Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 13, 2015	2015_286547_0005	O-001646-15	Resident Quality Inspection

Licensee/Titulaire de permis

ROYAL OTTAWA HEALTH CARE GROUP
1141 Carling Avenue OTTAWA ON K1Z 7K4

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

ROYAL OTTAWA PLACE
1145 CARLING AVENUE OTTAWA ON K1Z 7K4

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

LISA KLUKE (547), AMANDA NIXON (148), ANGELE ALBERT-RITCHIE (545)

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): February 23,24,25,26,27 and March 2,3,4,5, 2015

The following inspections were also conducted during the Resident Quality Inspection: Log #'s O-002568-15, O-002550-15 and O-001546-15.

During the course of the inspection, the inspector(s) spoke with several Residents, Families, the President of Resident's Council, the President of Family Council, the home's Acting Administrator, the Director of Care, the Environmental Services Manager/Food Services Manager, the Environmental Services Manager Assistant, the Maintenance-Building Operator, a RAI-MDS Coordinator, the Dietician, the Manager of Resident and Family Services and Recreation, the office Coordinator, Registered and Non-Registered Nursing staff (RN, RPN, PCA, DSW, PSW), Food Service Workers, Housekeeping Aides and the Infection Control Program Coordinator(ICP)

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
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)
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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home must be, kept closed and locked, equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system or is connected to an audio visual enunciator that is connected to the nurses station nearest to the door and has a manual reset switch at each door.

The building of the Royal Ottawa Place includes three floors, of which the 2nd and 3rd

floor resides the long term care beds, each with one nursing station. In addition to the 2nd and 3rd floor the long-term care home includes a lobby area whereby the main entrance and exit to the building exists along with a library space used by resident of the long-term care home. On the 1st floor of the building is a hospital unit, described as the Recovery Unit. Inspector #148 confirmed with the DOC, that the Recovery Unit is not a part of the long-term care home nor is the space of this unit accessed by residents. The Recovery Unit is described as outside of the long-term care home.

On March 2, 2015, Inspector #148, in the company of the Building Operator who is familiar with the door access control systems used by the home, reviewed the safety and security of the doors in the building. Within the lobby space there is a door leading to the outside; it was observed to be the main entrance and exit of the home used by long term care residents. In addition, there is door to a stairwell known as Stairwell Door A. Both doors are kept closed and locked, are equipped with a door access control system and an audible door alarm that allows calls to be cancelled only at the point of activation. However, the door alarm for both doors is connected to an enunciator at the Recovery Unit nursing station and is not connected to either of the two nursing stations of the long-term care home.

Within the lobby space there is a set of double doors that lead to the Recovery Unit; these doors were observed to be closed and unlocked during the time of the inspection. The double doors are equipped with a door access control system; however, the door is not equipped with an audible door alarm. The Building Operator reported that the doors may be locked at night, using the door access control system. The double doors leading to the Recovery Unit are closed, but not locked at all times and do not elicit an audible door alarm.

Within the lobby space there is a door leading to a stairwell that leads to the basement which is not a resident accessed area but rather is an area for building utilities. This door is kept closed and locked, is equipped with a door access control system; however, the door is not equipped with an audible door alarm.

Four doors were identified within the long-term care home that did not meet the requirements of section 9 of the Regulations. On March 2, 2015, the Building Operator indicated that a service company had been contacted to review possible solutions. [s. 9. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, annually.

In accordance with LTCHA 2007, s.76 (1), (2) and (4) and O.Reg 79/10, s. 219(1), all staff at the home shall receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and annually thereafter.

Seven staff members were interviewed related to the provision of training on the home's policy to promote zero tolerance of abuse and neglect. The staff members were not able to identify when they were last provided with such training. Upon request, the home's Director of Care could not demonstrate that four of the seven staff, including Staff #110, #117, #132, Staff #114 had completed training on the home's policy to promote zero tolerance of abuse and neglect of residents within the last year. Staff #110, #117, #132 were last provided training on the policy in June/July 2013. Staff #114, has not had any recorded training on the home's policy.

2. The licensee has failed to ensure that additional training to all staff who provide direct care to residents, specifically but not limited to: Skin and wound care, and Continence care and Bowel management , is received annually.

In accordance with LTCHA 2007, s.76 (7) 6 and O.Reg 79/10, s. 221.(2) 1 , all staff who provide direct care to residents shall receive , as a condition of continuing to have contact with residents, annual training specifically but not limited to: skin and wound care, and continence care and bowel management as indicated in O.Reg 79/10, s. 221.(1).

Related to Continence care and Bowel management:

On March 5, 2015 the Acting Administrator provided Inspector #545 with the home's training information for 2014. In reviewing the 2014 In-Service Attendance Records Binder, it was noted by Inspector#545 and the Acting Administrator that one of the six required areas in which training is required as per legislation was provided in 2014: the Bladder and Bowel Incontinence Care. The Bladder and Bowel Incontinence Care training Education Sign-in Sheets provided in June and July 2014 show that 15% (7 out of 48) direct care staff received this training.

Related to Skin and Wound care:

The following registered staff were interviewed on March 5, 2015 by Inspector #545 and indicated that they had not received skin and wound training in 2014:

-Staff#102: indicated he/she last received training in 2005
-Staff #133: indicated he/she was hired in 2005, and never received skin & wound training
-Staff# 114: indicated he/she was hired in 2007, and never received skin & wound training
-Staff# 103: indicated he/she was hired in 2004, and could not remember received skin & wound training
-Staff# 131: indicated he/she was an Agency nurse, started in February 2015, and was not provided any skin & wound training

Inspector #545 noted during an interview with the Acting Administrator on March 5, 2015, that she indicated that the home does not assess the individual training needs of the staff members. She indicated that the home did not provide any skin & wound training in 2014; The Acting Administrator further indicated that the last skin & wound training provided to any direct care staff was on August 6, 2008.

An attendance record was reviewed from this training date and seven registered staff, including the Acting Administrator and Director of Care were in attendance. The Acting Administrator indicated that out of the seven staff that attended, only four are employed in the home at this time.

The Long-Term Care Home's Act 2007 and O.Reg 79/10 came into effect July, 2010 however the home's program and training has not been revised to reflect this legislation or offered to staff as required by this section. [s. 76.]

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 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

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

Inspector #547 conducted an observation of a medication pass on the second floor and noted that once the medication was dispensed to the resident,that Staff #102 placed the medication packaging containing the resident's name, room number, and name and dose of the medication into the garbage container located on the medication cart. Staff #102

indicated that the garbage from medication cart is placed in a large garbage bag for housekeeping. Staff #102 indicated that if medication bottles were empty, they would place them in the medication destruction bins in the medication room. If bottles or medication packets did not fit, then these containers were emptied into the medication destruction bin, and the packaging would be placed in the regular garbage. Staff #102 has worked in the home for over ten years, and indicated that this has always been the process in the home.

On March 2, 2015 Inspector #545 observed Staff #114 throw the original package of the administered medication into the garbage container attached to the Medication Cart. Inspector #545 then interviewed Staff #114 and asked what was done with the garbage bag once full, he/she indicated that the Housekeeper may take it and through it away in the Soiled Utility Rooms with the other garbage, or he/she would do it later. Staff #114 indicated that he/she was not aware that he/she should be protecting the privacy of the Residents in relation to the original package of medications that has the resident name, medication, dosage, date and time. Staff #114 indicated he/she has been working at the home since 2007 and has always discarded the used original medication package in the regular garbage with other garbage.

It was further noted during the Resident Quality Inspection by Inspectors #148, #545 and #547 that the Medication Administration Records binders on both nursing units, were left on the top of the unit's medication carts, that were stored outside the nursing station in the resident care hallways, accessible to anyone walking in these hallways. On March 2, 2015, Inspector #547 observed Resident #005 standing next to the second floor medication cart, moving the medication administration binder off the shelf and return it to the shelf three times before walking away. Resident #005 did not open the binder, however had access to it.

Inspector #547 interviewed the Director of Care who indicated that the disposal of packaging or labels of resident medications would be exposing the resident's personal health information via the main garbage of the home, and understands how this is a problem. The Director of Care further indicated that the home's expectations with the Medication Administration Record binders, is that they should be stored inside the locked medication room or the locked nursing station when not in use by any Registered Nursing staff. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that destroying medication packaging/labels to protect the residents personal health information that it is required to be kept confidential in accordance with that Act., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were not clean and sanitary.
During the RQI inspection, the following issues related to housekeeping was observed on the second and third floors:
On February 24, 25 and 26, 2015 Inspector #545 observed the following:

-Black scuff marks along the baseboards with dust and debris in several resident rooms on the second and third floors.
-The wall across from the window in a resident's room on the third floor-South was noted to be soiled with brown dried matter which Resident #025 indicated to Inspector #545, that the stains came from a cola and that it had been there for a long time.
-The wall across from the window in a Resident's room on the third floor-North was also covered with brownish dried matter.
-Spa rooms on the North side had a cupboard that had two drawers that were noted to

be soiled with dust and debris, and sticky yellow/brown matter to the base of both drawers in both the tub room and shower room of this spa area containing an unlabelled hair brush, disposable razor and folded briefs.
- The Spruce Street Lounge on the third floor had two sticky red areas and several brownish areas on the floor in front of both sofas noted on the 24,25 and 26th of February 2015. The wall beside the wooden cupboard in this same space was observed to have several pencil marks drawn in the shape of hearts, approximately 20 to 25cm in diameter noted on each of these days.
- Daily from February 24, 2015 to March 2, 2015, Inspector #545 observed a large amount of dust and debris in the corners of the recessed door frames of all Resident rooms on the third floor.

On February 23, 24 and 25, 2015 six out of 40 Residents reported to Inspectors #148, #545 and #547 that the home was dusty, the floors were often dirty and the baseboards were never cleaned.

Inspector #545 interviewed Staff #118 on February 26, 2015 and indicated that the floors in the Lounges were swept and washed daily, and stated it was sometimes difficult to do when the residents were in the rooms. Black scuff marks on the baseboards were not his/her responsibility, that the Environmental Services Manager assigns those tasks as a special project as it was not part of the daily cleaning schedule.

On March 3, 2015, Inspector #545, accompanied by the Environmental Services Manager and the Environmental Services Manager Assistant, observed the common area Lounge (South) on the third floor, a residents Room on the third floor-South and the baseboards in the hallways.
The Environmental Services Manager indicated that it was the responsibility of the housekeeping staff to sweep and mop the floors daily, added that the two sticky red areas and several brownish areas on the floor observed on the floor should have been cleaned. The Environmental Services Manager further stated that staff were also expected to spot clean walls and baseboards as part of daily routine including removing dust and debris in the corners of the recessed door frames of all Resident's rooms. The Environmental Services Manager Assistant indicated that the black scuff marks on the baseboards were cleaned as part of special project and cleaned yearly and she would look into completing this more often as needed. [s. 15. (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 the home, furnishings and equipment are to be kept clean and sanitary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Skin & Wound program provide for assessment and reassessment instruments.

For Resident #011:

On a specified date in February and March, 2015, Inspector #545 observed altered skin integrity on Resident #011 approximately 5cm in diameter, red, slightly inflamed with several darkened red smaller elevated areas within the large area.
Inspector #545 conducted a record review for Resident #011 and noted most recent Pressure Ulcer Risk Score was 4 out of 8, indicating a high risk for developing a pressure ulcer. When Resident #011 was admitted to the home, the Resident was noted to have a lesion with no specific diagnosis. The admission notes had no skin assessment for the altered skin integrity completed.

On February 26, 2015, a progress note indicated that a Stage 1 Pressure Ulcer for Resident #011 was observed during care.

On March 3, 2015, Inspector #545 interviewed Staff #125 and verified Resident #011's health records and confirmed that a skin assessment was not completed for the altered skin integrity for either of these areas and added that the home did not use a clinically appropriate Skin Assessment Tool as the home did not have one.

For Resident #016:

Inspector #545 reviewed the most recent RAI-MDS 2.0 assessment for Resident #016, who required extensive assistance with dressing, toilet use, personal hygiene and bathing, has multiple episodes of bladder and bowel incontinence and wears briefs.

The progress notes for Resident #016 regarding skin and wound were reviewed by Inspector#545 and noted the following:

- on a specified date in January,2015 - skin breakdown in the crease of his/her buttocks and zinc cream was recommended, day nurse notified
- on a specified date in February, 2015(9 days later) - Resident's buttock was "very red and very close to skin break down" and that zinc cream was again applied during morning care, day nurse notified
- on a specified date in February, 2015(14 days later) - skin breakdown in the lower coccyx area was red and cream was applied
- on a specified date in February, 2015 - dressing applied to both buttocks
- on a specified date in February, 2015 - "Second degree ulcer on left lower buttock, cleaned with normal saline and covered with Mepilex, skin redness on right buttock"
- on a specified date in February, 2015 - Stage 2 open area measuring 2cm on left inner buttock and a second area starting to open and dressing applied as recommended by RN
- on a specified date in February, 2015 - Pressure Ulcer measuring 1.5cm by 1.5cm, wound base is red, no drainage, no tunnelling, periwound is pink. Area was cleansed with normal saline, mepilex was applied
- on a specified date in March, 2015 - Stage 2 Pressure Ulcer to right buttock, measuring 0.5cm, no drainage, no foul odour, area cleanse and zinc applied.

On March 5, 2015 Inspector #545 interviewed Staff #114 who indicated that he/she first assessed Resident#016's buttock last week with Staff #131. He/She confirmed that the Resident had a stage 2 pressure ulcer to the left buttock. Staff #131 indicated that he/she was asked to assess the wound on a specified date in February, 2015 and confirmed that Resident #016 had a Stage 2 Pressure Ulcer to the left buttock, and that the right buttock

was reddened.

Both staff members indicated that they did not assess the altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, because the home did not have one.

On March 4, 2015, the Director of Care provided Inspector #545 with the home's Skin & Wound Program, titled: Skin & Wound Care Management policy #312b.01, dated May 2005 and it was reviewed with the Director of Care and Acting Administrator. Under the section Procedure on page 2, in step 1, it was documented that "a Skin Integrity Risk Assessment (Body Diagram) shall be completed on admission, with any change in a resident's overall medical condition and upon return from an admission to hospital".

Inspector #545 interviewed the Director of Care and the Acting Administrator on March 4 and 5, 2015, the Acting Administrator indicated that the home does not have a Skin Integrity Risk Assessment instrument; added that a body diagram document is what registered nursing staff use that has no assessment elements. The Acting Administrator further indicated that the home has purchased from Specialty Care, a Skin & Wound Management Protocol – Guideline. The Director of Care stated that the policy was approved on February 19, 2014. The implementation date on this policy reviewed by the Inspector was: February 19, 2014. The Acting Administrator indicated that this policy, which includes a Skin & Wound - Weekly Skin Surveillance Tool and Worksheet had not yet been implemented in the home. [s. 48. (2) (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 ensure that the Skin & Wound program provide an assessment and reassessment instruments using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident body mass index and height upon admission and annually thereafter.

During the health care record review conducted at Stage 1 of this inspection, it was noted by the inspection team that not all residents had a recorded annual height.

Inspector #148 reviewed 10 residents from the random sample and it was demonstrated that Residents #001, #002, #003, #006, #019, #021, #022 and #025 had a last recorded height on a specified date in 2012. In addition, Resident #016 and #024 had a last recorded heights on specified dates in 2013.

Inspector #148 spoke with regular staff members, Staff #117 and Staff #105, who indicated that heights are taken on admission and if needed after that. Neither staff could speak to the occurrence of measuring and recording heights for each resident annually. [s. 68. (2) (e) (ii)]

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 ensure that height is measured and recorded, for each resident, upon admission and annually thereafter, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Inspector #545 reviewed the home's Housekeeping ROHCG LTCH: Odour Control procedure which indicated to clean area prior to proceeding with treatment, dilute Vert-2 Go into the mop bucket and apply solution on the area, then mop the area and place wet sign.

A lingering offensive odour was noted by Inspector #545 daily during this inspection in a Resident's room and bathroom on the third floor-South and in the common washroom on the main floor by the Chapel.

On March 2, 2015, Inspector #545 and Staff #110 noted an offensive lingering odour in a Resident's room on the third floor-South and indicated that it was difficult to get rid of the odour. Staff #110 pulled the Resident's bed away from the wall in this room and observed along the base of the wall behind the bed that dark yellow/brownish dried matter was observed as well as one large area near the head of bed which was sticky when the Inspector #545 walked on it. Staff #110 indicated that Resident#006 used a voiding device and that it might have been dropped on the floor. Staff #110 indicated that this room was deep cleaned weekly and was last cleaned on a specified date in February, 2015.

On March 3, 2015, Inspector #545, the Environmental Services Manager and the Environmental Services Manager Assistant observed this residents room on the third floor-South after it was cleaned with Vert-2-Go and the common washroom on the main floor by the chapel. The Environmental Services Manager and the Environmental Services Manager Assistant indicated that a lingering offensive odour remained present. The Environmental Services Manager Assistant indicated that she was aware of the odour in the common washroom, as it had been reported on February 27, 2015. In reviewing a work order, the work order was issued on March 3, 2015.
The Environmental Services Manager indicated that other than applying Vert-2-Go odour control directly to the problem area, no other procedure was developed and implemented to address incidents of lingering offensive odours and that the home was presently in the process of researching other products. [s. 87. (2) (d)]

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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure as per O.Reg.79/10 s.129.(1)(a)(ii). that drugs are stored in an area or a medication cart that is secure and locked.

On February 24, 2015 Inspector #547 arrived to the second floor nursing station and noted a locked medication cart was located outside the nursing station, unattended by any registered nursing staff. On top of this medication cart a bottle of prescribed liquid medication labelled for a resident on this unit that was not locked up or out of access to anyone on this unit while Resident #008 was seated next to this medication cart in a wheelchair. [s. 129. (1) (a)]

2. On March 2, 2015 Inspector #545 observed the medication cart on the third floor to be unlocked and unattended, in the North Side corridor in front of the Dining Room windows. Staff #114 had his/her back to the medication cart while administering medications to a Resident in the dining room. During this time, Inspector #545 was able to open the medication cart. Inspector #545 remained beside the unlocked/unattended medication cart until Staff #114 returned three minutes later.

Inspector #545 interviewed Staff #114 who indicated that this medication cart should have been locked as he/she was unable to see the cart while administering medications in the dining room. [s. 129. (1) (a)]

3. The licensee has failed to ensure as per O.Reg 129.(1)(a)(i). that drugs are stored in a medication cart that is used exclusively for drugs and drug related supplies.

On March 3, 2015 Inspector #547 observed a paper cup of coins stored inside Resident #020's medication drawer of the second floor medication cart. It was further noted in the bottom drawer of this same medication cart, two containers for prescription glasses also for Resident #020 and Resident #026.

On March 3, 2015 Inspector #547 interviewed Staff #102 who indicated that they have always stored resident's prescription glasses in the medication carts for certain residents to prevent them from being lost. The evening Registered Staff are to collect the glasses from these residents at bedtime and store them inside the medication cart, and the day shift registered staff provide them to the residents during the medication pass. Staff #102 indicated that he/she was not aware that personal items should not be stored inside the medication carts.

On March 4, 2015, Inspector #547 interviewed the Director of Care who indicated that money, resident glasses, or any other personal items that are not medication related should not be stored in the medication carts. [s. 129. (1) (a)]

4. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On March 3, 2015 Inspector #547 noted that the home's narcotic book on the second floor included a fridge stock count for an injectable medication, a controlled substance, which was stored in the unlocked fridge in the locked medication room.

Inspector #547 interviewed Staff #102 who indicated that the home has always counted this medication and signed for it, but it has always been kept in the unlocked fridge of the medication room, as they were not aware it required to be double locked. Staff #102 further indicated that daily dispensed benzodiazepines for residents in the home are dispensed in the individual dispense packages located in the unlocked medication drawers of the locked medication cart.

On March 4, 2015 Inspector #547 observed the following:
Resident #004 had orders for three different benzodiazepine medications, which are controlled substances, located in the daily dispense packages from the pharmacy located inside the medication drawer of the locked medication cart for this resident.
Resident #029 had an order for a benzodiazepine medication, a controlled substance, located in the daily dispense packages from the pharmacy located inside the medication drawer of the locked medication cart for this resident.
Resident #018 had orders for a benzodiazepine medication, a controlled substance, located in the daily dispense packages from the pharmacy located inside the medication drawer of the locked medication cart for this resident.

These controlled substances were not stored in a separate locked area within the locked medication cart.

On March 4, 2015 Inspector #547 interviewed the Director of Care and the Acting Administrator who indicated that they were not aware of Benzodiazepines required to be kept double locked. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked as well as to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #9: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that there is in place a hand hygiene program in accordance with evidence-based practices and with access to point-of-care hand hygiene agents.

During the initial tour of the home on February 23, 2015, it was observed that hand hygiene agents are not accessible at point of care locations within resident bedrooms. Inspector #148 spoke with staff members who provide direct care to residents, the home's Director of Care and the Infection Control Program Coordinator. It was confirmed that hand hygiene agents are provided in dispensers in the corridors and on some carts used by staff and that staff are not provided hand hygiene agents to carry.

On February 27, 2015, after Inspector spoke with the home's Director of Care, the home implemented a hand hygiene carry system. [s. 229. (9)]

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 ensure that a hand hygiene program with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #10: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 to make mandatory reports.

As identified by the home's Director of Care, the policy titled Zero Tolerance of Resident Abuse & Neglect (June 2013) is the home's policy as required by section 20 of the Act.

Upon review, it was determined that the policy does not contain an explanation of the duty under section 24 to make mandatory reports. LTCHA 2007, s.24 indicates that a person who has reasonable ground to suspect that abuse of a resident by anyone or neglect by staff member has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. The home's policy uses similar language to indicate that the immediate report and information upon which it is based will be reported to the resident and/or substitute decision maker. Within the procedures, the policy indicates that the Director of Care/delegate is expected to report to the Director all incidents of suspected or witnessed abuse of a resident by telephone and by the Critical Incident System. Within the Appendix 1 Activity List, the policy indicates that the Administrator/delegate will immediately upon notification, notify the Director in accordance with protocols established for reporting of abuse and critical incidents.

The policy does not provide for an explanation that a person who has reasonable grounds to suspect abuse or neglect of a resident has or may occur shall immediately report the suspicion to the Director. [s. 20. (2)]

WN #11: 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 :

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the observations conducted at Stage 1 of this inspection the following personal items were observed unlabelled in resident bedrooms by Inspector #545:

In an identified shared resident bathroom: 1 jar of used Vaseline, 1 jar of used Infazinc 15%, 2 toothbrushes, 2 hair combs, 1 used roll-on deodorant and 1 nail brush;
In an identified private resident bathroom: 1 toothbrush, 2 roll-on deodorant, 1 stick deodorant;
In an identified private resident bathroom: 1 toothbrush, 2 hair combs, 1 hair brush, 1 denture cup;
In an identified private resident bathroom: 1 hair comb, 1 bar of soap on sink (not in a container);
In an identified private resident bathroom: 1 hair brush, 1 toothbrush.

During the observations conducted at Stage 1 of this inspection the following personal items were observed unlabelled in resident bedrooms by Inspector #148:

In an identified shared resident bathroom: 1 disposable razor, 1 toothbrush, 1 hairbrush;
In an identified shared resident bathroom: 2 toothbrushes, 1 toothbrush, 1 hair brush.
In an identified private resident bathroom: 1 toothbrush;
In an identified private resident bathroom: 2 toothbrushes, 1 comb, 1 hair brush, 1 wet disposable razor, 1 used roll on deodorant, 1 lip chap;
In an identified shared resident bathroom: 1 disposable razor, 1 toothbrush, 1 hairbrush;
In an identified shared resident bathroom: 2 toothbrushes, 1 toothbrush, 1 hair brush.

In addition, items that were observed to be labelled using a typed stick on label were noted on occasion to be worn to the point that the name was no longer legible.

Inspector #148, spoke to staff on both the 2nd and 3rd floors regarding labelling of personal items. Registered staff indicated that labelling was the responsibility of the PSWs on the floor. PSWs indicated that there is a binder with a supply of typed stick on labels for each resident for use of labelling personal products, such as toothbrushes, hairbrushes and razors, both on admission and when new items are acquired. In the

case of dentures, glasses and hearing aids neither registered staff nor PSWs could identify a method by which such items are labelled.

Inspector #148 observed the dentures of Resident #010 and #011, while stored in containers on the counter in the resident bathroom. Both dentures were observed to be unlabelled. In addition, two sets of glasses for Resident #020 and #026 were not observed to have labels.

The home does not have a process in place that ensures that all personal items are labelled.

WN #12: 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 :

The licensee failed to ensure that 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.

The health care record of Resident #015 indicates that the resident is co-morbidities that may impact on continence status and the resident requires limited assistance with toileting. Staff #110, indicated that the resident is on a toileting plan whereby the resident is assisted by staff for toileting and peri care and that the resident is occasionally incontinent of both bowel and bladder.

At the time of admittance to the home, Resident #015 was continent of bowel and occasionally incontinent of bladder. Three months after the Resident's admission, the Minimum Data Set (MDS) Assessment indicated that the Resident had become fully incontinent of both bowel and bladder, whereby the continence status had deteriorated over the last three months. The following MDS assessment indicated the Resident was occasionally incontinent of bowel and frequently incontinent of bladder.

A review of the progress notes indicates that changes in continence status began to exhibit in within the first month after admission to the home, whereby the Resident was found to be incontinent of bowel and required care. The admission care conference did not speak to the bowel incontinence and notes that the Resident is incontinent of urine requiring incontinent products.

Inspector #148 spoke to Staff #133 who indicated that the MDS assessment is used as a tool to assess continence but it is only to assess the last 7 days (observation period). He/She is not aware of any tool used in the home to assess changes in incontinence outside of the MDS timeframes. Inspector #148 spoke to three RPNs, one RN and the home's Director of Care, who could not identify any tool in the home that is used to assess incontinence. Resident #015's continence status declined and a continence assessment was not completed at the time when continence care needs changed, with a tool specifically designed for continence assessment to determined causal factors, patterns, type of incontinence and potential to restore function.

WN #13: 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,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle includes alternative choices of entrees, vegetables and desserts at lunch and dinner.

Inspector #148 conducted a review of the three week menu cycle indicates that the planned puree texture modified menu does not provide for an alternate choice of vegetable at each lunch. This is exampled by the following:
Week 1: Monday ,Tuesday and Friday lunch plans for puree mixed vegetable, no alternative choice is planned.
Week 2: Thursday lunch plans for puree mixed vegetable, no alternative choice is planned
Week 3: Saturday lunch plans for puree mixed vegetable, no alternative choice is planned.

A review of the three week menu cycle indicates that the planned puree texture modified menu does not provide for an alternate choice of entree at each lunch and dinner. This is exampled by the following:
Week 2: Wednesday plans for meat sauce and pasta or alternate of lasagna
Week 3: Thursday plans for macaroni and cheese or alternate of lasagna [s. 71. (1) (c)]

2. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

The planned menu items for the puree texture modified menu at lunch on March 2, 2015, included a puree beef sandwich as the alternate choice. The prepared items did not include a puree beef sandwich but rather the puree chicken as the first choice and the puree chicken sandwich as the alternative choice. Whereby, the prepared puree texture modified menu for the lunch service did not provide for choice of entree. [s. 71. (4)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the communication of the seven-day and daily menus to residents.

In accordance with section 71(1) of the Regulations, the home's menu includes menus for regular, therapeutic and texture modified diets.

The home implements a regular menu, in addition to a minced texture modified menu, a puree texture modified menu and a modified diabetic menu to residents. The regular, minced and diabetic menus are similar, however, the puree menu varied from the regular menu. As discussed with the home's Registered Dietitian and Nutritional Manager, the seven-day and daily menus are communicated to residents by posting the menu in each dining location. It was observed that within each dining location the regular weekly and regular daily menus were posted. At this time the home does not have a method in place to communicate all menus, including the puree menu, to residents. [s. 73. (1) 1.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location.

In accordance with LTCHA 2007, s.79 (1) and (3), required information including the home's policy to promote zero tolerance of abuse and neglect of residents and notification of the long term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained, is to be posted in the home.
Upon initial tour of the home, the home's policy to promote zero tolerance of abuse and neglect of residents could not be found posted in the home. Inspector #148 inquired with the home's Director of Care and Manager of Resident and Family Services, whereby it was determined that the home's policy to promote zero tolerance of abuse and neglect of residents is accessible on the 3rd floor near the office of the Manager of Resident and Family Services. The policy is held within a stapled package of documents titled "Resident and Family Handbook". Upon further review of the home's required postings with the Director of Care and Office Coordinator, it was determined that notification of the home's policy to minimize the restraining of residents and how to obtain a copy of this policy was also contained within the handbook. Both policies are not posted in a conspicuous location where they are easily seen or noticed.

After discussion with the home's Director of Care related to the posting of required information in a conspicuous and easily accessible location, the home's policy to promote zero tolerance of abuse and neglect of residents was posted on each resident floor and near the administration offices. In addition, the policy to minimize the restraining of residents was also posted near the administration offices. [s. 79. (1)]

Issued on this 16th day of March, 2015

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

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) :	LISA KLUKE (547), AMANDA NIXON (148), ANGELE ALBERT-RITCHIE (545)
Inspection No. / No de l'inspection :	2015_286547_0005
Log No. / Registre no:	O-001646-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 13, 2015
Licensee / Titulaire de permis :	ROYAL OTTAWA HEALTH CARE GROUP 1141 Carling Avenue, OTTAWA, ON, K1Z-7K4
LTC Home / Foyer de SLD :	ROYAL OTTAWA PLACE 1145 CARLING AVENUE, OTTAWA, ON, K1Z-7K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KAREN DALEY

To ROYAL OTTAWA HEALTH CARE GROUP, 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. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee will ensure that:

1. All resident accessible doors that lead to the stairways and doors that lead to the outside of the home, and kept closed and locked, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, A. is connected to the resident-staff communication and response system, or B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
2. A plan is developed and implemented to ensure resident safety until such time when compliance with section 9 of the Act is achieved.

Grounds / Motifs :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home must be, kept closed and locked, equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system or is connected to an audio visual enunciator that is connected to the nurses station nearest to the door and has a manual reset switch at each door.

The building of the Royal Ottawa Place includes three floors, of which the 2nd and 3rd floor resides the long term care beds, each with one nursing station. In addition to the 2nd and 3rd floor the long-term care home includes a lobby area whereby the main entrance and exit to the building exists along with a library space used by resident of the long-term care home. On the 1st floor of the building is a hospital unit, described as the Recovery Unit. Inspector #148 confirmed with the DOC, that the Recovery Unit is not a part of the long-term care home nor is the space of this unit accessed by residents. The Recovery Unit is described as outside of the long-term care home.

On March 2, 2015, Inspector #148, in the company of the Building Operator who is familiar with the door access control systems used by the home, reviewed the safety and security of the doors in the building. Within the lobby space there is a door leading to the outside; it was observed to be the main entrance and exit of the home used by long term care residents. In addition, there is door to a stairwell known as Stairwell Door A. Both doors are kept closed and locked, are equipped with a door access control system and an audible door alarm that allows calls to be cancelled only at the point of activation. However, the door alarm for both doors is connected to an enunciator at the Recovery Unit nursing

station and is not connected to either of the two nursing stations of the long-term care home.

Within the lobby space there is a set of double doors that lead to the Recovery Unit; these doors were observed to be closed and unlocked during the time of the inspection. The double doors are equipped with a door access control system; however, the door is not equipped with an audible door alarm. The Building Operator reported that the doors may be locked at night, using the door access control system. The double doors leading to the Recovery Unit are closed, but not locked at all times and do not elicit an audible door alarm.

Within the lobby space there is a door leading to a stairwell that leads to the basement which is not a resident accessed area but rather is an area for building utilities. This door is kept closed and locked, is equipped with a door access control system; however, the door is not equipped with an audible door alarm.

Four doors were identified within the long-term care home that did not meet the requirements of section 9 of the Regulations. On March 2, 2015, the Building Operator indicated that a service company had been contacted to review possible solutions.

(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Order / Ordre :

The licensee of a long-term care home shall ensure that all staff at the home including those working in the home pursuant to a contract/agreement, receive training as required by this section specifically but not limited to the following areas:

-All staff at the home shall receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and annually thereafter.

- All staff who provide direct care to residents shall receive training on skin and wound care, prior to performing their responsibilities and annually thereafter.

-All staff who provide direct care to residents shall receive training on continence care and bowel management, prior to performing their responsibilities and annually thereafter.

-The home shall develop an annual schedule to ensure retraining and ongoing training is provided to staff and recorded.

Grounds / Motifs :

1. 1. The licensee failed to ensure that all staff at the home receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, annually.

In accordance with LTCHA 2007, s.76 (1), (2) and (4) and O.Reg 79/10, s. 219(1), all staff at the home shall receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and annually thereafter.

Seven staff members were interviewed related to the provision of training on the home's policy to promote zero tolerance of abuse and neglect. The staff members were not able to identify when they were last provided with such training. Upon request, the home's Director of Care could not demonstrate that four of the seven staff, including Staff #110, #117, #132, #114 had completed training on the home's policy to promote zero tolerance of abuse and neglect of residents within the last year. Staff #110, #117, #132 were last provided training on the policy in June/July 2013. Staff #114, has not had any recorded training on the home's policy.

2. The licensee has failed to ensure that additional training to all staff who provide direct care to residents, specifically but not limited to: Skin and wound care, and Continence care and Bowel management , is received annually.

In accordance with LTCHA 2007, s.76 (7) 6 and O.Reg 79/10, s. 221.(2) 1 , all staff who provide direct care to residents shall receive , as a condition of continuing to have contact with residents, annual training specifically but not limited to: skin and wound care, and continence care and bowel management as indicated in O.Reg 79/10, s. 221.(1).

Related to Continence care and Bowel management:

On March 5, 2015 the Administrator provided Inspector #545 with the home's training information for 2014.

In reviewing the 2014 In-Service Attendance Records Binder, it was noted by Inspector#545 and the Administrator that one of the six required areas in which training is required as per legislation was provided in 2014: the Bladder and Bowel Incontinence Care. The Bladder and Bowel Incontinence Care training Education Sign-in Sheets provided in June and July 2014 show that 15% (7 out of 48) direct care staff received this training.

Related to Skin and Wound care:

The following registered staff were interviewed on March 5, 2015 by Inspector #545 and indicated that they had not received skin and wound training in 2014:

-Staff#102: indicated he/she last received training in 2005
-Staff #133: indicated he/she was hired in 2005, and never received skin &

wound training
-Staff# 114: indicated he/she was hired in 2007, and never received skin & wound training
-Staff# 103: indicated he/she was hired in 2004, and could not remember received skin & wound training
-Staff# 131: indicated he/she was an Agency nurse, started in February 2015, and was not provided any skin & wound training
Inspector #545 noted during an interview with the Administrator on March 5, 2015, that she indicated that the home does not assess the individual training needs of the staff members. She indicated that the home did not provide any skin & wound training in 2014; The Administrator further indicated that the last skin & wound training provided to any direct care staff was on August 6, 2008.

An attendance record was reviewed from this training date and seven registered staff, including the Administrator and Director of Care were in attendance. The Administrator indicated that out of the seven staff that attended, only four are employed in the home at this time.

The Long-Term Care Home's Act 2007 and O.Reg 79/10 came into effect July, 2010 however the home's program and training has not been revised to reflect this legislation or offered to staff as required by this section. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 11, 2015

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 13th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

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