

During a discussion held at the time of the observation, PSW #111 indicated that she was using the bottle to clean and disinfect the tub bath after each use. She further indicated to Inspector #592 that she was spraying the product in the tub, scrubbing it and rinsing it right away. She further told Inspector #592 that she had not received any other instructions when using the product.

On the same day, in the presence of the Administrator, Inspector #592 observed one unlabelled spray plastic bottle containing a clear liquid located in the West tub room. The bottle did not have a manufacturers label, however the bottle was labeled "tub cleaner" with a permanent marker.

During a discussion held at the time of the observation, PSW #120 indicated that she was using the spray bottle to clean and disinfect the tub bath. She further told Inspector #592 that she was spraying the product in the tub, scrubbing it and rinsing it right away. She further told Inspector #592 that she had not received any other instructions when using the products.

During a discussion held with the Administrator October 19, 2016 who was in charge of the home's Environmental Services at the time of the inspection, he indicated to Inspector #592 that all hazardous substances used in the home, were to be labelled properly with the manufactures specifications.

Upon review of the manufacturer's label for the specifications and the use of the "AloMed Disinfectant 5 Cleaner" product, it was indicated that the product was used to treat different surfaces such as showers and bath areas. The specifications further indicated that the treated surfaces were to remain wet for 10 minutes for the product to be effective.

On October 20, 2016, during an interview with the Administrator, he reported to Inspector #592 that he was not aware of the PSW practice until it was communicated to the Inspector yesterday. He further told Inspector #592 that the staff had received education

on the "AloMed Disinfectant 5 Cleaner" product which included to leave the product on the surface for 10 minutes as per the manufacturer's specifications in order to be effective. [s. 87. (2) (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 ensuring that procedures are developed and implemented for cleaning and disinfection of resident care equipment 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances in the home were labelled properly and were inaccessible to residents at all times.

On October 19, 2016, Inspector #592 observed in the presence of the ADOC and the Administrator, one unlabelled spray plastic bottle containing a clear liquid located in the South tub room. The bottle did not have a manufacturers label however the bottle was labeled "tub cleaner" with a permanent marker.

During a discussion held at the time of the observation October 19, 2016, PSW #111 indicated to Inspector #592 that she was using the bottle to clean and disinfect the tub bath after each use. She further told Inspector #592 that she was unsure of what the product was inside the spray bottle but was using it because the regular product distributed by the tub hose located in the tub bath could not be used as the tub hose was broken.

On the same day, in the presence of the Administrator, Inspector #592 observed one unlabelled spray plastic bottle containing a clear liquid located in the West tub room. The bottle did not have a manufacturers label, however the bottle was labeled “tub cleaner” with a permanent marker.

During a discussion held at the time of the observation, PSW #120 indicated that she was using the spray bottle to clean and disinfect the tub bath. She further told Inspector #592 that when the spray bottle was empty, she would notify the housekeeping staff who would refill the bottle.

During a discussion held with the Administrator October 19, 2016, who was in charge of the home’s Environmental services at the time of the inspection, he indicated to Inspector #592 that all hazardous substances used in the home, were to be labeled properly with the manufactures specifications. He further told Inspector #592 that the product used to disinfect the tub bath was called "Aloemed Disinfectant 5 Cleaner” and that the product was distributed by the tub hose to disinfect the tubs.

On the same day, during an interview with Housekeeping staff #121, she indicated to Inspector #592 that she was mixing 1/8 of a solution called “Aloemed Disinfectant 5 Cleaner” with water in a spray bottle for the PSW’s to use to disinfect the tub baths. She further indicated to Inspector #592 that she did not receive any labels, therefore was not using any labels to properly identify the name of the product and the hazard precautions. [s. 91.]

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 ensuring that all hazardous substances at the home are labelled properly, to be implemented voluntarily.

WN #5: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

During an interview with Inspector #655 on October 12, 2016, the Administrator indicated to Inspector #655 that there was no designated staff member to co-ordinate the infection prevention and control program at this time. The Administrator further explained that a committee was being developed and that there will be a new designated lead for the infection prevention and control program moving forward. The Administrator indicated that a Registered Nurse was recently hired and that he or she may be designated as the infection prevention and control program lead; but he was not able to speak to the newly hired RNs qualifications for the role of infection prevention and control lead. [s. 229. (3)]

2. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis (TB) within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the

documented results of this screening were available to the licensee.

The licensee indicated on the Ministry of Health and Long-Term Care's Infection Prevention and Control LTCH Licensee Confirmation Checklist, that x-rays were done for the purpose of TB screening for the residents of the home but that "none [were] done recently".

During an interview on October 11, 2016, the Acting DOC was asked by Inspector #655 to clarify this response. The Acting DOC indicated that when residents have had a clear chest x-ray prior to admission to the home, there was no need for another chest x-ray on admission. On further questioning, the Acting DOC was unable to state with certainty whether or not the residents who were admitted without a prior clear chest x-ray received any TB screening; and indicated that it would be the Registered Nurse on duty at the time of a new admission who would be expected to coordinate the appropriate TB screening.

During an interview with Inspector #655 on October 11, 2016, RN #105 indicated that within the first 7-14 days of a residents' admission, TB screening was to be completed. RN #105 indicated that when a resident was admitted and had not had a recent chest x-ray, a Mantoux test and chest x-ray would be completed on admission. During the interview, RN #105 acknowledged that that the TB screening protocol was not always being followed.

On October 12, 2016, the ADOC with Inspector #655 reviewed the medical records found for residents #010 and #017. There was no documentation found to indicate that any TB screening had been done for these residents:

- Resident #010 was admitted to the home early 2016. In the medical record of resident #010 reviewed by Inspector #655, it was documented that resident #010's last chest x-ray was done several years prior to the admission. There was no documentation found to indicate that an x-ray was completed on admission to the home; or that a Mantoux skin test had been done.

- Resident #017 was admitted to the home early 2016. In the medical record of resident #017 reviewed by Inspector #655, it was documented that resident #017's last chest x-ray was done approximately six months prior to the admission. There was no documentation found to indicate that an x-ray was completed on admission to the home; or that a Mantoux skin test had been done. [s. 229. (10) 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 ensuring that a staff member of the home with appropriate education and experience is appointed the designated lead of the infection, prevention and control program; and that all residents admitted to the home are screened for tuberculosis within 14 days of admission, unless screening was conducted in the last 90 days prior to admission with documented results available, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #010 was provided as per the plan.

A review of resident #010's progress notes by Inspector #593 found a documented assessment by the home's Registered Dietitian (RD) on a particulate date in 2016. It was documented to increase a specific oral nutrition supplement from HS to BID due to significant weight loss since admission and fragile nutritional status.

A review of resident #010's physician's orders found a documented order from the RD with the same date: Discontinue specific oral nutrition supplement HS, start specific oral nutrition supplement BID.

A review of resident #010's electronic physicians orders found a documented order: Start specific oral nutrition supplement 235cc HS, dated one month earlier. A review of the Medication Administration Record (MAR) for resident #010 for approximately six months, found that the resident had been receiving the specific oral nutrition supplement once daily at HS as per the original order from the RD.

During an interview with Inspector #593, October 19, 2016, RPN #123 indicated that resident #010 did not receive the specific oral nutrition supplement on the day shift but confirmed through the MAR, that the resident received the specific oral nutrition supplement in the evening only.

During an interview with Inspector #593, October 19, 2016, RN #112 indicated that when the RD writes an order for a resident, the RD is to communicate this to nursing staff so that the order can be transcribed into the MAR. The practice has been that the RD will leave the resident's chart open for nursing staff so that nursing can sign off on the order and ensure that it is added to the MAR. RN #112 confirmed that the order for Boost Plus BID was not signed by nursing staff and they were unsure why the order was not transcribed to the MAR.

During an interview with Inspector #593, October 19, 2016, the Acting DOC indicated that the usual process for order's written by the RD was that the RD communicated these to the nursing staff and the nursing staff processed the orders to ensure that they were captured on the MAR. [s. 6. (7)]

WN #7: 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 comply with O.Reg 79/10 s. 8 (1) (b) in that the home did not ensure that the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

As per O.Reg 79/10 s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: Skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The Home's Skin and Wound Policy section: 4.16 Wound and Skin Care program (revised March 2008) was reviewed by Inspector #592. The following requirements were documented:

Under "Statement of Purpose";
To implement a consistent documentation tool for all resident treatments.

Under " When completing a resident treatment";

1. Review the Treatment Administration Record (TAR) sheet for the physician order, time and frequency of treatment.
2. Complete the treatment as ordered
3. Initial the TAR record to indicate that the treatment has been completed as ordered.

Resident #002 was admitted in 2016 with several diagnoses including cognitive impairment.

A review of resident #002's health care record was done by Inspector #592. The progress notes indicated that the resident had altered skin integrity. The progress notes further described the altered skin integrity present. The progress notes indicated that redness and swelling were also present. The physician orders were to clean with normal saline and apply a dressing daily.

On October 17, 2016, RN #102 told Inspector #592 that each treatment or dressing change was documented on the TAR. She further indicated that if it was not recorded on the TAR, the treatment could also be recorded in the Medication Administration Records (MAR) or the progress notes.

A review of the resident's health care records was completed by Inspector #592 following the physician orders, no documentation was found indicating any dressing changes.

Six days after the original order, the physician orders were changed to daily normal saline compress and application of a prescribed medication the altered skin integrity and leaving to air.

A review of the resident's TAR was done by Inspector #592 following the most recent physician orders. No documentation was found in the resident health care records for the daily normal saline compress and prescribed medication application for two dates.

On October 17, 2016 RPN #114 indicated to Inspector #592 that resident #002 still required to have the normal saline compress done with the application of the prescribed medication as the skin was not completely healed.

On October 17, 2016 the Acting DOC indicated to Inspector #592 that it was the expectation of the home, that the dressing changes should be documented on the resident's TAR. [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: 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:
14. Hydration status and any risks relating to hydration. 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 #010 and #015 was based on an interdisciplinary assessment of hydration status and any risks related to hydration.

A review of the current plan of care for resident's #010 and #015 was completed by Inspector #593. There was no hydration status or any risks related to hydration documented for either resident.

During an interview with Inspector #593, October 19, 2016, the Acting DOC reported that when a resident was admitted to the home, their care plan was started and then other disciplines added to it as required. The Acting DOC added that hydration was multidisciplinary and should fall under both nursing and dietary. [s. 26. (3) 14.]

WN #9: 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 has failed to ensure that each resident in the home was bathed by the method of his or her choice.

During an interview with Inspector #593, residents #003, #013 and #106 indicated that there was no option to have a shower in the home, that they were only able to have a

bath.

Resident #003 has been living in the home for several years and is cognitively well.

During an interview with Inspector #593, October 12, 2016, resident #003 indicated that they would prefer to have a shower but is only ever given a bath. They have never been offered a shower since admission to the home several years earlier. Resident #003 further reported that they have mentioned to several staff members that they would prefer a shower however has not really received a response to their request. The resident added that their choice of bathing before admission was showering and when they were admitted they brought their own shower chair which was taken away from them with the comment "well you won't need that".

A review of resident #003's current care plan, found a documented intervention "prefers bath, use whirlpool tub".

During an interview with Inspector #593, October 12, 2016, PSW #107 indicated that they do not have access to a shower on the South side and the normal practice was that residents received a tub bath and no resident on the South side currently received a shower. PSW #107 further reported that there was a shower on the West side of the home and if a resident requested a shower, they could take them to the West spa room to be showered. The PSW added that there were no residents in the home that she was aware of that currently received a shower.

During an interview with Inspector #593, October 12, 2016, PSW #100 indicated that they only used the tub baths in the home for bathing residents. PSW #100 further reported that the showers were in working condition however they were currently used for storage. The PSW added that she has worked in the home for over four years and residents have not been offered a shower and residents were automatically given a bath.

Observations of the South spa room on October 12, 2016 by Inspector #593 found that there was a shower room however it was currently used for storage.

Observations of the West spa room on October 12, 2016 by Inspector #593 found that there was a shower room however it was currently used for storage.

During an interview with Inspector #593, October 12, 2016, RPN #108 indicated that residents were given tub baths as majority of the residents preferred to receive baths.

The RPN added that residents should be given the choice at bathtime however confirmed that none of the showers in the home were currently in use as majority of residents preferred to have a tub bath. The RPN added that many of the residents could not stand in the showers and they would need to use a shower chair, which the RPN added, several were available in the home if needed.

During an interview with Inspector #593, October 12, 2016, the Acting DOC indicated that the home has two tub baths that the residents use in the home. They added that there was an admission assessment form that was completed for each resident and bathing preference was one of the questions however majority of the time, the form was not completed. The Acting DOC reported that as far as they were aware, the showers were in working order and should be accessible to residents and not used for storage. [s. 33. (1)]

WN #10: 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 ensure that semi-annual meetings have been convened to advise such persons of the right to establish a Family Council.

During an interview with Inspector #593, October 18, 2016, the Recreation and Leisure Manager reported that there was no Family Council established in the home and they have not had a Family Council for at least six years. The Recreation and Leisure Manager further reported that they have previously included recruitment information in newsletters and invoices which were sent out at the start of the year.

During an interview with Inspector #593, October 18, 2016, Finance Clerk #117 reported that information regarding Family Council recruitment has been sent out with invoices in the past however this was not done this year. Finance Clerk #117 checked her records at this time and reported that the last recruitment notice sent with invoices was done September, 2015, for a meeting to be held September 12, 2015.

During an interview with Inspector #593, October 18, 2016, the Recreation and Leisure Manager indicated that September, 2015 was the last time recruitment was attempted for the Family Council. [s. 59. (7) (b)]

WN #11: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

On October 7, 2016, upon review of the Resident Council minutes, Inspector #592 was not able to find any documentation in regards to the annual survey.

On the same day, during an interview with the Recreation and Leisure Manager, who was the appointed person for the Resident Council, indicated to Inspector #592 that a survey was distributed to the residents and the family members during February 2016. She further indicated to Inspector #592 that the next survey was planned to be distributed in February 2017. The Recreation and Leisure Manager was not able to provide any documentation to support that an annual survey had been distributed to residents in the home.

On October 07 and 12, 2016, Inspector #592 interviewed four residents identified as being alert and oriented and none of them could recall having received a satisfaction survey. [s. 85. (1)]

WN #12: 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 drugs were stored in an area or a medication cart, that was secure and locked.

On October 6 and 7, 2016, Inspector #592 and #593 observed in room #109, two different prescription medications for resident #003 on the counter of the vanity inside the residents room.

On October 7, 2016, in an interview, resident #003 indicated to Inspector #592 that both medications belonged to them for self-administration and that they were keeping both of them on the vanity for their convenience.

On October 7, 2016, in an interview, RPN #101 indicated to Inspector #592 that all prescribed medications were to be locked in the treatment cart located in the locked treatment room. She further indicated to Inspector #592 that no prescribed medications were allowed to remain in resident rooms.

On October 12, 2016, in an interview, the acting DOC indicated to Inspector #592 that prescribed medications should be kept locked in the treatment cart located in specific treatment rooms and medication rooms in the home. The Acting DOC further indicated to Inspector #592 that for the resident who was authorized to self administer a medication, the medication should be kept locked in the residents bedside top drawer. [s. 129. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On October 6 and 7, 2016, Inspector #592 and #593 observed in room #109, two prescription medications on the counter of the vanity inside resident #003's room.

On October 7, 2016, during an interview, resident #003 indicated to Inspector #592 that both medications belonged to them for self-administration.

A review of resident #003's health care records by Inspector #592 revealed documentation of a physicians order for both medications however no order was found for self-administration.

On the same day, during an interview, RN #102, indicated to Inspector #592 that resident #003 was able to self-administer the two medications. She further indicated to Inspector #592 that residents who were capable to self-administer medications have to be approved by the prescriber. Upon a review of the physicians order in the presence of the Inspector, RN #102 indicated that a physicians order had not been obtained for resident #003 as per the home’s policy.

On October 12, 2016, during an interview, the acting DOC indicated to Inspector #592 that any residents who self-administer drugs, need to be evaluated and approved by the prescriber. Upon review of resident #003's health care records in the presence of Inspector #592, she indicated that a physicians order had not been obtained as per the home’s policy for that resident. [s. 131. (2)]

Issued on this 1st day of December, 2016

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

Original report signed by the inspector.