Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 27, 2018	2018_752627_0012	008771-18	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the Town of Kirkland Lake
3 Kirkland Street West Postal Bag 1757 KIRKLAND LAKE ON P2N 3P4

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

Teck Pioneer Residence
145A Government Road East Postal Bag Service 3800 KIRKLAND LAKE ON P2N 3P4

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

SYLVIE BYRNES (627), CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 28 - June 1, 2018.

The following intakes were inspected during this Inspection:

One critical incident (CI) report related to alleged resident to resident sexual abuse and, one CI report related to care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Admin/DOC), Assistant Director of Care (ADOC), Dietary Manager (DM), Life Enrichment Manager (LEM), Human Resources (HR) Manager, Office Manager, Infection Prevention and Control (IPAC) Clinical Coordinator, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspectors also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **2 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 O.Reg 79/10, s. 74. Registered dietitian

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one Registered Dietitian (RD) for the home.

Through a record review by Inspector #609 and Inspector #627, resident #006, #004, #005 and resident #015 were identified as having had a significant weight change. Please see WN #2 and #3 for details.

Inspector #627 completed separate interviews with Registered Nurse (RN) #103 and Registered Practical Nurse (RPN) #109. They informed the Inspector that they no longer had a RD working in the home. They stated that any weight concerns for the residents were addressed by the Dietary Manager(DM).

Inspector #627 interviewed the DM, who stated that the home had been without a RD since August 2017. They stated that they had been told by the Administrator/Director of Care (Admin/DOC) that the duties of the RD were added to their role at that time. They further stated that they remained on a 26 hour per week schedule, which was the legislative requirement for the number of residents in the home in their role as DM. They acknowledged that they were not a Registered Dietitian and hadn't had the knowledge or time to initiate nutritional interventions for residents. They stated that the additional work required took over 10 hours per week and that they just hadn't had the time.

Inspector #627 interviewed the Admin/DOC, who stated that they had been without a RD since August 2017. They stated that they had posted the position last year in the newspaper, and it was currently posted in the" Kirkland Lake Job Bank". They stated that the Board of Management was aware of the legislative requirements to maintain a RD in the home.

Inspector #627 reviewed an email forwarded by the Human Resources (HR) Manager for the Town of Kirkland Lake. The email indicated that the only active job posting was for a Dietary Aide, which was published in December 2017. The HR Manager further indicated in the email that the Corporation (the licensee) and the Kirkland and District Hospital (the long-term care home and the hospital) shared a RD, therefore, there was RD working in the home.

Inspector #609 interviewed the Office Manager who stated that the home had employed a RD on a part time basis until August 2017, however they were no longer employed in the home. [s. 74.]

Additional Required Actions:

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

WN #2: 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 has failed to ensure that a RD who was a member of the staff of the home, completed a nutritional assessment for the resident on admission and whenever there was a significant change in a residents' health condition.

Through a record review, Inspector #609 identified residents #004 and #005 as having a significant weight change. Resident #004 had a change of greater than 10 per cent of body weight over six months; and resident #005 had a change of greater than 5 per cent of body weight over one month.

During an interview with the Admin/DOC, they indicated that the RD was supposed to complete a "Nutritional Risk Identification" assessment on residents of the home.

A review of the home's "Nutritional Risk Identification" assessment indicated the RD was required to complete the assessment on admission and whenever risk indicators changed, which included weight changes as significant as those cited for resident #004 and #005.

a) A review of the health care records for resident #004 and #005, found that no corresponding nutritional assessments for the significant weight changes were completed by the RD.

b) A further review of the health care records for resident #004 and #005, found that resident #005 had no admission nutritional assessment completed by a RD.

Inspector #609 interviewed the Admin\DOC who verified that a RD was to complete a "Nutritional Risk Identification" assessment upon a resident's admission and whenever a resident had a risk indicator change. In a subsequent interview with Inspector #627, the Admin/DOC stated that they had been without a RD since August 2017. [s. 26. (4) (a),s. 26. (4) (b)]

2. Resident #015 was identified as having had a significant weight change from their previous to most recent minimum data set (MDS) assessment. Please see WN #3 for details.

Inspector #627 completed a record review of resident #015's electronic records and noted that resident #015's "Admission Oral/Nutritional Status" assessment had been completed by the DM.

Inspector #627 interviewed the DM, who stated that they had completed the residents' initial "Admission Oral/Nutritional Status" assessment as the home no longer had a RD. The DM acknowledged that they were not a RD.

Inspector #627 interviewed the Admin/DOC, who stated that the DM completed the initial "Admission Oral/Nutritional Status" assessment for residents admitted to the home, with the input of the RNs and the Nurse Practitioner (NP). [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month, a change of 7.5 per cent of body weight, or more, over three months, change of 10 per cent of body weight, or more, over 6 months and any other weight change that compromised their health status were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated.

1) Resident #015 was identified as having had a significant weight change from their previous to most recent MDS assessment.

Inspector #627 completed a record review of resident #015's electronic record and noted that the resident had a change of greater than 7.5 per cent of body weight over three months.

Inspector #627 reviewed the home's policy titled "Changes in Weight", last revised January 2018, which identified that the DM was to investigate changes in weight and discuss findings and appropriate dietary interventions with nursing staff and the RD.

Inspector #627 interviewed RN #103 who stated that when a resident had a significant weight change, the DM assessed them and the Physician or the NP ordered a supplement, if needed. They further stated that they no longer had a RD working in the home.

Inspector #627 interviewed the DM, who stated that they had identified the resident at

risk upon admission. The DM stated that after discussing the resident’s nutritional needs with the resident's family member, they had decided to implement a specific nutritional intervention. They further stated that the ongoing weight change had been discussed with a family member, although no documentation or assessments had been completed. Since the resident’s family member was not concerned, the nutritional intervention was not adjusted until the resident had a significant weight change.

2) Resident #006 was identified as having had a significant weight change from the previous to most recent MDS assessment.

Inspector #627 completed a record review of resident #003's electronic record which identified a change of greater than 5 per cent over one month. The Inspector reviewed resident #007’s progress notes and electronic assessments and failed to identify any documentation or assessments regarding the significant weight change.

Inspector #627 interviewed RN #103, who stated that when a resident had a significant weight change, the DM assessed the resident and the Physician or the NP ordered nutritional interventions, as needed. The Inspector verified with the RN that the weight change amounted to over 5 per cent of the resident's body weight. The RN was unable to identify any documentation in the resident‘s electronic chart indicating that the weight change had been investigated.

During an interview with the DM, they acknowledged that they were not aware of the significant weight change for resident #006. They stated that they had a busy month as the home’s spring and summer menu was completed, and that they only had time to review critical weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a change of 5 per cent of body weight, or more, over one month, a change of 7.5 per cent of body weight, or more, over three months, change of 10 per cent of body weight, or more, over 6 months and any other weight change that compromises their health status was assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle was approved by a Registered Dietitian who was a member of the staff of the home.

Inspector #627 interviewed resident #016 who stated that the food in the home was not appetizing. The resident stated that when this concern was brought forth at a meeting, the DM had told the resident who had brought forth the complaint to "deal with it".

Inspector #627 interviewed the DM who indicated that they had completed the spring/summer menu in May, 2018. The DM indicated that it had not been approved by a RD who was a member of the staff of the home, as the home did not presently have a RD.

Inspector #627 interviewed the Admin/DOC, who indicated that the home hadn't had a RD on staff since August 2017. They stated that the menu came from the Kirkland and District Hospital. The DM, along with the DM for the hospital reviewed it. The menu was prepared by a RD in Ontario and was nutritionally approved. It was the same menu as at the hospital, with some variances. [s. 71. (1) (e)]

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 home's menu cycle is approved by a Registered Dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and O. Reg. 79/10, s. 229 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

a) During a tour of the home, Inspector #609 observed a white sheet of paper posted inside of a resident's room, adjacent to the bathroom. The Inspector had difficulty reading the instructions written on the sheet, which directed staff to use a gown and gloves when providing direct care, while all visitors were directed to report to the nursing station before entering the room.

Inspector #609 reviewed the "Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions, In All Health Care Settings, 3rd edition", which was a document that was developed to provide evidence-based practices to the Ontario Agency for Health Protection and Promotion (Public Health Ontario), on the prevention and control of health care-associated infections, considering the entire health care system for protection of both clients/patients/residents and health care providers. The document indicated that, additional precautions should be posted via signage that listed the required precautions at the entrance to the resident's room or bed space.

Inspector #609 interviewed RPN #109, who verified that the resident was positive for an infection and that staff were required to use a gown and gloves when providing direct care. The RPN further verified that staff and visitors would have had to enter the resident's room before being notified that they required additional precautions.

Inspector #609 interviewed the home's Clinical Coordinator, who verified that PIDAC was the document the home used as evidenced based practice, which outlined how isolation/precaution signage was to be placed when a resident required it, but felt that the signage broke the resident's privacy. They acknowledged that the white sheets of paper being used were also difficult to read.

The Inspector further reviewed the PIDAC document with the Clinical Coordinator who verified that:
- The required isolation/precaution signage from PIDAC had not violated residents' privacy;
- The white sheets currently being utilized by the home were not appropriate isolation/precaution signage; and
- That the PIDAC signage as well as directions for the location of the signage should have been used. [s. 229. (4)]

2. The licensee has failed to ensure that there was an outbreak management system in place for detecting, managing, and controlling infectious disease outbreaks including:
- defined staff responsibilities ;
- reporting protocols based on requirements under the Health Protection and Promotion Act ;
- communication plans; and,
- protocols for receiving and responding to health alerts.

During a tour of the home, Inspector #609 observed a white sheet of paper posted inside of a resident's room, adjacent to the bathroom, indicating that isolation precautions were utilized. Please see WN #5 for details.

During an interview with the Assistant Director of Care (ADOC), Inspector #609 requested any infection control documents related to the roles and responsibilities of staff when a resident was identified positive for Antibiotic Resistant Organisms (AROs) infection. The ADOC stated that there was no outlined procedure currently for staff to follow related to isolation/precautions for residents identified with an ARO infection, but that it was the responsibility of registered staff to utilize isolation/precautions.

A further review of the PIDAC document indicated that the home should have a policy authorizing any regulated health care professional to initiate the appropriate additional precautions at the onset of symptoms and maintain precautions. Additional precautions should be initiated for residents known to have, or considered to have been at high risk of

being colonized or infected with ARO infection in accordance with the home's policy.

A further review of the home's Infection Control policy indicated that infection control was the responsibility of all personnel and that the home should "designate clearly, as a matter of policy, the personnel responsible for placing a resident on isolation/precautions and the personnel who had the ultimate authority to make decisions regarding isolation/precautions when conflicts arose."

During an interview with the Clinical Coordinator, a review of the home's Infection Control program was conducted. The Clinical Coordinator verified that the home did not have a clear procedure which outlined the roles and responsibilities of staff when a resident with an ARO infection was identified. [s. 229. (8) (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 staff participate in the implementation of infection prevention and control program, to be implemented voluntarily.

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

During a resident interview, Inspector #627 observed that resident #007's had an area of altered skin integrity.

Inspector #627 reviewed the resident's electronic plan of care in effect at the time of the inspection and noted for the skin integrity focus that the resident was at risk for potential altered skin integrity. The PSWs were directed to complete specific interventions at a specified frequency. The registered staff were to assess the area being treated by the PSWs weekly and document the findings in the progress notes.

Inspector #627 reviewed the resident's electronic progress notes and identified that the last assessment completed by a RN was over one month ago, prior to the Inspector's observation.

Inspector #627 interviewed PSW #111 who stated that resident #007 often had an area of impaired skin integrity. The PSWs completed specific interventions as specified times.

Inspector #627 interviewed RPN #112, who stated that resident #007 had an area of impaired skin integrity and that specific interventions were carried out by the PSWs. They further stated that registered staff were supposed to assess the resident's skin integrity weekly and document their assessment in Point Click Care (PCC). They acknowledged that the last assessment documented in PCC was over one month prior to the Inspector's observations.

Inspector #627 interviewed the Admin/DOC, who stated that a skin integrity assessment to assess the effectiveness of the interventions by the PSWs should have been completed and documented weekly in the PCC, as indicated in the care plan.

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

A critical incident (CI) report was submitted to the Director regarding an alleged incident of resident to resident abuse between resident #005 and #010.

Inspector #627 reviewed the home's policy titled "Responsive Behaviours", last reviewed August 2017, which indicated that PSWs were to use the Dementia Observation System (DOS) charting template to monitor resident behaviour when directed by the Team Leader.

Inspector #627 reviewed the home's policy titled "Nursing Care Planning", last reviewed May 2018, which indicated that the care and services provided to each resident were to be documented in the resident's record according to facility policies and procedures.

Inspector #627 reviewed the care plan in effect at the time of the incident and noted that for the focus of responsive behaviours, the staff were directed to complete DOS charting whenever a responsive behavior was exhibited.

Inspector #627 reviewed the "DOS-Daily Observation Sheet" for the period of seven days and noted that no documentation was completed for the day shift during the that seven day period.

During separate interviews with PSW #106 and PSW #113, they stated to the Inspector that when a resident exhibited responsive behaviours, the resident was closely monitored for a period of one week and DOS charting was completed to monitor the resident's

behaviours. They stated that they could not explain why they had not completed the DOS charting for the day shift when they had completed the monitoring. They stated that the unit was busy and they may not have had time, and that the resident had "probably" not exhibited behaviours during the shifts.

Inspector #627 interviewed RN #103 who stated that when a resident exhibited responsive behaviours, they were monitored closely for a period of one to two weeks, and DOS charting was completed for a period of one week, (or more) on every shift. The RN acknowledged that the DOS charting for the incident was not completed for the day shift, for a period of seven days, and that the registered staff member on the floor should have followed up with the staff members to ensure that it was completed.

Inspector #627 interviewed the Admin/DOC, who stated that documentation should be completed every shift when a resident had DOS charting. They further stated that the registered staff should review the DOS charting to ensure that it had been completed to reflect the PSWs' observations of the resident's responsive behaviours throughout the shift .

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #609 observed that resident #008 had an area of impaired skin integrity.

a) Inspector #609 reviewed resident #008's health care records which identified a progress note indicating that the resident had developed an area of impaired skin integrity, two days prior to the Inspector's review.

Inspector #609 reviewed resident #008's plan of care, including the care plan and electronic medication administration record, referred to as Catalyst, and found no mention of the area of impaired skin integrity or of the care required for the impaired skin integrity.

Inspector #609 reviewed of the home's policy titled "Nursing Care Planning" last reviewed May 2018, which indicated that the plan of care was to reflect the resident's needs and was to be modified in response to the resident's changing needs.

Inspector #609 interviewed RN #118, who stated that during the nursing shift report, they

were notified that resident #008 had developed an area of impaired skin integrity. RN #118 reviewed the resident's care plan and Catalyst with the Inspector and verified that the plan of care for the resident should have been updated to identify the new area of impaired skin integrity along with interventions to care for the area.

b) Inspector #609 reviewed resident #008's plan of care and noted that the resident had a second documented area of impaired skin integrity.

During an interview with Inspector #609, resident #008 denied having the second area of impaired skin integrity.

During an interview with RN #118, they verified that resident #008's second identified area of impaired skin integrity had resolved "a long time ago". RN #118 reviewed the resident's plan of care with Inspector #609 and verified that the plan should have been updated when the area of impaired skin integrity had resolved.

During an interview with Admin/DOC, they verified that resident #008's plan of care should have been updated with the new area of impaired skin integrity and that the resolved area of impaired skin integrity should have been removed when it had resolved.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new times.

Inspector #609 observed;
- An unlabeled, used deodorant and denture brush in the shared bathroom ; and
- An unlabeled, used urinal and comb in another shared bathroom.

Inspector #609 reviewed of the home's policy titled "Personal Hygiene", last reviewed August 2017, which required all personal items including toiletries to be labelled.

Inspector #609 interviewed the Clinical Coordinator who verified that all residents' personal items should have been labelled to prevent sharing.

Inspector #609 interviewed the ADOC who indicated that all personal items should have been labelled. [s. 37. (1) (a)]

Issued on this 27th day of June, 2018

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), CHAD CAMPS (609)
Inspection No. / No de l'inspection :	2018_752627_0012
Log No. / No de registre :	008771-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 27, 2018
Licensee / Titulaire de permis :	Corporation of the Town of Kirkland Lake 3 Kirkland Street West, Postal Bag 1757, KIRKLAND LAKE, ON, P2N-3P4
LTC Home / Foyer de SLD :	Teck Pioneer Residence 145A Government Road East, Postal Bag Service 3800, KIRKLAND LAKE, ON, P2N-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Loach-Fourgere

To Corporation of the Town of Kirkland Lake, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 74. Registered dietitian

Order / Ordre :

The licensee must be compliant with Ontario Regulation (O.Reg.) 79/10, section 74 (1), (2) and (3).

The licensee shall prepare, submit and implement a plan to ensure that:
1) There is at least one Registered Dietitian for the home,
2) the Registered Dietitian, who is a member of the staff of the home is on site for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties,
3) Where the Registered Dietitian for the home is also a Nutrition Manager for the home, any time spent working in the capacity of the Nutrition Manager will not count toward the time requirements under subsection (2).

The plan must include, but not be limited to, a detailed description of how the licensee will recruit a Registered Dietitian, and how the nutrition and hydration needs of the resident are met until one is hired.

Please submit the written plan, quoting Inspection #2018_752627_0012 and Inspector, Sylvie Byrnes, by email to SudburySAO.moh@ontario.ca by July 6, 2018.

Please ensure that the submitted written plan does not contain any Personal Information and/or Personal Health Information.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one Registered Dietitian (RD) for the home.

Through a record review by Inspector #609 and Inspector #627, resident #006, #004, #005 and #015 were identified as having had a significant weight change.

Please see WN #2 and #3 for details.

Inspector #627 completed separate interviews with Registered Nurse (RN) #103 and Registered Practical Nurse (RPN) #109. They informed the Inspector that they no longer had a RD working in the home. They stated that any weight concerns for the residents were addressed by the DM.

Inspector #627 interviewed the DM who stated that the home had been without a RD since August 2017. They stated that they had been told by the Admin/DOC that the duties of the Registered Dietitian were added to their role at that time. They further stated that they remained on a 26 hour per week schedule, which was the legislative requirements for the number of residents in the home in their role as DM. They acknowledged that they were not a Registered Dietitian and had not had the knowledge or time required to initiate nutritional interventions for residents. They stated that the additional work required took over 10 hours per week and that they hadn't had the time.

Inspector #627 interviewed the Admin/DOC, who stated that they had been without a RD since August 2017. They stated that they had posted the position last year in the newspaper, and it was currently posted in the" Kirkland Lake Job Bank". They stated that the Board of Management was aware of the legislative requirements to maintain a RD in the home.

Inspector #627 reviewed an email, dated May 31, 2018, forwarded by the Human Resources (HR) Manager for the Town of Kirkland Lake. The email indicated that the only active job posting was for a Dietary Aide, which was published in December 2017. The HR Manager further indicated in the email that the Corporation (the licensee) and the Kirkland and District Hospital (the long-term care home and the hospital) shared a RD and therefore, there was a RD working in the home.

Inspector #609 interviewed the Office Manager who stated that the home had employed a RD on a part time basis until August 2017, however they were no longer employed in the home.

The decision to issue this compliance order was based on the scope which was widespread and the risk level which was determined to be actual harm. Although there was no compliance history related to this section of the legislation, the severity and scope of the non-compliance has the potential to

cause negative impacts on all residents in the home. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 13, 2018

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. 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
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee must be compliant with Ontario Regulation (O.Reg.) 79/10, section 26 (4).

1) Upon recruitment of a Registered Dietitian, a nutritional assessment shall be completed by the Registered Dietitian, for resident #005 and resident #015, and all other residents who were admitted to the home on or after August 2017, and who were not assessed by a Registered Dietitian upon admission.
2) A record shall be kept of all the residents who have had a nutritional assessment completed by the Registered Dietitian.

Grounds / Motifs :

1. Resident #015 was identified as having had a significant weight change from their previous to most recent minimum data set (MDS) assessment. Please see WN #3 for details.

Inspector #627 completed a record review of resident #015's electronic records and noted that resident #015's "Admission Oral/Nutritional Status" assessment had been completed by the DM.

Inspector #627 interviewed the DM, who stated that they completed the residents' initial "Admission Oral/Nutritional Status" assessment as the home no longer had a RD. The DM acknowledged that they were not a RD.

Inspector #627 interviewed the Admin/DOC, who stated that the DM completed

the initial "Admission Oral/Nutritional Status" assessment for residents admitted to the home, with the input of the RNs and the Nurse Practitioner (NP).

(627)

2. The licensee has failed to ensure that a RD who was a member of the staff of the home, completed a nutritional assessment for the resident on admission and whenever there was a significant change in a residents' health condition.

Through a record review, Inspector #609 identified two residents as having a significant weight change; Resident #004 had a change of greater than 10 per cent of body weight over six months; and resident #005 had a change of greater than 5 per cent of body weight over one month.

During an interview with the Admin/DOC, they indicated that the RD was supposed to complete a “Nutritional Risk Identification” assessment on residents of the home.

A review of the home’s "Nutritional Risk Identification" assessment indicated the RD was required to complete the assessment on admission and whenever risk indicators changed, which included weight changes as significant as those cited for resident #004 and #005.

a) A review of the health care records for resident #004 and #005, found that no corresponding nutritional assessments for the significant weight changes were completed by the RD.

b) A further review of the health care records for resident #004 and #005, found that resident #005 had no admission nutritional assessment completed by a RD.

Inspector #609 interviewed the Admin\DOC who verified that a RD was to complete a "Nutritional Risk Identification" assessment upon a resident's admission and whenever a resident had a risk indicator change. In a subsequent interview with Inspector #627, the Admin/DOC stated that they had been without a RD since August 2017.

The decision to issue this compliance order was based on the scope which was widespread and the risk level which was determined to be actual harm. Although there was no compliance history related to this section of the

legislation, the severity and scope of the non-compliance has the potential to cause negative impacts on all residents admitted in the home since August 2017. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 27, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Sylvie Byrnes

Service Area Office / Bureau régional de services : Sudbury Service Area Office