Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 19, 2015	2015_229213_0015	L-002229-15	Resident Quality Inspection

Licensee/Titulaire de permis

Oneida Nation of the Thames
2212 Elm Avenue R. R.#2 SOUTHWOLD ON N0L 2G0

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

Oneida Nation of the Thames Long-Term Care Home (Tsi' Nu: yoyantle' Na' Tuhuwatisni)

2212 Elm Avenue R. R.#2 SOUTHWOLD ON N0L 2G0

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

RHONDA KUKOLY (213), BONNIE MACDONALD (135), MELANIE NORTHEY (563), SALLY ASHBY (520)

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): April 28, 29, 30, May 1, 4, 5, 6, 2015

This Resident Quality Inspection was completed with four concurrent complaint inspections:
003808-14
003818-15
003824-15
005324-14

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Director of Quality and Health Information, the Nutrition and Environmental Services Director, the Maintenance Supervisor, the Activities Director, the Finance Director, a Geriatric Psychiatry Resource Nurse, 2 Dietary Consultants, one Registered Dietitian, one Registered Nurse, five Registered Practical Nurses, six Personal Support Workers, one Physiotherapy Assistant, one Janitor, three Dietary Aides, one Laundry Aide, two Family Members and 40+ Residents.

During the course of the inspection, the inspectors also conducted a tour of all Resident areas and common areas, observed Residents and the care provided to them; observed meal and snack service, medication administration and medication storage. Clinical records for identified Residents were reviewed. The inspectors reviewed policies and procedures, education records, as well as minutes of meetings pertaining to the inspection were reviewed, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 kept clean and sanitary. Observations during lunch service in Bear and Turtle Trail dining rooms revealed numerous dishes were soiled and had surface finish removed so they could not be sanitized, exposed wood that could not be sanitized and numerous areas of accumulated dirt, dust, and build up.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that the home's furnishings and equipment are to be kept clean and sanitary. [s. 15. (2) (a)]

2. The Licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. Observations during lunch service in Bear and Turtle Trail dining rooms revealed several cupboard surfaces and door/drawer fronts coming off or missing, walls damaged and dead insects in ceiling lights.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that the home's furnishings and equipment be maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with when the following occurred:

The Home's Pleasurable Dining Audit Policy, January 2012, states: Resident Pleasurable Dining Audits are conducted by Dietary Staff on a regular basis, and by the Registered Dietitian annually at minimum, as part of the Department's Quality Assurance Program. Interview with the Nutrition and Environmental Services Director confirmed the last documented Pleasurable Dining Audit was conducted on August 6, 2013, by the home's Director of Care and that audits have not occurred since then on a regular basis.

The Home's Production Temperature Policy, November 2011 states: Temperatures are taken during production of menu items and are recorded on a Food Temperature form. Record review revealed that the production temperatures for menu items were not recorded on the Food Temperature Form (Production Sheets) on 46 occasions or 92% of the time for a three day period.

The Home's Cooking/Hot Holding of Hazardous Foods Policy, November 2011 states: The Food Service Supervisor will provide a thermometer for staff to take temperatures of hazardous foods while holding foods. Record review revealed that Holding Food Temperatures taken in the servery were missing on 77 occasions or 27.6% of the time for a specified week.

During the Resident Quality Inspection, Residents shared several comments related to the food being served cold or not hot enough. Interview with the Nutrition and Environmental Services Director confirmed the expectation that policies and procedures related to dietary services that are put in place are to be complied with especially as it relates to Pleasurable Dining Audits and the taking and recording of Food Temperatures when food is produced and being held prior meal service. [s. 8. (1) (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. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: the complaint shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. The licensee also failed to ensure that a documented record of each verbal or written complaint is kept in the home and that the record is reviewed and analyzed at least quarterly.

Record review of "Resident Complaints" folder obtained from the Administrator/Director of Care revealed a number of written complaints were received from Resident #10. Complaints were related to insufficient staffing and not receiving baths, a Registered Staff Member's inappropriate response to a concern, and the Resident was upset about another Resident coming into their room.

Record review of the "4.2.10 Concerns, Issues and Complaints" Policy last reviewed March 2014 revealed, "every written or verbal complaint made to a staff member concerning the care of a resident or operation of the home is dealt with as follows: The complaint or concern shall be investigated and resolved where possible... the Manager/Supervisor investigates the issue and is required to document the investigation. A written response must be provided to the person making the complaint within 10 business days of receipt of the complaint. The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home... and the documented record is reviewed and analyzed for trends at least quarterly. The Administrator shall ensure that written complaints are reported to the Ministry of Health and Long Term Care within ten days of receiving the complaint".

Staff interview with the Administrator/Director of Care confirmed there was no investigation for one of the written complaints and no documentation for any. The Administrator also confirmed that there is no record of each verbal and written complaint, and complaints are not reviewed or analyzed quarterly. [s. 101.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Observations during stage 1 of the Resident Quality Inspection revealed 34 out of 40 Residents' beds were observed with two side rails in use.

The home's policy Bed Rails 4.1.3c dated March 2014 indicated:
- Use of bed rails should be based on residents' assessed medical needs and should be documented clearly and approved by the interdisciplinary team.
- Bed rail use for resident's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting not or out of bed, should be accompanied by a care plan.
- A decision to use them should be based on a comprehensive assessment and identification of the resident's needs, which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

Interviews with a Registered Staff member and the Director of Quality and Health Information confirmed that two side rails are put up for all Residents and the home does not complete Resident assessments related to bed rail use or for risk of entrapment.

Interviews with the Director of Quality and Health Information and the Maintenance Supervisor confirmed that the home completed bed system evaluations in 2011 when the home opened, but were unable to provide documentation of this assessment and that they were unaware of an assessment of any bed systems for risk of entrapment being done since that time. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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 planned menu items were available at each meal for the Fall/Winter Menu from April 27, 2015 to May 4, 2015.

Observations and record reviews of meals on April 29, 30, May 1 & 4, 2015, revealed numerous menu substitutions and absent menu items.

During interviews with Residents as part of the Resident Quality Inspection, a Resident indicated the menu gets changed a lot from what is posted. Dietary Staff stated that almost every day they have to change the menu as they are short items for the menu. They generally only have a 3 day supply of food or less.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that that planned menu items are available at each meal as per the planned menu. [s. 71. (4)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The Licensee has failed to ensure that there were standardized recipes and production sheets for all menus.

A record review with the Cook revealed that 42/98 (43%) of the standardized recipes and 74% of the production sheets for the lunch and dinner menus from April 27, 2015 to April 29, 2015, were not available to assist staff in food production. Some of the missing recipes included: Puree Oatmeal Cookie, Puree Krunchie Perch, Minced Waffles and Regular, Minced and Puree Quiche.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that there are standardized recipes and production sheets for all menus to guide staff in the production of the menu items for Residents. [s. 72. (2) (c)]

2. The licensee has failed to ensure that all food and fluids were prepared, stored and served using methods which preserve nutritive value, appearance and food quality.

Observations during lunch service in the Bear dining room the deli meat plate was served

using one ounce of sliced ham instead of the three ounces of sliced ham. The ham serving was two ounces less than the required amount of ham in the standardized recipe. This resulted in a lower nutritive value of the meal when served to Residents.

Interview with the Dietary Staff verified there was not enough ham available to provide three ounces/serving for Residents as indicated on the menu.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that all food and fluids are prepared, stored and served using methods which preserve nutritive value of the food served to Residents. [s. 72. (3) (a)]

3. The licensee has failed to ensure that records for all menu substitutions were kept for at least one year.

Record review of the home's Menu Substitution Record revealed a record of menu substitution for the home were kept for 5 months, from June 20, 2014 to January 5, 2015. Dietary staff and the Nutrition and Environmental Services Director verified that there have been additional menu substitutions since January 5, 2015.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that a record of menu substitutions be kept for at least one year. [s. 72. (4) (c)]

4. The licensee has failed to ensure that the home's cleaning schedule for Bear and Turtle Trail servery and dish-washing areas were complied with by staff. Observations revealed numerous areas of accumulated dirt, dust, and build up on counters, cupboard fronts, steam tables, microwaves and flooring.

Record Review of the home's Food Services Oneida Equipment Cleaning Schedule/List for the servery revealed the cleaning schedule had not been complied 55% of the time from April 1, 2015 to April 29, 2015.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that the home's cleaning schedule be complied with by staff for the servery and dish-washing areas. [s. 72. (7) (c)]

Additional Required Actions:

CO # - 006, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

a) Record review of the current care plan for Resident #9 revealed a specific intervention. Observation of Resident #9 revealed the intervention was not in place. Staff interview with a Personal Support Worker (PSW) confirmed the Resident does does not require this intervention and hasn't for at least six months. [s. 6. (1) (c)]

b) Record review of the current care plan for Resident #15 revealed a specific intervention. Observation of Resident #15 revealed the intervention was not in place. Staff interview with a PSW confirmed the Resident does not require this intervention and the PSW could not recall if Resident #15 ever did have this intervention in place. [s. 6. (1) (c)]

c) Record review of the current care plan and progress notes for Resident #23 revealed there were no interventions related to the use of two quarter side rails. Record review of the Minimum Data Set (MDS) Quarterly Assessment on specified date revealed side rails were used daily. Observation of and interview with Resident #23 revealed the Resident was lying in bed with two quarter rails in use and the Resident confirmed the rails are used to roll in bed. Staff interview with the Registered Nursing staff confirmed the Resident has two quarter rails in use. [s. 6. (1) (c)]

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 plans of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of the "4.1.2 Abuse and Neglect Prevention" Policy last reviewed March 2014 revealed, "any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to their Supervisor, the Director of care or the Administrator: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, abuse of a resident by anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm to the resident."

Record review of the "4.2.10 Concerns, Issues and Complaints" Policy last reviewed March 2014 revealed, "complaints or concerns regarding the abuse or suspected abuse shall be reported to the Ministry of Health and Long Term Care as soon as the complaint or concern is received. The Administrator shall provide a written report to the Ministry of Health and Long Term Care using the Critical Incident Report within ten business days of the incident. The Program/Service Manager initiates an investigation into the issue or concern and documents steps taken in the investigation".

a) Record review of the "Incident Note" progress note on a specified date revealed Resident #10 was upset that nothing is being done about a situation.

Record review of the "Incident Note" progress note on a specified date revealed Resident #10 noted a concern regarding care.

Record review of multiple progress notes on multiple days revealed Resident #10 voiced ongoing concern regarding another Resident's actions.

Staff interview with the Administrator/Director of Care (DOC) confirmed that the

complaints documented in the progress notes were not reported to the Administrator/DOC by the Registered staff and that it is the home's expectation that all complaints are dealt with in the moment by the Registered Nurse in charge and forwarded to the Administrator/DOC immediately. [s. 20. (1)]

b) Record review of progress notes revealed Resident #49 suffered an injury and had subsequent pain. No documentation was found related to investigation of the cause of the injury.

Interview with the Director of Quality and Health Information revealed that when asked, Resident #49 told staff that it happened during transport to/from the home. The Director confirmed that the home did not complete any investigation related to the cause of the injury.

Interview with the Administrator/Director of Care confirmed that they were not informed of Resident #49 suffering an injury. They confirmed that this should have been investigated and reported to the Director. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that there is a written policy in place to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Record review of "Resident Complaints" folder obtained from the Administrator revealed a written complaint was received on a specific date from Resident # 10 related to a Registered Nursing Staff's inappropriate response to a health complaint.

Staff interview with the Administrator/Director of Care confirmed the incident of alleged staff to resident abuse/neglect of Resident #10 was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident or may occur immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following interdisciplinary programs were developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

A finding of non-compliance related to no falls prevention and management program was issued by Inspector #610 in complaint inspection #003808-15 completed concurrently during the Resident Quality Inspection.

Record review of the Mandatory Meetings binder revealed the last Pain and Palliative Care Committee and the Continence Care & Bowel Management Committee Meeting meetings were documented as April 16, 2014. The last Skin and Wound Care Committee meetings was documented as April 14, 2014 and the last Falls and Least Restraint meeting was documented as February 26, 2014.

Interview with the Administrator/Director of Care and the Director of Quality and Health Information confirmed that plans are in place to re-start the four required programs in the next two months, but they are currently not functioning in the home. [s. 48. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Record review of progress notes and the Minimum Data Set (MDS) assessment for Resident #49 revealed that this Resident had an area of altered skin integrity.

Record review of assessments for Resident #49 revealed a Weekly Wound Assessment was completed on a specified date indicating an area of altered skin integrity. This assessment was created by the wound specialist. No other weekly wound assessments were noted in assessments or in progress notes in Point Click Care or in the Resident's paper chart.

Staff interview with a Registered Staff Member revealed that registered staff are expected to assess wounds weekly and document the assessment in an assessment or a progress note. They confirmed that the one weekly wound assessment was completed by the Wound Specialist who was called in to assess Resident #49. They also confirmed that Resident #49 currently has no areas of altered skin integrity and that weekly wound assessments were not completed for this Resident when applicable. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #12: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The Licensee failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

In review of the Resident Food Committee Minutes since February 2014 and interview the Nutrition and Environmental Services Director confirmed the meal and snack times had not been reviewed with the Residents' Council. Interview with the Nutrition and Environmental Services Director confirmed the expectation that that the dining and snack service includes a review of the meal and snack times by the Residents' Council. [s. 73. (1) 2.]

2. The Licensee failed to ensure that residents who require assistance with eating or drinking are served a meal when someone is available to provide the assistance.

The current nutritional plan of care for Resident #21 stated this Resident required assistance with eating. During Breakfast service on a specified date, this Resident was observed trying to feed themselves, they were unsuccessful in eating their entire meal and was not provided feeding assistance.

The Registered Dietitian confirmed in an interview that the Resident should be offered feeding assistance when the Resident is unable to feed his/herself meals.

Interview with the Administrator/Director of Care confirmed the expectation that Residents who require assistance with eating or drinking are served a meal when someone is available to provide the assistance to the Resident. [s. 73. (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 to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council and that residents who require assistance with eating or drinking are served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #13: 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. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) 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; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements.

Observations by Inspectors #135 and #213 on April 27, 2015 and by Inspector #213 on May 5 and 6, 2015 revealed the home's inspection reports for 2014 were posted on a bulletin board at the main entrance of the home with other required postings; however, no inspection reports for 2013 were observed.

Review of the Ministry of Health and Long Term Care Inspection records revealed inspections were conducted in the home on January 14, February 22, March 26, June 17, and December 27, 2013.

On May 5, 2015, the Administrator/Director of Care shared that they were not aware of the requirement to post inspection records for two years and was unable to locate inspection reports for 2013. [s. 79. (3) (k)]

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 copies of the inspection reports from the past two years for the long-term care home are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

A review of the Resident Council binder shows no evidence of the satisfaction survey or of any Resident Council input into the satisfaction survey.

An interview with the Resident Council President verified that the Council is not consulted in developing and carrying out the satisfaction survey.

An interview with the Activities Director revealed that the Residents' Council is not consulted in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that the licensee documented and made available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

A review of the Resident Council binder shows no evidence that results of the satisfaction survey were reported to the Residents' Council.

An interview with the Resident Council President verified that results of the survey are not given to the Residents' Council.

An interview with the Activities Director revealed that the Residents' Council was not given the results of the satisfaction survey. [s. 85. (4) (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 licensee seeks the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results as well as document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #15: 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 that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Observation of the medication room on east wing Turtle Trail with a Registered Staff Member revealed a single lock, separate, stationary cupboard for controlled substances to be destroyed.

Observation of the medication room on west wing Bear Trail with the Administrator/Director of Care revealed a single lock, separate, stationary cupboard for controlled substances to be destroyed.

An interview with the Administrator/Director of Care revealed they were unaware that controlled substances for destruction needed to be stored in a separate, double-locked stationary cupboard in the locked area. [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 controlled substances for destruction 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 #16: 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. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control Program that meets at least quarterly, the local medical officer of health was invited to the meetings; that the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, a written record is kept relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Director of Quality and Health Information confirmed in an interview that the home currently does not have a functioning interdisciplinary team coordinating and implementing infection prevention and control in the home, that meets at least quarterly and the program is not evaluated annually. [s. 229. (2)]

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

During Lunch service in Bear Dining room on a particular date, staff members were observed clearing Residents' soiled lunch plates, then serving Residents their desserts without practicing hand hygiene between Residents.

Interview with the home’s Administrator/Director of Care confirmed the expectation that staff participate in the implementation of the infection prevention and control program when serving Resident meals.

Observation by Inspector #563 revealed the Food Services Manager in the main kitchen walked the length of the kitchen without wearing a required hairnet past the sign indicating "hair nets are required past this point". (563) [s. 229. (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 there is an interdisciplinary team approach in the co-ordination and implementation of the program that meets at least quarterly, that the local medical officer of health is invited to the meetings; that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, a written record is kept relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Also to ensure that staff participate in the implementation of the infection prevention and control program, specifically in completing hand washing during meal service, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Resident Council advice related to concerns or recommendations.

A review of Residents' Council Meeting Minutes for February 9, 2015 revealed a concern brought forward related to Laundry (clothing shrinkage), Activities (Residents would like more), and Administration (heating & cooling).

A review of Residents' Council Meeting Minutes for March 9, 2015 revealed a concern brought forward related to Environmental (keeping the courtyard cleaner), Nursing, (hand physio), Activities (bingo) and Administration (Resident finances).

A review of Residents' Council Meeting Minutes for April 13, 2015 revealed a concern brought forth related to Housekeeping (dirt on floor), Laundry (clothing shrinkage), Dietary (out of juice) and Nursing (missing baths).

An interview with the Activities Director revealed that there was no documentation or process in place to respond to concerns or recommendations by Residents or Families. The Activities Director verified that concerns brought forward from February 9, 2015, March 9, 2015 and April 13, 2015 had not been addressed and responded to by the licensee in writing within 10 days. [s. 57. (2)]

Issued on this 21st day of May, 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) :	RHONDA KUKOLY (213), BONNIE MACDONALD (135), MELANIE NORTHEY (563), SALLY ASHBY (520)
Inspection No. / No de l'inspection :	2015_229213_0015
Log No. / Registre no:	L-002229-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 19, 2015
Licensee / Titulaire de permis :	Oneida Nation of the Thames 2212 Elm Avenue, R. R.#2, SOUTHWOLD, ON, N0L-2G0
LTC Home / Foyer de SLD :	Oneida Nation of the Thames Long-Term Care Home (Tsi' Nu: yoyantle' Na' Tuhuwatisni) 2212 Elm Avenue, R. R.#2, SOUTHWOLD, ON, N0L-2G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Maureen Kelly

To Oneida Nation of the Thames, 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 :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee will ensure that the home, furnishings and equipment in the dining rooms, serveries and main kitchen are kept clean and sanitary and are maintained in a safe condition and a good state of repair.

Grounds / Motifs :

1. The Licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary. Observations during lunch service in Bear and Turtle Trail dining rooms revealed numerous dishes were soiled and had surface finish removed so they could not be sanitized, exposed wood that could not be sanitized and numerous areas of accumulated dirt, dust, and build up.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that the home's furnishings and equipment are to be kept clean and sanitary. [s. 15. (2) (a)]
(135)

2. The Licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. Observations during lunch service in Bear and Turtle Trail dining rooms revealed several cupboard surfaces and door/drawer fronts coming off or missing, walls damaged and dead insects in ceiling lights.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that the home's furnishings and equipment be maintained in a safe condition and in a good state of repair. (135)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must take actions to achieve compliance by:
a) Ensuring that the Home's Production Temperature Policy, November 2011 is complied with related to the taking and recording of food temperatures and any corrective action taken at the time of food production.
b) Ensuring that the home's Cooking/Hot Holding of Hazardous Foods Policy, November 2011 is complied with related to the taking and recording of food temperatures and any corrective action taken at the point of service in the servery.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with when the following occurred:

The Home's Pleasurable Dining Audit Policy, January 2012, states: Resident Pleasurable Dining Audits are conducted by Dietary Staff on a regular basis, and by the Registered Dietitian annually at minimum, as part of the Department's Quality Assurance Program. Interview with the Nutrition and Environmental Services Director confirmed the last documented Pleasurable Dining Audit was conducted on August 6, 2013, by the home's Director of Care and that audits have not occurred since then on a regular basis.

The Home's Production Temperature Policy, November 2011 states: Temperatures are taken during production of menu items and are recorded on a Food Temperature form. Record review revealed that the production temperatures for menu items were not recorded on the Food Temperature Form (Production Sheets) on 46 occasions or 92% of the time from April 27, 2015 to April 29, 2015.

The Home's Cooking/Hot Holding of Hazardous Foods Policy, November 2011 states: The Food Service Supervisor will provide a thermometer for staff to take temperatures of hazardous foods while holding foods. Record review revealed that Holding Food Temperatures taken in the servery were missing on 77 occasions or 27.6% of the time for the week of April 20, 2015 to April 26, 2015.

During the Resident Quality Inspection, Residents shared several comments related to the food being served cold or not hot enough. Interview with the Nutrition and Environmental Services Director confirmed the expectation that policies and procedures related to dietary services that are put in place are to be complied with especially as it relates to Pleasurable Dining Audits and the taking and recording of Food Temperatures when food is produced and being held prior meal service. (135)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. Dealing with complaints

Order / Ordre :

The licensee will ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: the complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. The licensee will also ensure that a documented record is kept in the home that includes of each verbal or written complaint and that the record is reviewed and analyzed at least quarterly.

Grounds / Motifs :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: the complaint shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. The licensee also failed to ensure that a documented record of each verbal or written complaint is kept in the home and that the record is reviewed and analyzed at least quarterly.

Record review of "Resident Complaints" folder obtained from the Administrator/Director of Care revealed a number of written complaints were received from Resident #10. Complaints were related to insufficient staffing and not receiving baths, a Registered Staff Member's inappropriate response to a concern, and the Resident was upset about another Resident coming into their room

Record review of the "4.2.10 Concerns, Issues and Complaints" Policy last reviewed March 2014 revealed, "every written or verbal complaint made to a staff member concerning the care of a resident or operation of the home is dealt with as follows: The complaint or concern shall be investigated and resolved where possible... the Manager/Supervisor investigates the issue and is required to document the investigation. A written response must be provided to the person making the complaint within 10 business days of receipt of the complaint. The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home... and the documented record is reviewed and analyzed for trends at least quarterly. The Administrator shall ensure that written complaints are reported to the Ministry of Health and Long Term Care within ten days of receiving the complaint".

Staff interview with the Administrator/Director of Care confirmed there was no investigation for one of the written complaints and no documentation for any. The Administrator also confirmed that there is no record of each verbal and written complaint, and complaints are not reviewed or analyzed quarterly. (563)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The Licensee will ensure, where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices to minimize risk to the resident. Specifically, the licensee shall ensure that all residents who use bed rails are assessed for bed rail use and all bed systems are evaluated according to the Health Canada Guidance Document for Adult Hospital Beds.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Observations during stage 1 of the Resident Quality Inspection revealed 34 out of 40 Residents' beds were observed with two side rails in use.

The home's policy Bed Rails 4.1.3c dated March 2014 indicated:
- Use of bed rails should be based on residents' assessed medical needs and should be documented clearly and approved by the interdisciplinary team.
- Bed rail use for resident's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting not or out of bed, should be accompanied by a care plan.
- A decision to use them should be based on a comprehensive assessment and identification of the resident's needs, which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

Interviews with a Registered Staff member and the Director of Quality and Health Information confirmed that two side rails are put up for all Residents and the home does not complete Resident assessments related to bed rail use or for risk of entrapment.

Interviews with the Director of Quality and Health Information and the Maintenance Supervisor confirmed that the home completed bed system evaluations in 2011 when the home opened, but were unable to provide documentation of this assessment and that they were unaware of an assessment of any bed systems for risk of entrapment being done since that time. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must take actions to achieve compliance by ensuring that the planned menu items are offered and available at each meal and snack as per the planned menu.

Grounds / Motifs :

1. The licensee has failed to ensure that planned menu items were available at each meal for the Fall/Winter Menu from April 27, 2015 to May 4, 2015.

Observations and record reviews of meals on April 29, 30, May 1 & 4, 2015, revealed numerous menu substitutions and absent menu items.

During interviews with Residents as part of the Resident Quality Inspection, a Resident indicated the menu gets changed a lot from what is posted. Dietary Staff stated that almost every day they have to change the menu as they are short items for the menu. They generally only have a 3 day supply of food or less.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that that planned menu items are available at each meal as per the planned menu. (135)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee must take immediate action to achieve compliance by:
a) Ensuring there are standardized recipes for all menu items including therapeutic and texture modified diets for the home's four week menu cycle and any seasonal variations or " Residents' Choice" menu items.
b) Ensuring there are Food Production Sheets that correspond to the home's four week menu cycle for all seasons i.e. Fall/Winter and Spring/Summer and production counts for all home areas.

Grounds / Motifs :

1. The Licensee has failed to ensure that there were standardized recipes and production sheets for all menus.

A record review with the Cook revealed that 42/98 (43%) of the standardized recipes and 74% of the production sheets for the lunch and dinner menus from April 27, 2015 to April 29, 2015, were not available to assist staff in food production. Some of the missing recipes included: Puree Oatmeal Cookie, Puree Krunchie Perch, Minced Waffles and Regular, Minced and Puree Quiche.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that there are standardized recipes and production sheets for all menus to guide staff in the production of the menu items for Residents.
(135)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee must take immediate action to achieve compliance by ensuring Residents are provided the correct quantity of Food/fluid to preserve nutritive value of the planned menu.

Grounds / Motifs :

1. The licensee has failed to ensure that all food and fluids were prepared, stored and served using methods which preserve nutritive value, appearance and food quality.

Observations during lunch service in the Bear dining room the deli meat plate was served using one ounce of sliced ham instead of the three ounces of sliced ham. The ham serving was two ounces less than the required amount of ham in the standardized recipe. This resulted in a lower nutritive value of the meal when served to Residents.

Interview with the Dietary Staff verified there was not enough ham available to provide three ounces/serving for Residents as indicated on the menu.

Interview with the Nutrition and Environmental Services Director confirmed the expectation that all food and fluids are prepared, stored and served using methods which preserve nutritive value of the food served to Residents. (135)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 19, 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 19th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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