Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 3, 2014	2014_265526_0023	H-001336-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

THE WOODLANDS OF SUNSET
920 PELHAM STREET WELLAND ON L3C 1Y5

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

THERESA MCMILLAN (526), BARBARA NAYKALYK-HUNT (146), KELLY HAYES (583), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 7, 8, 9, 14, 15, and 16, 2014

Please note: inspection of critical incident H-001209-14, falls management of complaint H-000742-14, and complaint H-000980-14 were conducted simultaneously to this RQI inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Associate Director of Care (ADOC), Clinical Documentation and Informatics Coordinator (CDI Coordinator), the Dietary, Housekeeping, and Laundry Manager, Food Service Manager (FSM), Registered Dietitian (RD), registered staff including Registered Practical Nurses (RPN) and Registered Nurses (RN), non registered staff including Personal Support Workers (PSW) and Health Care Aids (HCA), dietary and housekeeping staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

15 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 2. Every resident has the right to be protected from abuse.

On a day in 2014 a family member reported to the home that on the previous day a staff member told a resident not to ring the bell again to go to the toilet until after supper; that the resident had better hold it until after supper. The resident reported to the home during their investigation that the staff person was very rude and mean. The family member reported to the home that the staff person had also told the resident that the resident had better learn to go to the bathroom alone. The resident's plan of care indicated that they were at high risk for falls and needed assistance of one person to use the bathroom.

When interviewed two months later, the resident clearly recalled the incident with no cueing other than to ask if they recalled any time in the past when a staff person was rude or unkind to them. The resident stated the staff person's name immediately. The resident recounted the incident as per the home's notes. When asked how the incident affected them, the resident stated that they felt very worried and upset because they didn't know if they could hold it (urine) long enough. The resident had suffered emotional abuse from the verbal abuse.

The home's internal investigation concluded that the incident was a staff to resident abuse and the staff was disciplined. [s. 3. (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 the resident's right to be protected from abuse is fully respected and promoted, 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out (c) clear directions to staff and others who provided direct care to the resident.

A) Resident #037's plan of care indicated conflicting and unclear information and directions about the resident's mobility. This information was confirmed by the Associate Director of Care (ADOC) and documentation nurse. (146)

B) A review of the Resident Assessment Instrument Minimum Data Set (RAI MDS) Quarterly review assessment for resident #015 that the resident was on a scheduled toileting plan. A review of the resident's written plan of care and the Kardex, available to the staff who provided direct care, outlined several continence interventions in addition to the toileting plan.

Interview with non registered staff indicated that care provided was not consistent with the interventions outlined in the resident's plan of care. Interview with the CDI Coordinator confirmed the plan of care did not set out clear direction to staff and others who provided direct care to resident #015. [s. 6. (1) (c)]

2. The licensee failed to ensure that resident #030's Substitute Decision Maker (SDM) was provided the opportunity to participate fully in the implementation of the resident's plan of care. Resident #030 was prescribed medications to manage the resident's behaviours. One day in 2014 one of the resident's medication was decreased and a week later another medication was discontinued. Clinical files indicated that a week after the second medication was discontinued, the resident was noted to have increased agitation and the second medication was resumed.

In both cases the resident's SDM was not consulted or given the opportunity to participate in the development of the resident's plan of care. During interview the resident's SDM stated being upset that the medications were discontinued without consulting them. They stated that the resident had been taking the second medication for a long time and that it had helped manage the resident's behaviours during that time. The SDM stated that, had they been consulted, they would have recommended against discontinuing the medication. Interviews with the DOC and the Administrator confirmed that the medications had been changed and confirmed that progress notes indicated that the resident's SDM was upset about not having been consulted about the change. [s. 6. (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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan included at a minimum, with respect to the resident, the diet orders including fluid consistencies.

A review of resident #045's 24 hour admission care plan and admission note completed by the CDI Coordinator on a day in 2014, explained that resident #045 required texture modified diet and fluids.

On the same day, a modified texture diet with no specified fluid consistency was ordered and communicated on the document the home referred to as resident #045's care plan. A review of the progress notes showed that four days later resident #045's family member asked staff why resident #045 received water, as the resident had been recently assessed by a speech language pathologist in hospital and required texture modified fluids. In an interview with registered nursing staff it was verified that the initial diet order did not include resident #045's fluid consistency requirements and that resident #045 received regular fluids for the first four days of admission. [s. 24. (2) 8.]

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 care plan includes at a minimum, with respect to the resident, diet orders including food texture, fluid consistencies and food restrictions, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who was a member of the staff of the home completed a nutritional assessment for residents whenever there was a significant change in the resident's health conditions.

A review of resident #045's plan of care for three months in 2014 indicated they had a condition requiring modified diet and fluid textures. During this time, resident #045's diet was changed from modified texture to pureed regular thin fluids. The diet/texture order sheet stated the puree regular thin fluid diet was a "temporary texture" that could be ordered for up to two weeks. A nutrition referral form was completed explaining further follow up was required by the Registered Dietitian (RD). A progress note completed by the Food Service Supervisor (FSS) showed that resident #045's average fluid intake during the seven day observation period was below the resident's minimum requirements. A review of the plan of care for the month following the progress note made by the FSS, showed a nutritional assessment had not been completed by the RD as stipulated by the FSS. In an interview with the Dietary Manager and the CDI Coordinator it was confirmed that a referral was made to the RD and that a complete nutritional assessment had not been completed in the plan of care by the RD. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home, (a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that (b) a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On a day in 2014, according to the progress note, resident #044 was noted by registered staff to altered skin integrity on an extremity and indicated the wound would be described in greater detail by the RPN completing the wound assessment. The Multiple Wound Assessment Form completed on that same day in 2014 did not include any information on the altered skin integrity. Interview with the DRC confirmed a skin and wound assessment was not completed for resident #044's altered skin integrity. [s. 50. (2) (b)]

2. The licensee failed to ensure that residents exhibiting altered skin integrity, including skin tears were assessed by a registered dietitian who was a member of the home.

A) A review of the clinical records for resident #044 indicated on a day in 2014, they acquired two areas of altered skin integrity to an extremity. According to the clinical record, a nutritional referral was completed by the registered staff to the RD on on that day. Interview with the RD confirmed they had not assessed the resident as per the referral. (511)

B) A review of the plan of care for resident #045 indicated that the resident received an initial skin assessment completed by the registered nursing staff on a day in May 2014 for altered skin integrity on an extremity. Documentation in the progress notes showed a referral to the dietitian was completed on that same day. A review of the plan of care showed a dietitian assessment was not completed for resident #045's altered skin integrity. In an interview with the CDI Coordinator on October 15, 2014 it was verified that a dietitian assessment had not been completed. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; and
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #6: 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. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who were incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) Clinical records indicated that resident #029 was considered a low risk for incontinence. The resident's health records indicated that the resident was incontinent of urine. Review of the clinical record indicated that the causal factors of the resident's incontinence had not been assessed using a clinically appropriate instrument. (526)

B) A review of resident #033's RAI MDS Quarterly assessment completed in 2014 indicated they were frequently incontinent of their bladder. Further review of the clinical record did not indicate a continence assessment that included identification of causal factors, patterns and type of incontinence was completed. (511)

C) Resident #041's MDS assessment completed in 2014 indicated that both bowel and bladder continence had declined since the previous assessment. The incontinence assessment did not include the type of incontinence. (146)

Interview with the DOC confirmed that for residents #029, #033, and #041, a clinically appropriate assessment instrument that was specifically designed for assessment and included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions of incontinence was not completed. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received speech-language therapy services based on his or her assessed needs.

Resident #045 was admitted to the long term care home in 2014. A discharge interdisciplinary note completed the day before being admitted to long term care by the Speech Language Pathologist (SLP) at the transferring hospital, recommended that resident #045 receive a followup assessment by SLP.

The Registered Dietitian (RD) completed an assessment approximately two weeks later, and the RD requested that the RPN refer resident #045 to the SLP; it was documented that SLP referral was completed. Resident #045's care conference progress note documented three weeks after the RD asked the RPN to refer the resident to SLP, indicated that family were told an SLP referral was completed for the resident to be reassessed. Two months after the RD assessment, resident #045 diet was downgraded from modified texture fluids to regular thin fluids following a feed swallowing screen done by registered nursing staff.

A review of the electronic and paper plan of care did not show documentation of the feeding swallowing screen as recommended by the SLP in hospital or the home's RD. A progress note completed three months following admission by the registered nursing staff explained resident #045 tolerated regular fluids on admission as part of the reason for fluid consistency change. However, documentation in progress notes by the registered nursing staff at the time of admission explained resident #045 required a modified fluid consistency. It was confirmed by the CDI Coordinator in an interview that there was no documented assessment completed to support the diet change made three months after admission and that the resident had not been followed up by a SLP for four months following admission to the home. [s. 59. (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 therapy services for residents of the home are arranged or provided under section 9 of the Act that include (b) occupational therapy and speech-language therapy, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Policy #RR00-001 entitled "Abuse and Neglect- Zero Tolerance" directed that the Administrator or Director of Resident Care (DRC) would notify the Ministry of Health and Long Term Care (MOHLTC) immediately if they became aware of an allegation that someone other than a resident made any form of verbal communication to a resident that was of a threatening, intimidating, belittling, or degrading nature. On a day in August 2014, the DRC confirmed that the home determined that a verbal complaint from a family member was actually staff to resident abuse. The Administrator or DRC did not report the abuse allegation to the MOHLTC until 11 days later. This information was confirmed by the DRC. [s. 20. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who had fallen had a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls.

Progress notes confirmed that resident #030 had sustained 14 falls during two months in 2014. The Clinical Documentation and Informatics (CDI) Coordinator confirmed that post falls assessments had not been completed for five of these falls. [s. 49. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident that demonstrated responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) According to resident #030's RAI MDS quarterly assessment conducted in 2014, the resident exhibited responsive behaviours four to six of the past seven days assessed.

The corresponding Resident Assessment Protocol (RAP) did not indicate the underlying cause or triggers of this responsive behaviour. Clinical records indicated that the resident had exhibited responsive behaviours 19 times of a total of 88 documented shifts in a one month time period during 2014. Non registered staff confirmed that the resident had exhibited responsive behaviours that were not easily altered. Registered staff confirmed that the resident's plan of care did not address the resident's resistance to care.

During interview, the DRC, ADC and CDI Coordinator confirmed the following: behavioural triggers for resident #030's resistance to care had not been assessed; strategies had not been developed and implemented to respond to these behaviours; and actions that were taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions had not been documented. (526)

B) Resident #033's, RAI MDS Quarterly assessment completed in 2014, and corresponding RAP indicated the resident had an increase in responsive behaviours. A review of the PSW seven day Responsive Behaviour report, for this assessment time period did not indicate resistance to care behaviours. The previous RAI MDS Quarterly assessment conducted three months earlier did not indicate resident #033 had responsive behaviours. A review of the clinical record did not identify behavioral triggers, strategies or actions taken to respond to this responsive behaviour.

Interview with the CDI coordinator confirmed that where resident #033 demonstrated an increase in resistance to care as a responsive behaviours that, (a) the behavioural triggers for the resident were not identified, where possible; (b) strategies were not developed and implemented to respond to these behaviours, where possible; and (c) actions were not taken to respond to the needs of the resident, including ssessments, reassessments and interventions and that the resident's responses to interventions were documented. [s. 53. (4) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

A review of the home's census with the Administrator on October 16, 2014 confirmed the home remained above 99% for home occupancy for 121 resident's in the home during September and October, 2014. The confirmed 121 residents at 30 minutes per resident per month calculated to 3,630 minutes or 60.5 on-site hours per month for the RD to carry out clinical and nutrition care duties.

A review of the August and September 2014, RD schedule and time paid cards provided by the home indicated the on-site hours did not equal the minimum required hours. In August, the total on-site RD hours were 38.5; the RD hours were short 22.0 hours from the required 60.5 hours. The Administrator confirmed the RD hours were not replaced when the RD was on vacation. In September 2014 the total RD on-site hours were 56.0; the RD hours were short 4.5 hours from the required 60.5 hours.

A review of the October 2014 projected hours, as confirmed by the Administrator, would equal 52.5 on-site hours; the RD hours would be short 8.0 hours from the required 60.5 hours. An interview with the Administrator confirmed, according the the RD schedules provided and RD timecards, that the home did not ensure that a RD who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. [s. 74. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Family Council was sought in developing and carrying out the satisfaction survey. An interview with Family Council representatives on October 14, 2014, indicated that the home would not add questions to the satisfaction survey according to the Council's recommendations. The Administrator confirmed that the Family Council had been advised that any changes to the satisfaction survey could only be minor changes as the survey was standardized and would be used by and compared to other homes using the same survey. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the process developed to report and locate residents' lost clothing was implemented.

When a resident reported lost clothing, the home's process as communicated by the Laundry Manager, was to record a detailed description of the lost articles in Point Click Care and complaint log. Neither of these steps were implemented when, in March 2014, resident #012's substitute decision maker (SDM) reported to nursing and the Laundry Manager at the time that two pieces of clothing were missing. The missing clothing was never found or replaced as confirmed by the SDM and the Laundry Manager. [s. 89. (1) (a) (iv)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offense.

On a day in August, 2014, a family member reported to the home an allegation of staff to resident verbal and emotional abuse. The identified employee was terminated from employment at the home. It wasn't until October 14, 2014 at 1600 hours during this RQI inspection that the home notified the appropriate police force. This information was confirmed by the administrator and the DRC. [s. 98.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the following immunization and screening measures were in place in the home: 3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A review of the clinical record on October 16, 2014, for resident #015, indicated the resident required an immunization. The request for a physician's order that the resident be immunized was also documented in the doctor's report book on October 10, 2014. Interview with the Registered Nurse stated a verbal consent was received in 2010 from the family, in collaboration with the resident. The Registered Nurse confirmed an order was not received and immunization was not provided to resident #015 since 2010. [s. 229. (10) 3.]

Issued on this 1st day of December, 2014

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

Original report signed by the inspector.