Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 3, 2016	2016_433625_0006	023467-15, 023480-15	Follow up

Licensee/Titulaire de permis

SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE
Fifth Avenue South PO Box 909 SIOUX LOOKOUT ON P8T 1B4

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

William A. 'Bill' George Extended Care Facility
75 FIFTH AVENUE SIOUX LOOKOUT ON P8T 1K9

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

KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 24 to 27, 2016.

A Critical Incident System Inspection #2016_433625_0007/004144-15 was completed concurrently with this inspection.

The following logs were completed during this inspection:
- one log related to a compliance order pursuant to s. 15 (1) regarding bed system evaluations; and
- one log related to a compliance order pursuant to s. 30 (1) regarding the home's Continence Care and Bowel Management Program.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Team Leader, a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), an Activity Worker and residents.

The Inspector also reviewed resident health care records, various home's policies and procedures. The Inspector completed observations of residents, observed the provision of care and services to residents, observed resident and staff interactions and conducted a tour of resident care areas.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_333577_0008	625
O.Reg 79/10 s. 30. (1)	CO #002	2015_333577_0008	625

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 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 has failed to ensure that the rights of residents were fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

On May 26, 2016, Inspector #625 observed resident #015 sitting in the front lobby of the home, inappropriately dressed. The resident's continent product was exposed. The resident remained unattended and in this state for several minutes.

Inspector #625 spoke to Activity Worker #104 about the resident's attire and exposed continent product. The Activity Worker had walked past the resident once and, when walking past the resident a second time, the Inspector asked the worker about resident

#015's presentation. During the discussion, the worker adjusted part of the resident's attire and stated they were always dressed like that.

During an interview with Inspector #625 on May 26, 2016, PSW #104 stated that the resident wore a long dress, pants and sweaters as their usual attire. The PSW stated that they, and a second PSW had assisted the resident to dress that morning using clothing that the staff on the night shift had left on the resident's dresser.

During an interview with Inspector #625 on May 26, 2016, RPN #105 stated that the resident was usually dressed in clothing such as shirts and pants and they were unsure as to why the resident was inappropriately dressed.

During an interview with Inspector #625 on May 26, 2016, Team Leader #101 stated that resident #015 usually wore a dress that covered their legs, and used a blanket for extra warmth.

The same day, Inspector #625 spoke with the DOC about resident #015's attire. The DOC stated that the resident usually wore a shirt and pants.

Inspector #625 reviewed resident #015's care plan in place at the time of the Inspector's observation of the resident's exposed continent product and inappropriate attire. The care plan identified that the resident required staff assistance with dressing, that an expected outcome was for the resident to be dressed appropriately for the season, and that staff were to promote the resident's dignity by ensuring their privacy. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, 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.

On May 25, 2016, Inspector #625 observed a "Resident/Room Check" flow sheet for resident #017 dated May of 2016, located on a table outside of a resident room, visible to any person in the hallway. The flow sheet identified resident #017 by their full name, date of birth, age and gender and also listed their health card number. Resident #017 did not reside in the room where their health information was outside of.

On May 25, 2016, Inspector #625 observed "Resident/Room Check" flow sheets posted

for eight specific residents in four specific washrooms.

On May 26, 2016, Inspector #625 observed "Resident/Room Check" flow sheets for two specific residents in the hallway outside of two specific rooms.

During an interview with Inspector #625 on May 25, 2016, the DOC stated that the "Resident/Room Check" flow sheets should not have been left on the table in the hallway, as staff were required to hang the flow sheet in the residents' washrooms to sign hourly. When the Inspector inquired about confidentiality of personal health information for the eight residents who shared washrooms and the three residents who required enhanced precautions whose flow sheets were observed to have been kept in the hallway outside of residents' rooms, the DOC stated that the information would be visible to other residents, visitors and staff who did not require the information to perform their duties. The DOC also stated that they recognized the posting of such information as a concern and would develop a system to ensure the information was not visible to those who should not have access to it, or did not require access to it. [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 the rights of residents are fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity; and the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to 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.

Inspector #625 reviewed resident #001's care plan dated a specific date in the spring of 2016. The care plan identified that the resident used two different types of continence products and that one type was "disposable/reusable".

During an interview with Inspector #625 on May 25, 2016, the Team Leader #101 clarified that the resident used disposable, not reusable products, and did not use one of the types of products listed. [s. 6. (1) (c)]

2. Inspector #625 reviewed resident #003's care plan dated a specific date in the winter of 2016. The care plan identified that the resident used two different sizes of continence products and that one product was “disposable/reusable".

During an interview with Inspector #625 on May 25, 2016, the Team Leader #101 clarified that the resident used one specific sized continence product that was disposable, and did not use reusable products. [s. 6. (1) (c)]

3. A review by Inspector #625 of resident #015’s care plan dated a specific date in the spring of 2016 identified that the resident fed themself and provided direction for staff to

monitor the resident's nutritional intake. The care plan also indicated that the resident required the assistance of staff during meals. The care plan also stated the the resident ate a specific type of food and that staff were to complete a specific hygiene practice related to the ingestion of the specific type of food.

A review by Inspector #625 of resident #015's health care record included a dietary order entry sheet dated the winter of 2016, and the home's current "Serving Schedule for Dining Room" sheet, both of which indicated that the resident received a specific type of diet texture which was different from the type of food listed in the reviewed care plan.

During an interview with Inspector #625 on May 27, 2016, Team Leader #101 stated that the care plan was correct in identifying that staff were to assist the resident during the meal, but not in that the resident fed themself. They also stated that the dietary order entry and "Serving Schedule for Dining Room" sheets which reflected the resident received a specific type of diet texture were correct, but that the care plan that indicated that the resident required a specific type of food was incorrect. As a result, the written plan of care did not set out clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Inspector #625 reviewed the home's policy "Resident Supervision – LTC.1.50" last revised July 7, 2015, that stated the whereabouts of each resident was to be identified hourly and the visual checks were to be noted using the "Resident/Room Check" flow sheet.

A review of resident #002's "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 13 days in May, or 52 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 59 consecutive hours, which did not contain any documented signatures.

A review of resident #003's "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 14 days in May, or 56 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 59 consecutive hours, which did not contain any documented signatures.

A review of resident #0011’s "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 14 days in May, or 56 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 59 consecutive hours, which did not contain any documented signatures.

A review of resident #014’s "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 15 days in May, or 60 per cent of the dates listed. The flow sheet contained periods of time, including two periods of 47 consecutive hours each, which did not contain any documented signatures.

A review of resident #015’s "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 14 days in May, or 56 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 59 consecutive hours, which did not contain any documented signatures.

A review of resident #016’s "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 15 days in May, or 60 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 47 consecutive hours, which did not contain any documented signatures.

A review of resident #017’s "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 15 days in May, or 60 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 57 consecutive hours, which did not contain any documented signatures.

A review of resident #018’s "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 14 days in May, or 54 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 47 consecutive hours, which did not contain any documented signatures.

A review of resident #019’s "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 11 days in May, or

44 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 56 consecutive hours, which did not contain any documented signatures.

A review of resident #020's "Resident/Room Check" flow sheet for May of 2016, identified that staff had not documented on the flow sheet hourly on 11 days in May, or 44 per cent of the dates listed. The flow sheet contained periods of time, including periods of 35 and 47 consecutive hours, which did not contain any documented signatures.

During an interview with Inspector #625 on May 25, 2016, the DOC confirmed that signatures on the "Resident/Room Check" flow sheets were to be entered hourly. The DOC stated that the PSWs had not documented the flow sheets hourly as required, to indicate that the hourly monitoring was provided, and confirmed that the flow sheet for resident #017 had no documented signatures for 57 consecutive hours. [s. 6. (9) 1.]

5. Inspector #625 reviewed resident #001's care plan dated a specific date in the spring of 2016, which listed that staff were to assist the resident with a specific activity of daily living (ADL) at a specified frequency as required, related to continence.

Inspector #625 reviewed the "Resident Flow Sheet" for resident #001, related to continence, beginning on a specific date in the spring of 2016. Staff had not documented any data for two specific day shifts and one specific night shift, resulting in these areas being blank.

During an interview with Inspector #625 on May 25, 2016, the Team Leader #101 confirmed that staff had been required to document the provision of care, related to the resident's continence, on two specific day shifts and one specific night shift, but had neglected to do so. [s. 6. (9) 1.]

6. Inspector #625 reviewed resident #002's care plan dated a specific date in the winter of 2016, that listed that staff were to provide specific care related to the resident's bladder function.

A review of the home's policy "Care of Urinary Catheter in Long Term Care - LTC.2.30" last revised September 4, 2015, identified that the staff were to empty the catheter bag when it became one-half to two-thirds full and at least every shift, and document the amount on the "Urinary Output Flowsheet".

Inspector #625 reviewed the "Resident Flow Sheet" related to bladder continence beginning on a specific date in the spring of 2016, for resident #002. Staff had not documented any data for two specific day shifts, and one specific night shift. Staff had not documented specific information on the "Resident Flow Sheet" as required.

Inspector #625 reviewed the resident's "Urinary Output Sheet" for three specific months in 2016, and identified that 36 out of 219, or 16 per cent, of the entries were blank.

During an interview with Inspector #625 on May 25, 2016, the Team Leader #101 confirmed that staff had been required to document the care provided to resident #002's related to bladder continence on the "Resident Flow Sheet" for the two specific day shifts, and the one specific night shift, but had neglected to do so. The Team Leader also stated that the areas that staff had not documented on the "Urinary Output Sheet" for the three specific months in 2016, reflected that staff did not document specific information on those dates, but should have. [s. 6. (9) 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 the provision of the care set out in the plan of care is documented, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10 s. 51. (1) 4. requires the licensee to ensure that the continence care and bowel management program must, at a minimum, provide for strategies to maximize residents’ independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

A review of resident #011's health care record by Inspector #625 identified that the resident was admitted to the home on a specific date in the winter of 2016.

A review of resident #011's health care record identified a record titled "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" dated beginning on the specific date in the winter of 2016. The record was blank for days six and seven, and the required information was not documented on those days.

A review of the policy "Continence Care and Bowel Management Program in Long Term Care" last revised September 2015, identified a copy of "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" listed as Appendix C. The policy stated that registered nursing staff were to initiate the "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" and that registered nursing staff and personal support workers were to complete the record for a seven day period to establish the resident's individual voiding pattern and monitor trends.

During an interview with Inspector #625 on May 26, 2016, the DOC stated that the home had initiated the "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" in the fall of 2015. The DOC acknowledged that the record for resident #011, which was initiated during a specific winter month in 2016, had not been completed on days six and seven. [s. 8. (1) (b)]

2. A review of resident #012's health care record identified documents "Appendix A: Bladder & Bowel Continence Assessment" completed on a specific date in the spring of 2016, "Quarterly Continence Assessment" dated a specific date in the winter of 2016, and "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" initiated on a specific date in the winter of 2016. The "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" was blank for days five, six and seven.

A review of the policy "Continence Care and Bowel Management Program in Long Term Care" last revised September 2015, indicated that registered nursing staff were to conduct a bowel and bladder continence assessment utilizing Appendix A ("Bladder and Bowel Continence Assessment") and Appendix B ("Quarterly Continence Assessment"). The policy indicated that these documents were to be completed on admission, quarterly and after any change in condition that may have affected bladder and bowel continence.

During an interview with Inspector #625 on May 26, 2016, the DOC stated that resident #012 was admitted to the home on a specific date in the winter of 2016, and that the "Bladder & Bowel Continence Assessment" was completed on a specific date in the spring of 2016, 17 days after the resident's admission, but should have been completed within 24 to 48 hours of the resident's admission. The DOC identified that staff had not completed the "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" on days five, six and seven, but should have. [s. 8. (1) (b)]

3. A review by Inspector #625 of resident #013's health care record identified a "Quarterly Continence Assessment" dated a specific date in the spring of 2016, and an "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" initiated on a specific date in the spring of 2016. The "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" was blank for days two to seven. The Inspector was not able to locate an initial continence assessment titled "Bladder & Bowel Continence Assessment" in the resident's health care record.

During an interview with Inspector #625 on May 26, 2016, the DOC stated that resident #013 was admitted to the home on a specific date in the spring of 2016. The DOC was not able to locate a completed admission "Bladder and Bowel Continence Assessment" but stated one should have been completed within 24 to 48 hours after admission to the home. The DOC identified that staff had not completed the "ECU - 7 Day Voiding/Bowel Movement/Fluid Record" on day two through to day seven, but should have. [s. 8. (1) (b)]

4. A Critical Incident System (CIS) report was submitted to the Director regarding a fall on a specific date in the winter of 2016, where resident #011 was taken to hospital and which resulted in a significant change in the resident's health status.

Ontario Regulation 79/10 s. 49. (1) requires the licensee to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls.

The home's policy in place at the time of the resident's admission, "Fall Prevention – LTC.2.90" last revised April 5, 2012, identified that, within 24 hours of admission, every resident would be assessed for risk for fall and injury using the "Fall Risk Assessment" and a score derived from this assessment tool. The policy also indicated that the "Fall Risk Assessment" would be reassessed with quarterly assessment, with any change in resident status and with any falls. The policy identified that the score derived from the "Fall Risk Assessment" would be used to determine fall interventions.

A review of resident #011's progress notes identified that the resident was admitted to the home on a specific date in the winter of 2016, and that the resident had a fall on the date they were admitted, which resulted in an injury to the resident.

A review of resident #011's health care record by Inspector #625 did not identify a "Falls Risk Assessment" completed for resident #011 on the specific date in the winter of 2016, the date of their fall, or within 24 hours of their admission on that date.

During an interview with Inspector #625 on May 26, 2016, the DOC confirmed that a "Falls Risk Assessment" was not completed when resident #011 was admitted to the home, but should have been. [s. 8. (1) (b)]

5. A review by Inspector #625 of the home's policy "Use of a Bladder Volume Instrument – LTC.2.80" last revised September 14, 2015, identified that all residents with urinary incontinence were to undergo an assessment of bladder habits using a "Bladder Diary" to be maintained for at least three days. The policy stated that, at the end of three days, staff were to analyze the "Bladder and Bowel Diary" to determine a toileting schedule.

During an interview with Inspector #625 on May 26, 2016, the Inspector asked the Director of Care (DOC) for a copy of the "Bladder and Bowel Diary" that was listed in the policy "Use of a Bladder Volume Instrument – LTC.2.80". The DOC stated that the home no longer used the three day "Bladder and Bowel Diary". [s. 8. (1) (b)]

6. A review by Inspector #625 of the policy "Choosing Incontinence Products in Long Term Care – LTC.4.10" last revised September 14, 2015, identified that the home used Prevail brand continence products.

During an interview with Inspector #625 on May 25, 2016, the Team Leader #101 stated that the home no longer used Prevail continence products that were listed in the "Choosing Incontinence Products in long Term Care" policy, but had switched to Attends

continence products. The Team Leader could not locate a policy related to the use, sizing, selection criteria or considerations for the Attends continence products, similar to the policy indicating this information for the Prevail products.

During an interview with Inspector #625 on May 26, 2016, the Inspector asked the DOC about the continence products used in the home. The DOC confirmed that the home had changed products used from Prevail to Attends in January of 2016, and that the policy "Choosing Incontinence Products in Long Term Care" did not reflect the current products used by the home. [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, where the Long-term Care Homes Act or Ontario Regulation 79/10 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 is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and kept closed and locked when they were not being supervised by staff.

On May 24, 2016, Inspector #625 observed the door to the clean linen room to be held open with a door stop.

During an interview with Inspector #625 on May 24, 2016, the DOC stated that the clean linen room was a non-residential area and, being such, should be closed and locked when not in use.

On May 25, 2016, Inspector #625 observed the nursing station door to be unlocked and unsupervised, and the door to the clean linen room to be held open with a door stop.

During an interview with Inspector #625 on May 25, 2016, Team Leader #101 stated that the nursing station was not an area that residents were permitted access to and that the door should be locked when unsupervised. The Team Leader also stated that the clean linen room door should have been closed, and then closed the door.

On May 26, 2016, Inspector #625 observed the door to the clean linen room to be unlocked and unsupervised, and the door to the nursing station to be opened and unsupervised.

During an interview with Inspector #625 on May 26, 2016, PSW #102 stated that the door to the nursing station should have been closed and locked.

On May 27, 2016, Inspector #625 again observed the door to the clean linen room to be unlocked and unsupervised. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program, at a minimum, provided for an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts were negotiated or renegotiated.

A review of the home's policy "Continence Care and Bowel Management Program in Long Term Care – LTC.4.20" approved April 22, 2016, identified that an annual evaluation of the residents' satisfaction with continence care products would be conducted and that the results would guide the home when making purchasing decisions.

A review of the home's policy "Continence Care and Bowel Management Program in Long Term Care" draft policy dated effective September 2014 also contained the statement that an annual evaluation of the residents' satisfaction with continence care products would be conducted, and that the results would guide the home when making purchasing decisions.

During an interview with Inspector #625 on May 26, 2016, the DOC stated that an annual product evaluation of the continent products by the residents and their families had not be completed formally. The DOC stated that staff would notify them if there was a problem with the products as had occurred when the home changed continent products from Prevail to Attends, but that the home did not have much control over the products. As a result of the staff feedback after the change, the home switched the residents to the night time Attends products 24 hours per day, to keep the residents drier, as the home found resident beds required more frequent changes before switching to night time product exclusively. When asked if an annual continence product evaluation had been completed over the last five years, the DOC stated that a formal annual evaluation of the range of continence products had not occurred during that time. [s. 51. (1) 5.]

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 continence care and bowel management program, at a minimum, provides for an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated, to be implemented voluntarily.

Issued on this 7th day of November, 2016

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

Original report signed by the inspector.