Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 9, 2014	2014_291552_0026	O-000926-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

HALLOWELL HOUSE
13628 LOYALIST PARKWAY, PICTON, ON, K0K-2T0

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

MARIA FRANCIS-ALLEN (552), BARBARA ROBINSON (572), DARLENE MURPHY (103), JESSICA PATTISON (197)

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): September 22, 23, 24, 25, 26, 29,30 and October 1, 2014

The following complaint inspections were completed concurrently during this inspection (log # 318-14 and 932-13) and the following critical incident inspections were also completed concurrently during this RQI inspection (log 00857-14 and 00180-14)

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Environmental Service Manager, Pharmacy Clinical Liaison,Physiotherapist (PT), Registered Dietitian (RD), Food Services Supervisor, Resident Services Clerk, Program Manager, RAI-Coordinator, Registered Nurse (RN), Registered Practical Nurses (RPN's), Personal Support Workers (PSW's),dietary staff, Resident Council President, Family Council President, Residents and families.

During the course of the inspection, the inspector(s) toured the home, observed dining services, reviewed resident health records, reviewed the home's investigation reports and reviewed the home's policies (Infection Control and prevention, Medication Administration, Skin and Wound, Resident Non-Abuse, Least Restraints, Personal Assistive Services Devices and Continence Care

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 69 in that specified weight changes were not assessed.

Resident #27 current care plan indicates that the resident is at high nutritional risk, requires total feeding assistance and is on a mechanically altered diet. Resident #27 has been receiving a dietary supplement at AM, PM and HS snack times since an identified date.

Resident #27's weight history was reviewed and was identified in the home's electronic chart as having a significant weight loss over a 5 month period. The Registered Dietitian completed an assessment that was documented in the progress notes on April 8, 2014. This assessment identified the resident as having a significant weight loss and the plan was to encourage the resident with food intake at meals and snacks and to continue with supplements between meals.
Since April 8, 2014 there have been no nutritional assessments related to the resident's significant weight loss and no new interventions put in place to mitigate further weight loss.
The documentation of the resident's intake of the supplement showed that in the last two weeks, the resident has refused to eat it 30 times.
During an interview with the Registered Dietitian on September 30, 2014, she confirmed that she had not assessed Resident #27 in relation to weight loss since April 2014. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. Resident #20 is identified in the current care plan as moderate nutritional risk due to chewing difficulty, variable intake at meals and impaired cognitive ability. The resident currently receives two types of supplements with meals and at HS snack.

Resident #20 was identified as having a significant weight loss.
Upon review of the resident's health care record, no assessments were found in relation to this weight loss.

During an interview on September 30, 2014 with the Registered Dietitian, she confirmed that she did not assess weight loss for Resident #20. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 229 (10) 1. whereby residents admitted to the home are not screened for tuberculosis (TB) within fourteen days of admission unless the resident has already been screened at some time in the ninety days prior to admission and documented results of this screening are available to the licensee.

Chart reviews were conducted on the following residents: #44, #45, #46, #47, #48 and #49. There was no documented evidence to support the completion of TB screening for Residents #44, #45, #46, #47, and #48. The Director of Care (DOC) was interviewed and stated the home currently screens new admissions for TB by completing a 2-step mantoux skin test. The DOC further stated the home has been unable to receive the vaccine from the Public Health Unit because the vaccine fridge has not been maintaining a consistent temperature to support the storage of the vaccine. As a result, any admissions admitted to the home over the past few weeks have not had a completed 2-step mantoux test. The DOC stated no other means of screening for TB have been completed on any of these residents.
The DOC indicated the home has been notified of the local Public Health Unit's new recommendations for TB testing in Long Term Care homes. A letter signed by the Medical Officer of Health which outlined these recommendations was received in August 2014. Both the DOC and the Administrator indicated there are no plans in place at this time to adopt these recommendations. [s. 229. (10) 1.]

2. The licensee has failed to comply with O. Reg 79/10 s. 229 (10) 3 whereby residents are not offered immunizations against pneumococcus, tetanus and diphtheria.
Record reviews were conducted for the following residents: #44, #45, #46, #47, #48 and #49. There was no documented evidence to support the offering of immunizations against pneumococcal, tetanus or diphtheria for any of these residents.
Staff #101 was interviewed and stated that at the time of admission, a resident's pneumococcal immunization status is reviewed and that if required, this may be offered to the resident. The home's admission checklist does indicate pneumococcal vaccine should be offered if there is no record of prior immunization or unclear immunization. Additionally, S#101 stated she can recall one resident receiving a tetanus shot following an injury sustained in the home, but had no recall of any resident being offered immunizations against diphtheria or that either of these are offered to residents on a consistent basis.
The Director of Care (DOC) was interviewed and confirmed residents are not offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the legislation. [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 all residents admitted to the home will 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. 1. The licensee has failed to comply with LTCHA 2007, s. 6 (1)(c) whereby the licensee did not ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.
A review of the health care record indicates that Resident #7 has multiple comorbidities. In an interview on September 29, 2014, Resident #7 noted that their skin is fragile and bruises easily during transfers. On September 29, 2014, Staff #107

stated that to maintain skin integrity and prevent discomfort during transfers with a lift, a pillow or soft blanket is placed over the resident's arms. Staff #108 and Staff #109 confirmed that direct care providers are aware of this strategy and Resident #7 stated that it is beneficial.
The current plan of care from August 6, 2014 states that Resident #7 requires the use of a mechanical lift but it does not include the strategy to protect the resident's skin with a pillow or soft blanket during transfers. On September 29, the DOC acknowledged that the plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA 2007, s. 6(5) in that residents are not always given the opportunity to participate in the development and implementation of the plan of care with respect to their diet order.

During the period of September 22 to September 24, 2014, it was noted by inspectors in the health records that 9 residents out of 40 reviewed were on an energy-restricted diet.

On September 30, 2014 an interview was conducted with the Registered Dietitian. She stated that she will put residents on an energy-restricted diet for either weight maintenance or if their Body Mass Index (BMI) is approaching or over 32. She stated she does often speak with residents before making this change but in some cases she said that she will make the change without their knowledge since she feels some of them would not be agreeable.

Resident #26 was started on an energy-restricted diet on an identified date as part of the Quarterly Nutritional Assessment. The assessment states "Resident's weight continues to increase and the BMI is >32. The resident will be changed to a modified diabetic restricted diet to curb further weight gain." There is no indication in this assessment that the Dietitian spoke with the resident about the change or whether the resident was agreeable. During an interview with the Registered Dietitian she could not recall if she had spoken to the resident about the change. [s. 6. (5)]

3. The licensee has failed to comply with LTCHA, 2007 s. 6 (7) whereby 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 review of the health care record indicates that Resident #42 had multiple comorbidities. The Care Plan from October 29, 2013 stated that the resident was on a

prompted voiding and bowel program and directed staff to "Take to the washroom qam, hs, ac and pc meals."

On an identified date a PSW reported to Staff #104 that Resident #42 was found in an incontinent product which was saturated with urine and resulted in reddened, slightly macerated skin. In an interview on September 26, 2014, Staff #104 confirmed that the incontinent product was saturated with urine, and that the resident required assistance with toileting, so it was clear that the resident had not been taken to the toilet in the day as per the Care Plan. On September 26, 2014 the DOC confirmed that Resident #42 did not receive care to be assisted to the toilet as specified in the Care Plan. [s. 6. (7)]

WN #4: 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 they did not comply with their system for documenting food and fluid intake of a resident identified at high nutritional risk.

O. Reg. 79/10, s. 68(2)(d) indicates that every licensee of a long-term care home shall ensure that the nutrition care and hydration programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Resident #27 is identified in her clinical health records as having had significant weight loss over the last 6 months and their nutritional needs was reassessed. The current care plan also indicated high nutritional risk due to refusal of food and fluids and total dependence for feeding. The resident receives a supplements three times during the day.

The Director of Care and Assistant Director of Care were interviewed on October 1, 2014 and stated that staff are supposed to document Resident #27's food and fluid intakes, including supplements, under specified tasks on the home's electronic chart. A report of the documentation for these tasks was reviewed for the months of August and September 2014 for Resident #27 and the following was found.
August 2014:
- 8 fluid intakes during meals were not documented
- 7 food intakes during meals were not documented
- 8 snack intakes, including the resident's supplement, were not documented

September 2014:
- 6 snack intakes including the resident's supplement, were not documented
- 6 fluid intakes during meals were not documented
- 6 food intakes during meals were not documented [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 15 (2) (c) whereby the home, furnishings and equipment are not maintained in a safe condition and in a good state of repair.

Throughout the inspection period, the inspectors noted the following examples to support this non-compliance:
-Resident #1: the bathroom door and door frame was observed to have scarring/chips out of paint and there was visible rust on the grab bar located in the bathroom (197),
-Resident #2: the grab bar located in the bathroom beside the toilet had visible rust (197),
-Resident #3: the room was observed to have disrepair to the wall located below the window; there was yellow staining on the wall, cracks to ceiling tile and discolored floor tile around toilet bowl in the bathroom(552),
-Resident #4: the grab bar in bathroom had visible rust (197),
-Resident #8 : there were cracks to wall tiles in this shared washroom , scuff marks on walls and the furniture appeared worn (552),
-Resident #10: staining was observed on the floor tile (552),
-Resident #11: the sink drain was rusted and there was corrosion around the taps (103),
-Resident #14: a small area of disrepair was observed at corner of closet; appears to have been repaired but not painted; the sink drain was rusted and there was corrosion around the taps (103).
-Resident #15: there were missing floor tiles in bathroom (552),
-Resident #16: floor tiles in bathroom had chipped edges, the sink drain was rusted/missing finish (103),
-Resident #26: rust was visible around base of toilet and on floor between tiles in bathroom; rust was also visible on the grab bar in the bathroom (197),
-Resident #27: there was observed wall disrepair at the closet edge with paint

missing; the area appears to have been patched but not painted; there were yellow stains up the wall indicative of a liquid having been spilled; the sink drain was rusted and there was corrosion around the taps (103),
-Resident #28- there were stains on the ceiling tiles (552),
-Resident #33: there were missing tiles on the wall in bathroom and staining was observed on ceiling tiles (552),
-Resident #35: wall tiles in shared washroom were cracked (552),
-Resident #37: chipped/ missing paint was observed to wall in shared washroom (552), and
-Resident #40: wall disrepair was observed along the entire length of wall on the right as you enter the room; the wall board has top layer missing in an area to right of bathroom door (103). [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 24 (1) whereby the licensee did not ensure that that an incident of witnessed sexual abuse of a resident was immediately reported to the Director.
On an identified date, a PSW reported to S#105 that she had observed Resident #9 with their hands placed over the clothing in the area of Resident #13's genitals. Resident #13 was angry and upset. Resident #9 was removed from the area and placed on half hour checks.
A review of the health care record indicates that Resident #13 has multiple comorbidities and impaired mobility. Resident #9 is cognitively impaired. In an interview on September 26, 2014, Staff #105 stated that she reported the incident to the manager on call and documented this in the health care record of Resident #9.

On August 11, 2014 at 1544, the Critical Incident Report was submitted to the Director. In an interview on September 26, 2014 the Executive Director confirmed that the incident of witnessed sexual abuse was not immediately reported to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 2 (b) (iv) whereby a resident exhibiting altered skin integrity was not assessed at least weekly by a member of the registered nursing staff.
Resident #23's plan of care identified the resident as being at risk of skin impairment related to immobility and impaired circulation. This resident has a documented open which requires regular dressing changes.
Staff #101 and Staff #102 were interviewed and reported weekly assessments for stageable wounds are documented on the "Ongoing Assessment/Treatment Observation Record". Resident #23's treatment observation record and progress notes were reviewed for a three month period. During this time, documented wound assessments for the right heel skin impairment were found dated June 27, July 7, July 27, August 8 and September 9, 2014.
The assessment dated September 9 was incomplete. [s. 50. (2) (b) (iv)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Upon review of the Residents' Council Meeting Minutes the following was noted:

-A dietary concern that was brought forward on March 21, 2014 was not responded to as of the May 28, 2014 meeting minutes. A written response was later documented on the concern sheet, but it was unclear as to the date it was written. Staff #125 confirmed that the response to this concern was not provided to the Residents' Council within 10 days.

-Two concerns were brought forward at the May 28, 2014 Resident's Council meeting - one related to maintenance and the other related to communication and having clocks/calendars in dining room. Staff #125 reported that answers were documented and actions were taken but that the responses were not provided in writing to the Resident's Council within 10 days of receiving the advice.

Staff #125, who is the assistant to the Residents' Council, stated that the home's practice would normally be to present responses to resident concerns/recommendations at the next meeting, which would not occur within 10 days. [s. 57. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 60.(2) in that the licensee had not responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.
s. 60. (2)
Interview with the Family Council president indicated that a concern was raised by the council related to the pathway to the gazebo. The Council found the path to be unsafe and raised this concern with the home. The Executive Director responded verbally to the concern. The Family Council President indicated that any concerns are generally addressed verbally by the Executive Director during the Council meeting when she is invited to attend or when the Family Council president meets with her. [s. 60. (2)]

WN #10: 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).

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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)1 in that the daily and weekly menus were not communicated to residents in one area of the long-term care home.

During dining observation of the sunset unit on September 22, 2014, it was noted that the daily menu was not posted and the weekly menu that was posted was not on the correct week (week 2 posted but in week 1 of menu cycle).
The cook that was in the dining room was interviewed and stated that the daily menu is not normally posted in this dining room and acknowledged that the wrong weekly menu was posted and proceeded to change it.

In an interview with the Food Service Supervisor on September 29, 2014, she confirmed that the daily menu is not posted for residents on the sunset unit.

During a second dining observation of the sunset unit on September 30, 2014, the daily menu was not posted and the weekly menu was again on the wrong week of the menu cycle. [s. 73. (1) 1.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)4 in that residents eating in their room were not monitored during meals.

On September 22, 2014 during dining observation of the sunset unit, Inspector # 602 observed Resident #8 eating lunch in their room. The resident's tray was delivered at 1210 hours. Staff members did not check on Resident #8 throughout the meal. This resident resides in a room which is not within sight of the dining room where all the staff were observed during the meal service.

On September 29, 2014, Inspector #197 observed Resident #50 eating lunch meal in their room. The resident stopped the inspector and asked if a staff member could bring milk for their coffee. When asked if staff check in on her during the meal the resident said no.

On September 29, 2014 an interview was conducted with the Food Service Supervisor. She provided a list of residents who eat in their rooms regularly. She stated that she was unaware of any formal process for monitoring residents during meals who do not require feeding assistance.

On October 1, 2014 an interview was conducted with the Director of Care. She stated that there is no particular staff member assigned to monitor residents that eat meals in their rooms, but that staff are usually in and out of residents rooms often during meals. When asked how resident's eating in their rooms on the sunset unit are monitored she said she was unsure of the monitoring process on this unit, as the residents do not typically eat in their rooms. [s. 73. (1) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 97(1)(a) whereby the licensee did not ensure that the resident's SDM and any other person specified by the resident were notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.
O. Reg. 79/10, s. 5. defines neglect as " the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.
A critical incident occurred on an identified date. A PSW reported to Staff #105 that she had observed Resident #9 with hands placed over the clothing in the area of Resident #13's genitals. Resident #13 was angry and upset. Resident #9 was removed from the area and placed on half hour checks.
A review of the health care record indicates that Resident #13 has multiple comorbidities including impaired mobility. Resident #9 is cognitively impaired.
Review of the progress notes indicate that on an identified date the SDM of Resident #13 was notified of the witnessed sexual abuse.

In an interview on September 26, 2014, Staff #105 stated that she reported the incident to the manager on call and documented this in the health care record of

Resident #9.
In an interview on September 26, 2014 the Executive Director confirmed that the SDM of the resident was not notified immediately of the witnessed sexual abuse [s. 97. (1) (a)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 97(1)(a) whereby the licensee did not ensure that the resident's SDM and any other person specified by the resident were notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.
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On an identified date a PSW reported to Staff #104 that Resident #42 was found in an incontinent product which was saturated with urine and resulted in reddened, slightly macerated skin. The resident requires assistance with toileting.
A review of the health care record indicates that Resident #42 had multiple comorbidities including restricted mobility. The Care Plan stated that the resident was on a prompted voiding and bowel program and directed staff to "Take to the washroom qam, hs, ac and pc meals."
In an interview on September 26, 2014, Staff #104 confirmed the incontinent product was saturated with urine, and that the resident requires assistance with toileting, so it was clear that the resident had not been taken to the toilet in the day as per the Care Plan. Staff #104 also confirmed that her documentation stated that she left a message for the SDM of Resident #42 to call a manager on Monday (the incident occurred on a Friday). She acknowledged that this would not constitute immediate notification of an incident of neglect.

On September 26, 2014 the DOC confirmed that the SDM of Resident #42 was not notified immediately of an incident of neglect. [s. 97. (1) (a)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 97(2) whereby the licensee did not ensure that the resident and the resident's SDM were notified of the results of the investigation of neglect, immediately upon the completion of the investigation.

On an identified date a PSW reported to Staff #104 that Resident #42 was found in an incontinent product which was saturated with urine and resulted in reddened, slightly macerated skin.
The Care Plan stated that the resident was on a prompted voiding and bowel program and directed staff to "Take to the washroom qam, hs, ac and pc meals."
In an interview on September 26, 2014, Staff #104 confirmed the resident had not

been toileted in the day as per the Care Plan.
On September 26, 2014 the DOC confirmed that the resident's SDM was not notified of the results of the investigation of neglect immediately on completion of the investigation. [s. 97. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 98 whereby the licensee did not ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense.

On an identified date, a PSW reported to Staff #105 that she had observed Resident #9 with their hands placed over the clothing of Resident #13's genital area. Resident #13 was angry and upset. Resident #9 was removed from the area and placed on half hour checks.
A review of the health care record indicates that Resident #13 is cognitively impaired and also has impaired mobility. Resident #9 is cognitively impaired. In an interview on September 26, 2014, Staff #105 stated that she reported the incident to the manager on call and documented this in the health care record of Resident #9.
The police were notified by the DOC more than 24 hours later. In an interview on September 26, 2014 the Executive Director confirmed that the police were not immediately notified of the witnessed sexual abuse [s. 98.]

Issued on this 31st day of October, 2014

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