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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 19, 2014 | 2014_266527_0014 | H-0005550-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

SPECIALTY CARE / WOODHALL PARK INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

SPECIALTY CARE WOODHALL PARK
10260 KENNEDY ROAD NORTH, BRAMPTON, ON, L6Z-4N7

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

KATHLEEN MILLAR (527), PHYLLIS HILTZ-BONTJE (129), VIKTORIA SHIHAB (584), YVONNE WALTON (169)

**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): June 18, 19, 20, 23, 24, 25, 26 and 27, 2014**

**The Resident Quality Inspection included three Complaint Inspections. They are as follows: Log #H-000027-14; H-000953-14 and H-000363-14.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), the Director of Dietary and Support (DDSS) Services, the Food Service Supervisor (FSS), The Director of Environmental Services, the Director of Resident Programs and Admissions, the Registered Dietitician, the Registered Nurses (RN), the Registered Practical Nurses (RPN), the Personal Support Workers (PSW), Dietary Aides, Laundry Aides and Housekeeping Aides.**

**During the course of the inspection, the inspector(s) toured the home, reviewed clinical records, the home's policies, procedures, protocols and training records, reviewed the home's complaint and critical incident logs, reviewed minutes of meetings and annual evaluations of legislated programs, reviewed operational plans for renovations, interviewed the Resident and Family Council, and interviewed residents and family members.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Continence Care and Bowel Management**
**Dining Observation**
**Family Council**
**Food Quality**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 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:**
**6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee did not ensure that foods and fluids are served at a temperature that is both safe and palatable to residents.

A review of the Pleasurable Dining Committee meeting minutes revealed that residents brought forth complaints of inappropriate food temperatures in July and December of 2013 and February and May of 2014. Residents complained that eggs, waffles, meatballs and potato wedges were not hot at service. During interviews in June 2014, two residents brought forth concerns regarding inappropriate food temperatures at meal service.

In June 2014 the inspector tasted all foods offered at lunch one day and noted that the mashed potatoes were cold. The inspector informed the Dietary Aide (DA). DA confirmed that potatoes are often cold. No corrective actions were taken by staff to reheat the mashed potatoes.

Monthly temperature logs for all meals served on all home areas were reviewed in the presence of the Director of Dietary and Support Services (DDSS). The DDSS confirmed the home defined acceptable food temperatures to be less than or equal to 40 degrees Fahrenheit (F) for cold foods and greater than or equal to 140 degrees F for hot foods (less than or equal to four degrees Celsius (C) and greater than or equal to 60 degrees C, respectively). On the Heritage home area, the temperatures fell out of the acceptable range 27 times at breakfast and 63 times at lunch time over twenty-five consecutive days in June 2014. The temperatures ranged from 41 to 59 degrees Celsius for hot food. No corrective actions or corrected temperatures were documented. The DDSS confirmed that staff were to take corrective actions and document them in the temperature log immediately. Staff could not confirm that corrective actions were taken.

During an observation, the inspector noted that a DA was mentally converting temperatures from degrees F to degrees C incorrectly. In an interview, the DA confirmed that this was their regular practice. The DDSS confirmed that the practice was inappropriate and the temperature log on the staff's home area was unreliable. The DDSS and the Food Services Supervisor (FSS) did not provide verification of temperature log audits. The home did not ensure that residents were served with foods that were safe and palatable to the residents. [s. 73. (1) 6.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: 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).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that 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 or procedure that the plan, policy, protocol or procedure is complied with, in relation to the following: [8(1)(b)]

A) The Home's policy "Responsive Behaviours", dated September 2013, number VII-F-30.00 identifies that the registered staff conduct and document a Responsive Behaviour referral of a resident for a number of reasons. Two of the reasons to make a referral include: when the resident is assessed quarterly and if the resident triggers escalating behaviours, delirium indicator, or increased depression, or when there is a change in the resident's condition with responsive behaviours. During the Inspection the clinical record was reviewed for a resident. Although the resident had escalating responsive behaviours, there was no Responsive Behaviour referral. The Charge Nurse and DOC were interviewed and confirmed there was no Responsive Behaviour Referral for this resident. The DOC confirmed there should have been a Responsive Behaviour referral as per the home's policy.

B) The policy also identifies that the level of risk, low, medium or crisis triggers should be documented on the individualized plan of care. The Charge Nurse confirmed the level of risk had not been identified and documented on the plan of care for a resident.

The Director of Care confirmed the level of risk should have been identified on the resident's plan of care. [s. 8. (1) (a),s. 8. (1) (b)]

2. Staff did not comply with the home’s "Restraint Implementation Protocols" identified as VII-F-10.08, and revised in July 2011.

The protocol directed that prior to the implementation of restraint or positioning device a comprehensive nursing assessment must be in place. Staff did not comply with this direction when a tilt wheelchair identified as a PASD was included in the plan of care for a resident and was being used during this inspection when the clinical record indicated that there had not been an assessment of the use of this PASD. [s. 8. (1) (b)]

3. A resident required good pain management due to their developing gangrene.The infection was increasingly getting worse over a five day period in June 2014. The "Pain and Symptom - Assessment and Management Protocol", policy number VII-G-70.00 dated February 2013 identifies that the registered staff were to determine the type of pain using the Abbey Pain Assessment tool, initiate the Pain and Symptom Monitoring tool until the resident's pain control was achieved, and include interventions related to assessed pain and symptom management in the plan of care and update as necessary. The resident's POA stated the resident was in severe pain for at least four days before their pain was under control. The RN and RPNs confirmed the document they use to direct care was not updated and therefore they were not in compliance with the home's policy. In addition, the protocol states that Occupational Therapy or Physiotherapy should develop, implement and carry out therapeutic interventions for the assessed conditions including adjunct non-pharmacological pain interventions, therapeutic modalities and/or joint supports such as splints, braces and other positioning aids. Based on the clinical record review there was no documentation to support this type of assessment required by the protocol for this resident. This was confirmed by the RN and RPN.
(PLEASE NOTE: The above noted non-compliance was identified during the inspection of Complaint Log #H-000953-14) [s. 8. (1) (b)]

4. The licensee did not ensure that the policy named "Weights - Monitoring of Resident Weights", number VII-G-40.50, reviewed in January, 2013 was complied with.

The policy directed registered staff to instruct Personal Support Workers (PSWs) to

reweigh a resident if they had a weight change of two kilograms or more. Resident #010 had a documented weight loss of 7.6 kilograms from March to April 2013. No reweigh was documented. The resident had another significant weight loss of 5.8 kilograms from February to March 2014. No reweigh was documented. A review of the Registered Dietitian's (RD's) documentation confirmed that the RD requested a reweighing of the resident in order to clarify accuracy of the documented weight loss. The RD and Assistant Director of Care (ADOC) confirmed the resident had not been reweighed as per policy although staff were further reminded to reweigh the resident. [s. 8. (1) (b)]

5. The licensee did not ensure that policy named "Food Temperatures", numbered XXIII-E-10.20 and updated November, 2013 was complied with.

The policy states that hot food must be kept at a minimum of 140 degrees Fahrenheit (F), 60 degrees Celsius (C). The policy further instructs staff to take the following corrective actions if hot food is cooler than the specified minimum: contact the cook immediately, re-heat the food and re-check the temperature. Staff are instructed to document corrective actions in the Corrective Action Taken column in the temperature log and to write the new acceptable temperature in the Record Corrected Temp column.

In June 2014 the inspector tasted all foods offered at lunch and noted that the mashed potatoes were cold. The inspector informed the Dietary Aide (DA). DA confirmed that potatoes are often cold. No corrective actions were taken by staff to reheat the mashed potatoes. No corrective actions or corrected temperatures were documented.

Monthly temperature logs for all meals served on all home areas were reviewed in the presence of the Director of Dietary and Support Services (DDSS) in June 2014. On the Heritage home area, the temperatures fell out of the acceptable range 27 times at breakfast and 63 times at lunch time over twenty-five consecutive days in June 2014. No corrective actions or corrected temperatures were documented. The DDSS confirmed that staff were to take corrective actions and document them in the temperature log immediately. Staff could not confirm that corrective actions were taken. [s. 8. (1) (b)]

6. Staff did not comply with the home’s "Skin and Wound Care Management Protocol" identified as VII-G-20.10, and revised in September 2013.

The protocol directed staff to complete a Head to Toe assessment upon return of a resident from hospital. A resident returned from hospital at the beginning of March 2014; however the Head to Toe assessment was not completed and did not contain information related to the surgery the resident had or the condition of the dressing or the surgical site. The protocol also directed staff to complete weekly skin assessments. Staff did not complete weekly skin assessments for the resident when the resident returned to the home with a surgical wound. Staff did not complete weekly skin assessments for the resident until the end of March 2014 and at that time identified the resident had two pressure ulcers with one being an unstageable pressure ulcer. The clinical documentation indicated the weekly skin assessment of the unstageable pressure ulcer was not completed until sixteen days later in mid-April 2014 and there was no documentation in the clinical record that there was a further weekly skin assessment completed related to the other identified pressure ulcer. (129) [s. 8. (1) (b)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**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).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident, in relation to the following:

Staff did not ensure that the written plan of care for a resident provided clear directions to staff providing care when the resident returned from the hospital to the home at the beginning of March 2014. Clinical documentation indicated that the

document the home used to provide care directions to staff did not provide clear directions related to how staff were to position the affected limb during transfers or while the resident was sitting in the chair, directions for monitoring the dressings over the site or the surgical site and did not provide clear directions regarding the surgical incision closure and when staples were to be removed. The DOC confirmed that the care plan did not provide clear directions related to these aspects of the care required by this resident. (129)
(PLEASE NOTE: The above noted non-compliance was identified during the inspection of Complaint Log #H-000363-14) [s. 6. (1) (c)]

2. The plan of care for a resident does not provide clear directions to staff and others who provide direct care since the resident's condition had significantly changed. The documents which the Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs) use to direct the care for the resident stated the resident can weight bear. When the resident was observed over several days in June 2014; the resident was in bed. The resident was unable to stand due to pain. After reviewing the health record the documentation reflects the resident was unable to stand for mobility or transferring. This was confirmed by the PSWs and the RPNs. In addition, the skin and wound care treatments, goals and interventions did not reflect what the Physician had ordered in June 2014. The document used by the RPN to direct care identifies the dressing is to be done every Monday, Wednesday and Friday and whenever necessary. The Physician's order in June 2014 also identifies that the wounds were to be painted with betadine; cover the left heel with 3M foam; continue offloading the resident's bootie and wound care areas; and change the dressing every day. The physician had had changed the order for the dressing from three times per week to daily. This was confirmed in the clinical record, and confirmed by the RPN and RN.
(PLEASE NOTE: The above noted non-compliance was identified during the inspection of Complaint Log #H-000953-14) [s. 6. (1) (c)]

3. The written plan of care for a resident did not provide clear directions to staff providing care when the resident's pain management needs had changed and after their quarterly assessment in June 2014. The resident had developed gangrene and it was noted in the clinical record as deteriorating. This was causing significant pain for the resident. The assessment in June 2014 identifies the frequency of pain to be daily and the intensity to reflect the resident's pain as excruciating at times. Clinical documentation indicated that the document the home used to provide care directions to staff did not provide clear directions related to how staff were to initiate pain and symptom monitoring until the resident achieved good pain control, determine the type

of pain utilizing the Abbey Pain Assessment tool, and include interventions related to assessed pain and symptom management. The RN, RPNs and PSWs confirmed the care plan did not provide clear directions related to these aspects of care required by the resident.
(PLEASE NOTE: The above noted non-compliance was identified during the inspection of Complaint Log #H-000953-14) [s. 6. (1) (c)]

4. The plan of care for a resident included unclear nutrition and hydration interventions. In May, 2010 the Registered Dietitian created an intervention that instructed staff to provide nectar thick fluids. In August, 2010 the RD added an intervention stating the resident refuses nectar-thick fluids and the family had confirmed the resident will refuse. In August, 2011 the RD confirmed the resident wants regular fluids. In September, 2011 another intervention was added by the RD confirming refusal and instructions to offer both regular and thickened fluids. In January, 2012 another RD intervention indicated that the resident's Power of Attorney (POA) wants the resident to receive regular foods. The resident's current diet order was for minced food texture and nectar thick fluids with pureed soup. The RD confirmed that the instructions were unclear during a phone interview in June 2014. [s. 6. (1) (c)]

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**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. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that alternatives to restraining the resident were considered and tried where appropriate before implementing a restraint device for a resident, in relation to the following: [31(2)2]

In June 2014 a resident was noted to be sitting in a tilted wheelchair. The resident's plan of care identified the resident at risk for falling and directed staff to place the wheelchair in the tilted position when in use for safety. The plan of care also identified the tilted wheelchair as a restraint. There was no evidence in the clinical record that alternatives to the use of a tilted wheelchair were considered. At the time of this inspection the DOC was unable to provide documentation to indicate that alternatives to the use of a tilt wheelchair to restrain the resident were considered or tried prior to the use of this restraint [s. 31. (2) 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 alternatives to restraining residents are considered and tried where appropriate before implementing a restraint device, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

1. The licensee did not ensure that alternatives to the use of a PASD were considered before including the use of a tilt wheelchair in a resident's plan of care, in relation to the following: [33(4)1]

In June 2014 a resident was noted to be sitting in a wheelchair that was tilted back. The position of the wheelchair inhibited the resident's freedom of movement and the resident was not able to reposition the wheelchair. The plan of care indicated that the tilt wheelchair was used as a PASD for pressure management, postural positioning and comfort. The Director of Care confirmed that at the time of this inspection there was no documentation in the clinical that the use of the wheelchair as a PASD had been assessed or alternatives to the use of this device had been considered before including the use of this PASD in the resident's plan of care. [s. 33. (4) 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 alternatives to the use of a PASD are considered before including the use of tilt wheelchairs in the plan of care, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes**

**Specifically failed to comply with the following:**

**s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:**
**1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).**
**2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).**

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**Findings/Faits saillants :**

1. The licensee of a long term care home shall not commence any of the following work without first receiving the approval of the Director:
    1. Alterations, additions or renovations to the home.
    2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents.

When conducting the initial tour for the Resident Quality Inspection (RQI) in June 2014, it was observed that one of the units (Country) on the third floor was empty, there was no residents, and there was new flooring installed. Painting was occurring and housekeepers were cleaning the unit in preparation to move residents back to the unit. Residents had been dispersed to other units after breakfast and returned each day to their unit for dinner during an eleven day period in June 2014. At the Entrance Conference the Administrator confirmed they had renovated the unit on the third floor. The home had an operational plan and a plan to minimize the resident impact, however the operational plan for renovations and the plan for resident accommodation had not been approved by the Ministry of Health and Long Term Care (MOHLTC) prior to commencement of the work. The Administrator stated that she was told by her Vice President that approval for the renovations by the MOHLTC was not required. The DOC confirmed that approval had not been sought from the MOHLTC because they were advised corporately that it was not required. The Environmental Inspector at the Hamilton Service Area Office, and the Health Capital Investment and Redevelopment Branch of the MOHLTC were contacted and they confirmed that the home had no approval to complete the renovations. [s. 305. (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 if the home has plans to conduct any work, such as alterations, additions or renovations to the home, or any other work on the home and/or its equipment, and if this work may significantly disturb or inconvenience residents, that the work is approved by the Director prior to the work commencing., to be implemented voluntarily.***

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**WN #7: 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:**
**3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. A resident was identified as requiring a hearing aid when in August 2014 the clinical record indicated the resident's aid was missing. A review of the resident's plan of care in place at this time confirmed that the plan did not include information related to the resident's hearing deficit and care that was to be provided in order to ensure effective communication with the resident. In June 2014 the DOC confirmed that the resident currently has one hearing aid that is pinned to the resident's clothing because the resident removes the aid. The clinical record confirmed that the current plan of care does not include a focus of care related to this hearing deficit, care required to ensure the aid is available for use by the resident and the impact the resident's hearing deficit may have on responsive behaviours being demonstrated by the resident. (PLEASE NOTE: The above noted non-compliance was identified during the inspection of Compliant Log #H-000363-14) [s. 26. (3) 3.]

**WN #8: 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 interventions and the resident's responses to interventions are documented.

A resident had documented a significant weight loss of 8.9 kilograms between February and June of 2014. In June 2014 the Registered Dietitian (RD) added a nutritional intervention to meet the goals of weight maintenance. Staff were instructed to provide 125ml Instant Breakfast at lunch time and to document the amount consumed. The resident's nutrition and hydration records were reviewed; no documentation of the intervention was found. Two nurses and two Personal Support Workers confirmed that there were no records of nutritional intervention intake. Staff confirmed they were not documenting intake because the intervention had not been included in the intake spreadsheet as per the home's practices. [s. 30. (2)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.**

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**Findings/Faits saillants :**

1. The licensee did not ensure mobility devices were available for a resident when staff requested the resident's Power of Attorney to pay a rental fee for a chair the resident required in order to be positioned. The resident returned from the hospital to the home at the beginning of March 2014. Directions for care required the resident to wear a splinting device continuously during the post-operative period. Clinical record documentation and the DOC confirmed that the resident's POA was asked and agreed to pay a rental fee for a chair the resident required in order to be positioned properly after returning to the home. The DOC confirmed that the home did not pay for the cost of the short term rental of this positioning device as required, using funds provided to the home through the Nursing and Personal Care funding envelope. (PLEASE NOTE: The above noted non-compliance was identified during the inspection of Compliant Log #H-000363-14) [s. 39.]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums**

**Specifically failed to comply with the following:**

**s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,**
**(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).**
**(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).**
**(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).**
**(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).**

**Findings/Faits saillants :**

1. The licensee did not ensure that there were sufficient food service workers for the home to meet the minimum calculated staffing hours of 463.05 hours per week.

A review of the Time Report for the Dietary Department revealed that total weekly food service hours were 462. The minimum food service hour requirements were calculated to be 463.05. The Director of Dietary Services (DDSS) confirmed that the home had a deficit of 1.05 food service hours weekly for the past year. [s. 77. (1)]

**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee did not ensure that staff applied the seatbelt used to restrain a resident in accordance with manufacturer's instructions, in relation to the following: [110(1)1]

Staff did not apply a seatbelt restraint in accordance with manufactures directions, when in June 2013 a resident was noted to be sitting in the lounge in a tilted wheelchair with a loose fitting front fastening seatbelt applied. It was noted that there was a six inch gap between the resident's body and the seatbelt. Registered staff confirmed that the resident was a high risk for injury and reapplied the seatbelt. The resident's plan of care indicated the resident was a high risk for falling and directed that staff apply the seatbelt at all times when the resident was sitting in the wheelchair for safety. The Director of Care confirmed directions for application of seatbelts provided by the supplier were that the seatbelt was to be applied with just enough room for two fingers to fit between the belt and the resident. [s. 110. (1) 1.]

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**WN #12: 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).**

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**Findings/Faits saillants :**

1. The licensee did not ensure staff participate in the implementation of the infection prevention and control program. Observation of dining areas over several days in June 2014 revealed Personal Support Workers and Dietary Aides do not wash their hands after touching soiled items and then serve residents their food. Staff were observed assisting residents with eating and wiping resident mouths, then serving food and beverages to other residents without washing hands or using sanitizer. Staff confirmed they do not wash their hands as often as they should. [s. 229. (4)]

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**Issued on this 22nd day of August, 2014**

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

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | KATHLEEN MILLAR (527), PHYLLIS HILTZ-BONTJE (129), VIKTORIA SHIHAB (584), YVONNE WALTON (169) |
| **Inspection No. / No de l'inspection :** | 2014_266527_0014 |
| **Log No. / Registre no:** | H-0005550-14 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Aug 19, 2014 |
| **Licensee / Titulaire de permis :** | SPECIALTY CARE / WOODHALL PARK INC<br>400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3 |
| **LTC Home / Foyer de SLD :** | SPECIALTY CARE WOODHALL PARK<br>10260 KENNEDY ROAD NORTH, BRAMPTON, ON, L6Z-4N7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Debbie McIntosh |

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

To SPECIALTY CARE / WOODHALL PARK INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that foods and fluids are served to residents at palatable and safe temperatures at all meals and snacks. The plan shall include:

1. A process for ensuring that temperatures are consistently recorded in a standardized unit of measurement.
2. An educational plan to review safe temperature guidelines and appropriate measurement and accurate documentation techniques.
3. A regular auditing process to ensure staff documentation accuracy and compliance with corrective actions and documentation.

The plan should be submitted on or before October 31, 2014 and submitted to Kathy.Millar@ontario.ca.

**Grounds / Motifs :**

1. The licensee did not ensure that foods and fluids are served at a temperature that is both safe and palatable to residents.

A) A review of the Pleasurable Dining Committee meeting minutes revealed that residents brought forth complaints of inappropriate food temperatures in July and December of 2013 and February and May of 2014. Residents complained that eggs, waffles, meatballs and potato wedges were not hot at service. During interviews over a five day period in June 2014, two residents brought forth concerns regarding inappropriate food temperatures at meal service.

B) In June 2014 the inspector tasted all foods offered at lunch one day and noted that the mashed potatoes were cold. The inspector informed the Dietary Aide (DA). DA confirmed that potatoes are often cold. No corrective actions were taken by staff to reheat the mashed potatoes.

C) Monthly temperature logs for all meals served on all home areas were reviewed in the presence of the Director of Dietary and Support Services (DDSS). The DDSS confirmed the home defined acceptable food temperatures to be less than or equal to 40 degrees Fahrenheit (F) for cold foods and greater than or equal to 140 degrees F for hot foods (less than or equal to four degrees Celsius (C) and greater than or equal to 60 degrees C, respectively). On the Heritage home area, the temperatures fell out of the acceptable range 27 times at breakfast and 63 times at lunch time in June 2014. The temperatures ranged from 41 to 59 degrees Celsius for hot food. No corrective actions or corrected temperatures were documented. The DDSS confirmed that staff were to take corrective actions and document them in the temperature log immediately. Staff could not confirm that corrective actions were taken.

D) During an observation, the inspector noted that a DA was mentally converting temperatures from degrees F to degrees C incorrectly. In an interview, the DA confirmed that this was their regular practice. The DDSS confirmed that the practice was inappropriate and the temperature log on the staff's home area was unreliable. The DDSS and the Food Services Supervisor (FSS) did not provide verification of temperature log audits. The home did not ensure that residents were served with foods that were safe and palatable to the residents
(584)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 31, 2014

**Order # / Ordre no :** 002

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure the policies, procedures and protocols related to Responsive Behaviours, Restraint Implementation Protocol, Skin and Wound Care Management Protocol, and the Food Temperatures policy are complied with.

The plan is to include, but is not limited to:

1. The development and implementation of a training program for all registered staff to ensure they are knowledgeable in the above noted policies and protocols.
2. The development and implementation of an audit process and any other strategies to ensure compliance with the policies and protocols.
3. The development and implementation a system to monitor staffs performance related to ensuring their individual compliance with the policies and protocols.

The plan is to be submitted on or before October 31, 2014 to Kathy.Millar@ontario.ca.

**Grounds / Motifs :**

1. The Home's policy "Responsive Behaviours", dated September 2013, number VII-F-30.00 identifies that the level of risk, low, medium or crisis triggers should be documented on the individualized plan of care. The Charge Nurse confirmed the level of risk has not been identified and documented on the plan of care for a

resident. The Director of Care confirmed the level of risk should have been identified on the resident's plan of care. (527)

2. The licensee did not ensure that 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 or procedure that the plan, policy, protocol or procedure is complied with, in relation to the following:

A) Previously identified non-compliant in February 2011 (related to pain, lifts and transfers) as a Voluntary Plan of Correction (VPC), in December 2012 (related to quarterly assessment completion related to bed rails) as a Written Notice (WN), and in May 2014 (related to foot care and falls) as a WN and VPC.

B) The Home's policy "Responsive Behaviours", identified as number VII-F-30.00, and reviewed in September 2013 directs registered staff to conduct and document a Responsive Behaviour referral of a resident for a number of reasons. Two of the reasons to make a referral include: when the resident is assessed quarterly and if the resident triggers escalating behaviours, delirium indicator, or increased depression, or when there is a change in the resident's condition with responsive behaviours. During the Inspection the clinical record was reviewed for a resident, and there was no Responsive Behaviour referral although the resident had worsened responsive behaviours. The Charge Nurse and DOC were interviewed and confirmed there is no Responsive Behaviour Referral for this resident. The Director of Care confirmed there should have been a Responsive Behaviour referral for the resident as per the home's policy. (527)

The Home's policy "Responsive Behaviours", identified as number VII-F-30.00, and revised in September 2013 directs registered staff to identify the level of risk, low, medium or crisis triggers and they are to be documented on the individualized plan of care for the resident. The resident's clinical record did not reveal any risk levels related to the triggers for responsive behaviours for a resident. The Charge Nurse confirmed the level of risk had not been identified and documented on the plan of care for a resident. The Director of Care also confirmed the level of risk should have been identified on the resident's plan of care. The Responsive Behaviours policy was not complied with. (527)

C) Staff did not comply with the home's Restraint Implementation Protocols identified as VII-F-10.08, revised in July 2011. The protocol directed that prior to the implementation of restraint or positioning device a comprehensive nursing

assessment must be in place. Staff did not comply with this direction when a tilt wheelchair identified as a PASD was included in the plan of care for a resident and was being used during this inspection when the clinical record indicated that there had not been an assessment of the use of this PASD. (129)

D) Staff did not comply with the home's "Skin and Wound Care Management Protocol" identified as VII-G-20.10 revised in September 2013. The protocol directed staff were to complete a Head to Toe assessment upon return from hospital. A resident returned from hospital at the beginning of March 2014; however the Head to Toe assessment was not completed and did not contain information related to the surgery the resident had or the condition of the dressing or the surgical site. The protocol also directed staff to complete weekly skin assessments. Staff did not complete weekly skin assessments for the resident when the resident returned to the home. Staff completed a weekly skin assessment three weeks later in March 2014 and identified the resident had two pressure ulcers and one of the ulcers was unstageable. Clinical documentation indicated a weekly skin assessment of the unstageable pressure ulcer completed sixteen days later in mid-April 2014 and there was no documentation in the clinical record that there was a further weekly skin assessment completed related to the other identified pressure area on the resident. (129)

E) A resident was in significant pain and required good pain management due to their developing gangrene. Their infection was increasingly getting worse over a five day period in June 2014. The "Pain and Symptom - Assessment and Management Protocol" policy, number VII-G-70.00, and revised February 2013 directs the registered staff to determine the resident's type of pain using the Abbey Pain Assessment tool, initiate the Pain and Symptom Monitoring tool until the resident's pain control was achieved, and include interventions related to assessed pain and symptom management in the plan of care, and update as necessary. The resident's Power of Attorney (POA) stated that the resident was in severe pain for at least four days before they were comfortable. The RN and RPNs confirmed that the document they use to direct care was not updated and therefore they were not in compliance with the home's policy. In addition, the protocol states that Occupational Therapy or Physiotherapy should develop, implement and carry out therapeutic interventions for the assessed conditions including adjunct non-pharmacological pain interventions, therapeutic modalities and/or joint supports such as splints, braces and other positioning aids. Based on the clinical record review there was no documentation to support this type of assessment required by the protocol for the resident. This was confirmed by the

RN and RPN. (527)

F) The policy named "Weights - Monitoring of Resident Weights", number VII-G-40.50, reviewed in January, 2013 was not complied with. The policy instructed registered staff to instruct Personal Support Workers (PSWs) to reweigh a resident if they had a weight change of two kilograms or more. A resident had a documented weight loss of 7.6 kilograms from March to April 2013. No reweigh was documented. The resident had another significant weight loss of 5.8 kilograms from February to March 2014. No reweigh was documented. During the Inspection review of the Registered Dietitian's (RD's) documentation confirmed that the RD requested a reweigh of the resident in order to clarify accuracy of the documented weight loss. The RD and Assistant Director of Care (ADOC) confirmed the resident had not been reweighed as per policy.

G) The policy named "Food Temperatures", number XXIII-E-10.20, and revised November, 2013 was not complied with. The policy states that hot food must be kept at a minimum of 140 degrees Fahrenheit (F), 60 degrees Celsius (C). The policy further instructs staff to take the following corrective actions if hot food is cooler than the specified minimum: contact the cook immediately, re-heat the food and re-check the temperature. Staff where instructed to document corrective actions in the Corrective Action Taken column in the temperature log and to write the new acceptable temperature in the Record Corrected Temp column. The inspector tasted all foods offered at lunch one day in June 2014 and noted that the mashed potatoes were cold. The Inspector informed the Dietary Aide (DA). DA confirmed that potatoes are often cold. No corrective actions were taken by staff to reheat the mashed potatoes. No corrective actions or corrected temperatures were documented. Monthly temperature logs for all meals served on all home areas were reviewed in the presence of the Director of Dietary and Support Services (DDSS) in June 2014. On the Heritage home area, the temperatures fell out of the acceptable range 27 times at breakfast and 63 times at lunch time over a period of twenty-five consecutive days in June 2014. The temperatures ranged from 41 to 59 degrees Celsius for hot food. No corrective actions or corrected temperatures were documented. The DDSS confirmed that staff where to take corrective actions and document them in the temperature log immediately. Staff could not confirm that corrective actions were taken.

(527)

3. Staff did not comply with the home's "Skin and Wound Care Management Protocol" identified as VII-G-20.10, and revised in September 2013.

The protocol directed staff were to complete a Head to Toe assessment upon return of a resident from hospital. A resident returned from hospital at the beginning of March 2014; however the Head to Toe assessment was not completed and did not contain information related to the surgery the resident had or the condition of the dressing or the surgical site. The protocol also directed staff to complete weekly skin assessments. Staff did not complete weekly skin assessments for the resident when the resident returned to the home with a surgical wound. Staff completed a weekly skin assessment at the end of March 2014 and identified the resident had two pressure ulcers with one being an unstageable pressure ulcer. Clinical documentation indicated a weekly skin assessment of the unstageable pressure ulcer was completed sixteen days later, mid-April 2014 and there was no documentation in the clinical record that there was a further weekly skin assessment completed related to the other identified pressure ulcer. (527)

4. The licensee did not ensure that policy named "Food Temperatures", numbered XXIII-E-10.20 and updated November, 2013 is complied with.

The policy states that hot food must be kept at a minimum of 140 degrees Fahrenheit (F), 60 degrees Celsius (C). The policy further instructs staff to take the following corrective actions if hot food is cooler than the specified minimum: contact the cook immediately, re-heat the food and re-check the temperature. Staff are instructed to document corrective actions in the Corrective Action Taken column in the temperature log and to write the new acceptable temperature in the Record Corrected Temp column.

During the inspection, the inspector tasted all foods offered at lunch one day in June 2014 and noted that the mashed potatoes were cold. Inspector informed the Dietary Aide (DA). DA confirmed that potatoes are often cold. No corrective actions were taken by staff to reheat the mashed potatoes. No corrective actions or corrected temperatures were documented.

Monthly temperature logs for all meals served on all home areas were reviewed in the presence of the Director of Dietary and Support Services (DDSS) in June 2014. On the Heritage home area, the temperatures fell out of the acceptable

range 27 times at breakfast and 63 times at lunch time over a twenty-five consecutive days in June 2014. No corrective actions or corrected temperatures were documented. The DDSS confirmed that staff were to take corrective actions and document them in the temperature log immediately. Staff could not confirm that corrective actions were taken. (584)

5. The licensee did not ensure that the policy named "Weights - Monitoring of Resident Weights", number VII-G-40.50, reviewed in January, 2013 was complied with.

The policy instructed registered staff to instruct Personal Support Workers (PSWs) to reweigh a resident if they had a weight change of two kilograms or more. A resident had a documented weight loss of 7.6 kilograms from March to April 2013. No reweigh was documented. The resident had another significant weight loss of 5.8 kilograms from February to March 2014. No reweigh was documented. A review of the Registered Dietitian's (RD's) documentation confirmed that the RD requested a reweighing of the resident in order to clarify accuracy of the documented weight loss. The RD and Assistant Director of Care (ADOC) confirmed the resident had not been reweighed as per policy although staff were further reminded to reweigh the resident. (584)

6. A resident required good pain management due to their developing gangrene, which was deteriorating over a five day period in June 2014. The "Pain and Symptom - Assessment and Management Protocol", policy number VII-G-70.00 dated February 2013 identifies that the registered staff were determine the type of pain using the Abbey Pain Assessment tool, initiate the Pain and Symptom Monitoring tool until the resident's pain control was achieved, and include interventions related to assessed pain and symptom management in the plan of care and update as necessary. The RN and RPNs confirmed the document they use to direct care was not updated and therefore they were not in compliance with the home's policy. In addition, the protocol states that Occupational Therapy or Physiotherapy should develop, implement and carry out therapeutic interventions for the assessed conditions including adjunct non-pharmacological pain interventions, therapeutic modalities and/or joint supports such as splints, braces and other positioning aids. Based on the clinical record review there is no documentation to support this type of assessment required by the protocol for this resident. This was confirmed by the RN and RPN. (527)

7. The licensee did not ensure that 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 or procedure that the plan, policy, protocol or procedure is complied with, in relation to the following: [8(1)(b)]
A) Staff did not comply with the home's Restraint Implementation Protocols identified as VII-F-10.08, revised in July 2011.
The protocol directed that prior to the implementation of restraint or positioning device a comprehensive nursing assessment must be in place. Staff did not comply with this direction when a tilt wheelchair identified as a PASD was included in the plan of care for a resident and was being used during this inspection when the clinical record indicated that there had not been an assessment of the use of this PASD.
B) Staff did not comply with the home's Skin and Wound Care Management Protocol identified as VII-G-20.10 revised in September 2013.
The protocol directed staff were to complete a Head to Toe assessment upon return from hospital. A resident returned from hospital at the beginning of March 2014; however the Head to Toe assessment was not completed and did not contain information related to the surgery the resident had or the condition of the dressing or the surgical site.
The protocol also directed staff to complete weekly skin assessments. Staff did not complete weekly skin assessments for a resident when the resident returned to the home with a surgical wound. Staff completed a weekly skin assessment at the beginning of March 2014 and identified the resident had two pressure ulcers with one being an unstageable pressure ulcer. Clinical documentation indicated a weekly skin assessment of the unstageable pressure ulcer was completed sixteen days later in mid- April 2014 and there was no documentation in the clinical record that there was a further weekly skin assessment completed related to the other identified pressure ulcer. (129) (129)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 31, 2014

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 003

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure the plans of care for all residents, including Resident #200, Resident #210 and Resident #010 provide clear directions to staff providing are when the resident requires care related to pain management, mobility, transfers, wound care, post-surgical care including care of the surgical site, nutrition and hydration.

The plan is to include, but is not limited to:

1. The development and implementation of a process that staff responsible for developing plans of care must follow to ensure care directions identified in the plans of care provide clear directions to staff providing care.
2. The development and implementation of a training program for all staff, based on the above noted process and any other strategies for ensuring the plans of care provide clear directions.
3. The development and implementation of a system to monitor staffs performance related to ensuring the plans of care developed provide clear direction to staff providing care.

The plan is to be submitted on or before October 31, 2014 to Kathy.Millar@ontario.ca

**Grounds / Motifs :**

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

The plan of care for a resident was unclear related nutrition and hydration interventions. In May, 2010 the Registered Dietitian created an intervention that instructed staff to provide nectar thick fluids. In August, 2010 the RD added an intervention stating the resident refuses nectar-thick fluids and the family had confirmed the resident will refuse. In August, 2011 the RD confirmed the resident wants regular fluids. In September, 2011 another intervention was added by the RD confirming refusal and instructions to offer both regular and thickened fluids. In January, 2012 another RD intervention indicated that the resident's Power of Attorney (POA) wants the resident to receive regular foods. The resident's current diet order was for minced food texture and nectar thick fluids with pureed soup. The RD confirmed that the instructions were unclear during a phone interview in June 2014. (584)

2. The plan of care for a resident did not provide clear directions to staff providing care when the resident's pain management had changed and after their quarterly assessment in June 2014. The resident had developed gangrene of their left foot and it was deteriorating, which was causing tremendous pain for the resident. The assessment identified the frequency of pain to be daily and the intensity to reflect the resident's pain as excruciating at times. Clinical documentation indicated that the document the home used to provide care directions to staff did not provide clear directions related to how staff were to initiate pain and symptom monitoring until the resident achieved good pain control, determine the type of pain utilizing the Abbey Pain Assessment tool, and include interventions related to assessed pain and symptom management. The RN, RPNs and PSWs confirmed the care plan did not provide clear directions related to these aspects of care required by the resident. (527)

3. The plan of care for a resident did not provide clear directions to staff and others who provide direct care since the resident's condition has significantly changed. The documents which the Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs) use to direct the care for a resident state the resident can weight bear. The inspector observed the resident over several days in June 2014 and the resident was in bed. It was confirmed the resident was unable to stand due to pain. After reviewing the health record the documentation reflected the resident was unable to stand for mobility or transferring. This was confirmed by the PSWs and the RPNs. In addition, the skin and wound care treatments, goals and interventions did not reflect what the Physician had ordered in June 2014. The document used by the RPN to direct care stated the

dressings were to be done every Monday, Wednesday and Friday and whenever necessary. The Physician's order in June 2014 also stated that the wounds were to be painted with betadine; cover the one of the wounds with 3M foam; continue offloading the resident's bootie and offloading the wound care areas; and change the dressing every day. The dressing had changed from three times per week to daily. This was confirmed in the health record, confirmed with the RPN and RN. (527)

4. The licensee did not ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident, in relation to the following: [6(1)c]
Staff did not ensure that the written plan of care for a resident provided clear directions to staff providing care when the resident returned to the home at the beginning of March 2014. Clinical documentation indicated that the document the home used to provide care directions to staff did not provide clear directions related to how staff were to position the affected limb during transfers or while the resident was sitting in the chair, directions for monitoring the dressings over the site or the surgical site and did not provide clear directions regarding the surgical incision closure and when staples were to be removed. The DOC confirmed that the care plan did not provide clear directions related to these aspects of the care required by this resident. (129)
(PLEASE NOTE: The above noted non-compliance was identified during the inspection of Complaint Log #H-000363-14) (129)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 31, 2014

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 19th day of August, 2014**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Kathleen Millar

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office