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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 10, 2014	2014_247508_0013	H-000467-14	Resident Quality Inspection

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

VALLEY PARK LODGE
6400 VALLEY WAY, NIAGARA FALLS, ON, L2E-7E3

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

ROSEANNE WESTERN (508), CATHY FEDIASH (214), GILLIAN TRACEY (130), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 2014

The following complaint inspection was conducted concurrently with this RQI (H-000569-14).

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered staff, Personal Support Workers (PSW), Recreation Director, Maintenance Coordinator, Resident Assessment Instrument (RAI)Coordinator, Physiotherapist (PT), Registered Dietitian (RD), Cook, Dietary Aides (DA)

During the course of the inspection, the inspector(s) toured the home, observed provision of care, observed meal service, reviewed relevant policies and procedures, reviewed clinical records, committee meeting minutes, interviewed staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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 did not ensure that every resident was afforded privacy in treatment and in caring for his or her personal needs.

a) It was observed on three occasions in May, 2014, that resident #006 was administered insulin, in the abdomen, while seated at the dining room table with two co-residents.(508)(583) [s. 3. (1) 8.]

2. The licensee did not fully respect and promote the resident's right to participate in decision making.

a) On an unidentified date in 2014, staff in the home transferred resident #110 to another room within the home without notifying or consulting with the resident's Power of Attorney (POA). The DOC stated it was the home's expectation that the resident and/or their POA would be informed, prior to such a move occurring. The DOC verified the POA was not informed of the move until after it had occurred. [s. 3. (1) 9.]

3. The licensee did not ensure that every residents' 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.

a) Registered staff confirmed that medication packages, which contained residents' names and medication regimes were discarded with the general garbage and 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 that every resident is afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

According to the clinical record, resident #001 sustained a fracture, as a result of a fall on an unidentified date in 2014. A review of this resident's written plan of care

indicated the following:

a) The focus statement for dressing indicated that the resident required limited assistance; the goal indicated that they would maintain their independence to dress with minimal assistance and the interventions indicated that the resident required extensive assistance to dress and undress.

b) The focus statement for transferring indicated that the resident required supervision with transfers, however, the interventions indicated that the resident required limited assistance of one staff.

c) The focus statement for bed mobility indicated that the resident required assistance of two staff, however, the interventions indicated that the resident required assistance of one to two staff.

d) The focus statement for delirium or disordered thinking/awareness indicated that the resident was demonstrating increased confusion, however, the interventions indicated that the resident was very aware and alert to her surroundings.

e) The focus statement for smoking indicated that the resident no longer smoked, however, the written plan of care for activity/interest, indicated that the resident was a smoker and did so regularly throughout the day.

f) The focus statement for activity/interest indicated that the resident could independently get to all program areas; however, the interventions for locomotion on the unit indicated that the resident required staff to push them in their wheelchair.

The DOC confirmed that the written plan of care did not provide clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee did not ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

a) Resident #300 was assessed as having a stage 3 ulcer, which was documented on the assessment tool and on the Treatment Administration Record(TAR). The resident's care plan identified the wound as a stage 2. It was confirmed by registered staff that the resident did have a stage 3 ulcer and that the resident's care plan was not consistent with assessment.

b) Resident #101 was assessed as having a scheduled toileting plan with identified times. The resident's care plan that staff refer to for directions in caring for residents did not include the information from the assessment. It was confirmed by registered staff that the care plan did not identify the resident`s needs and preferences as assessed.

c) A review of resident #109's most recent Minimum Data Set (MDS) assessment that was completed in March, 2014, indicated in the Resident Assessment Protocol (RAP), for physical restraints that this resident preferred to sleep with two bed rails up as this provided them with a sense of comfort and security. A review of the Personal Assistive Services Device (PASD) assessment, completed in March 2014, also indicated that the use of the two bed rails in the upright position was for the purpose of safe and secure reasons. A review of this resident's written plan of care indicated that the use of two bed rails in the upright position, were for the purpose of security as well as for positioning. An interview with registered staff confirmed that the purpose of the two bed rails in the upright position was to provide the resident with a sense of safety as well as for positioning and that the plan of care was not entirely based on the assessed needs of the resident.(214)

d) According to the clinical record, resident #001 sustained a fracture as a result of a fall on an unidentified date in 2014. A review of the significant change Minimum Data Set (MDS) coding that was completed in May, 2014 indicated that the resident required extensive assistance of two staff for toileting, however the written plan of care indicated that the resident required limited assistance of one staff for toileting. An interview with the RAI Coordinator confirmed that the resident required extensive assistance of two staff and that the plan of care was not based on an assessment of the resident's needs.(214) [s. 6. (2)]

3. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other.

a) A record review of resident #207's plan of care for continence care and bowel management showed the assessments were not consistent. The narrative RAP in April, 2014 specified that the resident required one staff to assist with transfers as they could stand and pivot when toileted while holding onto the grab bar and that the

resident had some control during wake times and staff were to promptly toilet on routine basis as requested. The care plan in point click care and the paper format located in the treatment binder specified resident #207 was to be toileted with sit to stand lift with two staff and they were to be toileted first thing in the am, after meals and before bed. An interview with registered staff confirmed the assessments were not integrated and consistent with each other. [s. 6. (2)]

4. The licensee did not ensure that all staff and others involved in the different aspects of care collaborated with each other in the assessment residents so that their assessments were integrated, consistent with and complemented each other.

a) A review of resident #002's plan of care showed that the assessments of wounds in the skin integrity active care plan, TAR, wound assessment tool and Nurse Practitioner assessment were not integrated, consistent and did not complement each other. The April skin integrity section of the care plan identified a stage 3 skin breakdown on an area on an extremity. The TAR indicated that there was a treatment for this area but did not identify the stage of the wound. The TAR also indicated that there was a stage 2 wound located on another area of the extremity. The wound assessment tool identified this area as well, however, there was no assessment or staging of this wound. According to the Nurse Practitioner's assessment, one wound was assessed as a stage X ischemic ulcer, and the other as a stage 2 pressure ulcer. In an interview with the registered and non-registered staff, they were unable to identify resident #002's active skin integrity issues. [s. 6. (4) (a)]

5. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) A review of resident #207's care plan in point click care and the paper format located in the personal support worker (PSW) treatment binder specified that resident #207 was to be toileted with a sit to stand lift with two staff and they were to be toileted first thing in the am, after meals and before bed per scheduled toileting plan. In April, 2014 resident #207 shared they were toileted in the morning with a one person transfer not using a lift, they notified staff when they needed to be toileted and they were not toileted per a scheduled plan. An interview with resident #207's PSW confirmed that the information provided by resident #207 was correct and the care was not provided as specified in the care plan.

b) A review of resident #012's clinical record indicated that they were positive for Methicillin-Resistant Staphylococcus Aureus (MRSA). On May 6, 7 and 14, 2014, interviews were conducted with front line staff, who provided direct care to this resident, which resulted in the front line staff indicating that they were unaware of what infection the resident had. Front line staff interviewed in May, 2014, indicated that they wore gloves to provide care to the resident and that the gloves were stored inside the resident's bathroom. A review of this resident's plan of care identified the infection that the resident had and instructed staff to follow the home's policy. A review of the home's policy, Antibiotic-Resistant Organism (ARO) (CIC-05-05-1-10), indicated that staff were advised to wear gloves when entering a room of a resident for whom contact precautions are in place for suspected or confirmed MRSA and to wear a gown if direct contact with the resident or environmental surfaces was likely. The policy also stated to advise staff to wear a surgical/procedure mask and eyewear when providing direct care for a resident known to have MRSA nasal . Front line staff interviewed did not know to wear these items, nor were they readily available to them.

Registered staff confirmed that the care set out in the plan of care, was not provided to resident #012 as specified in the plan.(214) [s. 6. (7)]

6. The licensee did not 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.

According to the clinical record, resident #001 sustained a fracture, as a result of a fall in April, 2014. A review of the resident's clinical record indicated that the resident's care needs changed due to their fracture where resident #001 required increased assistance from staff. The resident's care plan was not revised to reflect changes in their needs until April 20, 30, and May 6, 2014. On April 20, 2014, revisions of the resident's care plan only included changes in their dressing, transferring and continence. On April 30, 2014, revisions included bed mobility, walking, locomotion, bathing, personal hygiene, oral care, aids to daily living, delirium or disordered thinking/awareness and restraints. Toileting was not updated until May 6, 2014. The reassessment of the resident through the Minimum Data Set (MDS), significant change in status, did not occur until May 5, 2014, which was 20 days after their occurrence. The DOC confirmed that the resident was not reassessed and their plan of care reviewed and revised when their care needs changed. [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 there is a written plan of care for each resident that set out the goals the care is intended to achieve, that set out clear directions to staff and others who provided direct care to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) A review of the home's policy, Skin Care and Wound Care Program (CN-S-13-18), indicated that the frequency and method of bathing should be identified on the resident's plan of care. A review of resident #106's plan of care did not identify this resident's preference of bathing as well as the frequency of their bathing. The DOC confirmed that this information was not identified on the resident's plan of care as required by the bathing policy.

b) The home's policy, CN-S-13-18 Skin And Wound Care Program, Bathing Requirements indicated, never leave a resident alone during bath/shower, (if they request privacy, provide call bell and stand outside curtain but remain in bathing suite).(130)

c) On an unidentified date in 2014, resident #109 reported they were left unattended in the tub room, during their shower. The home investigated the incident and the Administrator verified, the resident was left alone and unsupervised in the tub room during their shower. There was no injury resulting from the incident. The Administrator confirmed that it was the expectation that all residents be supervised during a bath or shower, in accordance with the home's policy.(130) [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee did not ensure that where a resident was being restrained by a physical device under subsection (1), that (a) the device was used in accordance with any requirements provided for in the regulations; staff did not apply the device in accordance with any manufacturer's instructions; the resident was not released from the device and repositioned at least once every two hours; the resident's condition was not reassessed and the effectiveness of the restraint was not evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

The Manufacturer's instructions indicated the belts were to be positioned snugly around the patient. The DOC confirmed it was the expectation of the home that seat belts be fastened snugly, allowing only one hand to slide between the device and the abdomen.

a) Residents #011, #100 and #205, were observed in May, 2014 seated in their wheelchair with loose fitting seatbelts fastened.

b) It was observed in May, 2014 that resident #309 was sitting in their wheelchair with a seatbelt loosely applied.
It was verified that the seat belts were too loose.

c) Resident #400 was restrained in bed with two bed rails and relied on staff for repositioning. A review of the resident's restraint flow sheet for May, 2014 indicated that the staff did not monitor the resident every hour while restrained. It was confirmed by the DOC that the staff did not monitor the resident hourly. [s. 31. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a physical device is used in accordance with any requirements provided for in the regulations;that, to be implemented voluntarily.

WN #5: 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 did not ensure that weights were recorded for each resident monthly.

A review of the records in point click care and the weight book showed there was no documented weight for resident #109 in April 2014, resident #208 in October 2013 and resident #302 in November 2013. It was confirmed with the registered staff that these weights were not available. [s. 68. (2) (e) (i)]

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 weights are recorded for each resident monthly, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that a registered dietitian who is a member of the staff of the home approved the menu cycle.

The Ontario Menu Spring/Summer 2014 three week cycle menu currently in place was not approved by the Registered Dietitian(RD). An interview with the Food Service Manager confirmed that the current menu cycle has not yet been approved by the RD. [s. 71. (1) (e)]

2. The licensee did not ensure the menu provided a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide.

a) A review of the Resident food services – menu planning policy (CD-02-05-01) explained menus are planned for variety and that the same food or form of food will not be served at the same meal or on the same day. A review of the Ontario menu spring/summer 2014, 21 day menu cycle was completed. A sandwich was the first and second choice for lunch once, mashed potatoes were the first and second choice for dinner four times and steamed rice was the first and second choice for dinner once. A form of potatoes was offered on the dinner menu 34 times out of the possible 42 dinners in the menu cycle. During interviews with resident's #001, #207 and #208 it was shared that they would like more variety in the menu. An interview with the Food Service Supervisor confirmed the current menu did not comply with the menu planning policy and lacked variety. [s. 71. (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 to ensure that a registered dietitian who is a member of the staff of the home approves the menu cycle, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the homes dining service included, at a minimum the communication of the seven-day and daily menus to residents.

A review of the meal service and delivery policy (CD-04-11-1) explained the means by which a resident is offered a choice of menu items shall be appropriate to each resident's ability and/or limitations; visual, verbal or written. It was observed during dining service on two separate dates in May, 2014 that Dietary Aids (DA) offer choice at the end of meal service for the next meal, explained choice verbally and did not describe meal choices as described on menu. It was observed that a number of residents were not offered dinner choice during one of the dining service observations, and it was confirmed with DA that 14 residents were unable to make meal choices. Resident 220, 301 and 303 were not offered a choice. A record reviewed of their care plans and cooks resident diet sheets did not indicate that these residents were unable to make choice. [s. 73. (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 be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not seek advice of the Residents' Council when developing and carrying out the satisfaction survey, and in acting on their results.

During an interview with the Residents' Council President, the resident indicated that the licensee did not seek their advice in developing and carrying out the satisfaction survey. It was confirmed by the Recreation Director that the survey was developed without seeking advice from Residents' Council. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee seeks advice of the Residents' Council to develop and carry out the satisfaction survey, and in acting on their results, to be implemented voluntarily.

WN #9: 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 did not ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area stored in a separate locked area within the locked medication cart.

a) The DOC confirmed that surplus narcotic drugs were kept in a locked "toolbox", which was stored in an unlocked medication storage room. The medication storage room door was observed to be fully ajar in May, 2014, for a period in excess of 20 minutes. During this time, a resident and a housekeeper were observed in the office space adjacent to the medication storage room. The DOC confirmed the medication storage room door was not equipped with a locking mechanism. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that all areas where drugs were stored was kept locked at all times, when not in use.

a) The medication storage room door was observed to be fully ajar in May, 2014 for a period in excess of 20 minutes. During this time, a resident and a housekeeper were observed in the office space adjacent to the medication storage room. The DOC confirmed the medication storage room door was not equipped with a locking mechanism. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #11: 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).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the infection prevention and control program.

A review of resident #012's clinical record indicated that they were positive for Methicillin-Resistant Staphylococcus Aureus (MRSA), and that contact precautions were in place. A review of the home's policy, Antibiotic-Resistant Organism (ARO) (IC-05-05-7), dated September 2011, indicated that to discontinue contact precautions 3 negative cultures taken one week apart with monthly screening for six months, was to be done. The home also had a memo, dated February 21, 2013 and titled, Infection Control Policy Update, which indicated that effective immediately, the home would no longer do every other week surveillance to all positive cases if Antibiotic Resistant Organisms were not being treated or decolonized and that routine surveillance would still be conducted but in a lesser frequency which was every three months. A review of the home's tracking tool, used to monitor the results of swabs obtained and titled, Methicillin Resistant Organism Precautions: Specimen Monitoring, indicated for resident #012, that swabs were initially obtained on an unidentified date in 2014, which had positive results and then not obtained again, until five weeks later.

An interview with registered staff, assigned to Infection Control in the home, and the DOC, confirmed that the swabs were not obtained weekly, as required by the home's

policy and that the memo dated February 21, 2013, which the home was following, did not coincide with the home's ARO policy. [s. 229. (4)]

2. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis 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.

An interview conducted with the DOC and a review of the home's policy, Screening Protocols (CIC-02-17-1), confirmed that a two step tuberculosis (TB) test is conducted within 14 days of admission for all residents.

a) A review of resident #013's clinical record indicated that they were admitted to the home on an unidentified date in 2013. They had their first step TB test completed a month after admission and their second step TB test completed 12 days after that, which was a total of 41 days since their admission.

b) A review of resident #015's clinical record indicated that they were admitted to the home on an unidentified date in 2014. They had their first step TB test completed 27 days after admission and their second step TB test completed 13 days after that, which was a total of 40 days since their admission.

An interview with the DOC confirmed that these two residents did not receive their two step TB test, within 14 days of their admission. [s. 229. (10) 1.]

3. The licensee did not ensure that residents were offered immunizations against tetanus and diphtheria.

A review of the home's policy, Immunization Protocols (CIC-02-14-3), indicated that all residents shall be asked about status of their tetanus and diphtheria boosters upon admission. If unknown or more than 10 years since last booster, residents, with informed consent would be offered tetanus/diphtheria booster. An interview with the DOC confirmed that the home did not offer these immunizations to their residents. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee did not ensure that staff used all equipment supplies, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

It was observed in May, 2014, that staff were bathing a resident in the bath tub using a chair lift. According to manufacturers' instructions for the chair lift, residents were to be secured using the chair lift's lap belt. During this observation, the resident was not secured with the lap belt and it was identified that the chair's lap belt had been removed. It was confirmed by staff that the lap belt had been removed and was not being used while residents were in the chair. [s. 23.]

WN #13: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

a) An interview conducted with resident #008 in May 2014 identified that the resident preferred to go to bed around 2100 hours, however, this resident stated that they were assisted to bed at approximately 1945 hours. A review of the resident's written plan of care only indicated how this resident sleeps and did not identify their patterns and preferences.

b) An interview conducted with resident #109 in May 2014 identified that the resident preferred to be up at 0700 hours. A review of the resident's written plan of care did not identify their patterns and preferences for waking. Interviews with front line and registered staff confirmed that the plan of care did not identify this resident's preferences in relation to their wake time. [s. 26. (3) 21.]

WN #14: 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 did not 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.

a) During an interview with resident #106, it was identified that the resident received their twice weekly bathing. A review of this resident's bathing flow sheet record from March to May, 2014, identified that no documentation was recorded for the residents scheduled bathing on four occasions. An interview with the DOC indicated that the bath sheets were to be marked with a letter, "R" if refused and if the bath was given, the flow sheets were marked with the number of staff that provided the assistance. The DOC confirmed that the resident's bathing sheets were not documented on the identified dates above.

b) A record review of resident #207's plan of care indicated they were to be toileted in the am, after meals and before bed as per the scheduled toileting plan. A review of the daily toileting flow sheets located in the resident's chart and in personal support worker treatment binder from April to May, 2014 showed that the documentation was incomplete and did not specify times the resident was toileted. An interview with registered staff confirmed that documentation was incomplete.(583)

c) Resident #300 had a stage 3 pressure ulcer that required dressing changes twice per week and when necessary (PRN). A review of the Treatment Administration Record (TAR) indicated that the dressing changes were not documented 10 out of the 21 scheduled times. It was confirmed by registered staff that the expectation was to sign on the TAR beside the dressing order when the dressing changes were completed.

d) Resident #100 was identified as having visual impairment which was documented on the residents care plan. The last quarterly assessment for this resident had been signed off but no assessment had been done for the residents vision. It was confirmed by the Director of Care (DOC) that the assessment had been signed off but not completed.

e) On May 4, 2014, it was documented that resident #101 had a change in their condition. A review of the resident's clinical record indicated that there was no reassessment or interventions documented after this date. An interview with the Director of Care confirmed that it was the expectation that staff follow up and document at minimum every shift.(508)

f) Resident #002's clinical health records were reviewed and resident was found to have several wounds. A review of the registered treatment records and PSW administration records from April 1 to May 14, 2014 showed daily wound care treatments were not documented 33 times. It was confirmed by registered staff that the expectation was to document all wound treatments and that they were incomplete. (583) [s. 30. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the skin and wound care program was fully developed and implemented in the home to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound interventions.

It was identified during this inspection that the skin and wound care program was not fully implemented to include skin and wound care protocols. An interview conducted with the Nurse Practitioner and the Director of Care confirmed that they were working on implementing the program but currently do not have a skin and wound program. [s. 48. (1) 2.]

WN #16: 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 did not ensure that all residents with 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.

a) A review of resident #002's plan of care showed a stage 2 pressure ulcer on the left lateral heel per Nurse Practitioner (NP) assessment in April, 2014. No follow up assessments were completed. Registered staff were not aware of NP assessment or the current status of resident #002's skin integrity. It was observed on resident #002's shower day, in May, 2014 with inspector 508 that the left lateral heel was closed. No documentation was found assessing that the wound had healed. It was confirmed with the NP in May, 2014 that the wound was present as documented in April, 2014. [s. 50. (2) (b) (iv)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.

a) Resident #001 had informed their family of a concern regarding their care in April 2014. The family of resident #001, verbally informed the licensee of this concern regarding the care of their loved one in April, 2014 and to date, had not yet received a response from the home as to the outcome. An interview with the Administrator, DOC and RAI Coordinator indicated that an investigation into this concern had taken place, however the home was unable to produce all of the investigative notes, specifically, the notes involving the meeting with the resident in regards to what had occurred. The DOC confirmed that the investigation was incomplete and that a response to the complainant had not been provided within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

2. The licensee did not ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Resident #001 had informed their family of a concern regarding their care in April 2014. The family of resident #001, verbally informed the licensee of this concern regarding the care of their loved one in April, 2014 and to date, had not yet received a response from the home as to the outcome. A review of the home's complaint log indicated that there was no documented record of this verbal complaint; no date when the complaint was received; no documentation as to the type of action that was taken to resolve the complaint; no documentation of the final resolution, if any; no documentation regarding the date(s) for which a response was provided to the complainant and no documentation of any responses made in turn by the complainant. The Administrator confirmed that the home did not ensure that a documented record was kept that included the requirements listed. [s. 101. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee did not ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

a) The medication storage room contained 200 dulcolax suppositories, 144 glycerin suppositories and 36 bottles of milk magnesia. The DOC confirmed the medication supply exceeded the home's three month usage. [s. 124.]

Issued on this 17th day of June, 2014

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