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
Feb 24, 2016	2016_281542_0003	034929-15	Resident Quality Inspection

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

JENNIFER LAURICELLA (542), GILLIAN CHAMBERLIN (593), LISA MOORE (613)

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): January 18-22, 2016 and January 25-29, 2016.

Additional Logs conducted concurrently with the RQI include; 035263-15, 035840-15, 000051-16, 000078-16, 000811-16, 000820-16, 035101-15 and 001534-16.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care (ED/DOC), Assistant Director of Care (ADOC), Registered Staff, Program Manager, Director of Program Services, Maintenance Staff, Personal Support Workers (PSWs), Registered Dietitian, Physiotherapy, Residents and Family Members.

The Inspectors reviewed various policies and procedures, resident health care records, employee files, conducted daily walk through of the resident care areas, observed staff to resident interactions and the provision of care to residents.

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

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

12 WN(s)
4 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 101. (4)	CO #001	2015_281542_0020	542
O.Reg 79/10 s. 131. (2)	CO #001	2015_281542_0022	542

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #542 and #613 reviewed complaints that were submitted to the Ministry indicating that some residents of the home were not receiving their scheduled baths/showers twice a week due to staffing shortages.

A health care record review for resident #002 was completed. The bathing assignment sheets indicated that resident #002 was to receive their scheduled baths on Tuesdays and Saturdays. The current care plan revealed that resident #002 preferred to have a bath. The Activity of Daily Living (ADL) flow sheets that were completed by the Personal Support Workers (PSW) indicated that resident #002 received a bed bath on one of their scheduled bath days in January, 2016 contrary to what the care plan indicated.

During an interview with the scheduling clerk they confirmed that the home did not have a full complement of PSW's on the day that resident #002 received a bed bath.

During an interview with PSW #115 they confirmed that a bed bath was in fact provided to resident #002 on that specific day in January, 2016 as they were working short a PSW and orientating a staff member. PSW #115 stated that when they are working short they will sometimes give the residents a bed bath instead of a bath or shower as they do not have enough time.

During an interview with PSW #105 they confirmed that when the home does not have a full complement of PSW staff, they will often give the residents a bed bath instead of a bath or shower.

A further review of the ADL flow sheet documents revealed that on another day in January, 2016, resident #002 received another bed bath instead of their scheduled bath. The nursing complement documents indicated that the home did not have a full complement of PSW staff working on that day.

The health care records for resident #017 and #024 were reviewed. On a specific day in January, 2016, resident #017 and resident #024 received bed baths on their scheduled bath days according the ADL flow sheets. The current care plans for both residents did not indicate that they were to receive bed baths. The nursing complement documents indicated that the home did not have a full complement of PSW staff working that day.

During an interview with the scheduling clerk they confirmed that the home did not have a full complement of PSW staff on both of the days in January where the residents did not receive their scheduled baths.

Inspector #613 reviewed the bathing assignment document and the Activity of Daily Living (ADL) flow sheets for residents #022 and #023 for December 2015 and January 2016. The home's nursing complement documents for December 2015 and January 2016 were also completed.

Upon review of the bathing assignment document, it was noted that resident #022 was to receive their scheduled baths on Sundays and Thursdays evenings. The current care plan indicated that the resident preferred to have a tub bath. The ADL flow sheets were reviewed for resident #022 and the documentation identified that on four specific days in December, 2015 there were no baths documented to support that resident #022 received their scheduled baths.

The nursing complement documents verified that the home did not have a full complement of PSW staff working on those specific evening shifts.

As per the documentation, resident #022 did not receive a bath for two weeks (14 days).

The ADL flow sheets for resident #022 from January 2016 were reviewed and identified that there were no baths documented for two specific days in January, 2016. The nursing complement staffing documents verified that the home did not have a full complement of PSW staff on those days.

As per the documentation, resident #022 did not receive a bath for 11 days.

During an interview with PSW #120 they confirmed that resident #022 did not receive their baths during the month of December due to short staffing. They also indicated that residents were only being bathed/showered once per week in the evenings because they did not have enough staff.

Inspector #613 reviewed the bathing assignment document which, indicated that resident #023's scheduled bath days were on Sundays and Thursdays. Upon review of the ADL flow sheets for resident #023, it was noted that there was no documentation to identify that a bath had been provided over a period of 10 days in December, 2015. Resident

should have received a bath twice during that period.

During an interview on January 28, 2016, the Executive Director/Director of Care (ED/DOC) confirmed that tub baths/showers are to be provided to the residents as scheduled even if working short staffed. The ED/DOC confirmed that if a PSW did not document on the Activity of Daily Living Flow Sheets then it indicates that the tub baths/showers were not provided. [s. 8. (1) (b)]

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. 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 an interdisciplinary continence care and bowel management program was developed that promoted continence and ensured that residents were clean, dry and comfortable.

During the Resident Quality Inspection (RQI), resident #016 was observed by Inspector #542 to be incontinent, on three separate occasions over a five day period. The current care plan revealed that resident #016 required assistance for toileting and that they were

continent of their bowels and frequently incontinent of bladder.

On January 18, 2016, resident #012 was observed to be incontinent with feces. The current care plan indicated that resident #012 was continent of bladder and bowels and was independent for toileting. The ADL flow sheets indicated that the resident required extensive assistance for toileting and was incontinent of bladder.

During an interview with PSW #115 they confirmed that the residents of the home were not on any specific toileting plans.

On January 25, 2016, Inspector #542 overheard PSW #104 ask another staff member to assist them with transferring resident #018 from their wheel chair to the bed pan as the resident needed to use the bathroom. Inspector #542 spoke with PSW #104 who indicated that resident #018 cannot be transferred to the toilet as the home lacks the proper equipment.

On January 26, 2016, Inspector #542 overheard resident #018 requesting to use the bathroom. PSW #105 then asked RPN #116 to assist with transferring resident #018 from their wheel chair and onto the bedpan. Inspector #542 asked the PSW #105 why the resident could not be transferred to the toilet. PSW #105 stated that resident #018 could not use the toilet because they do not have the required equipment for resident #018 to use the toilet. RPN #116 confirmed that the home does not have enough of the proper equipment to safely toilet residents and that is why some of them are placed on bed pans. Resident #018 informed this Inspector that they would like to use the toilet instead of the bed pan.

During an interview with RN #110 they confirmed that the home does not have enough of the proper equipment to meet the toileting needs of certain residents.

During an interview with the Assistant Director of Care (ADOC) they stated that the home did not have the proper equipment for resident #018 to use for toileting purposes.

A health care record review was completed for resident #012. A continence care assessment was completed in May, 2015 and it was documented that the resident was continent of bladder and bowel. The current care plan accessible to the direct care team identified the resident as being independent for toilet use and continent of bladder and bowels. The documentation on the Activity of Daily Living (ADL) flow sheets over a five day period indicated that resident #012 required extensive assistance from staff for their

toileting needs and was incontinent.

During an interview with PSW #104 and PSW #105 they confirmed that the resident has been incontinent for quite some time now.

During an interview with the RAI Coordinator they confirmed that the home should have completed a continence care assessment for the resident since their condition changed.

During an interview with the Executive Director/Director of Care and the Assistant Director of Care they confirmed that the home does not have a Continence Care and Bowel Program implemented at this time. [s. 48. (1) 3.]

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. 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 has failed to ensure that interventions to mitigate and manage nutrition and hydration risks were implemented for resident #006 and resident #010.

A review of resident #006's care plan found that the resident was a nutrition risk, had altered skin integrity and had an intervention of a nutritional supplement ordered four times a day with the medication pass to manage this.

A review of the physician's order for resident #006 found the nutritional supplement order four times a day with medication pass and signed by the Registered Dietitian (RD).

The Medication Administration Record (MAR) was reviewed for resident #006. There was no order entered for the nutritional supplement for three months after the original order.

During an interview with Inspector #593 on January 22, 2016, the RD reported that resident #006 should have been receiving the nutritional supplement four times a day as part of the medication pass. They further added that when they order a nutrition supplement, they write an order for the supplement and update the care plan and then it is up to the registered staff to carry the order to the MAR and ensure that the resident is receiving the supplement.

During an interview with Inspector #593 on January 21, 2016, RPN #111 reported that resident #006 does not receive any oral nutrition supplements as part of the medication pass and there was no order for any supplements for this resident.

During an interview with Inspector #593 on January 26, 2016, the Assistant Director of Care (ADOC) reported that resident #006 has been receiving the nutritional supplement in the morning from dietary staff. The ADOC added that resident #006 has only been receiving this in the morning and was not aware that it was ordered more frequently than this.

A review of resident #010's care plan found that the resident was a nutrition risk with altered skin integrity and had an intervention of a nutritional supplement four times a day with the medication pass to manage this.

A review of the physician's orders for resident #010 found an order for the nutritional supplement four times a day with the medication pass dated and signed by the

Registered Dietitian (RD).

The Medication Administration Record (MAR) was reviewed for resident #010. There was an order entered for the nutritional supplement four times a day.

During an interview with Inspector #593 on January 22, 2016, the RD reported that resident #010 should be receiving the nutritional supplement four times a day as part of the medication pass. They further added that when they order an oral nutrition supplement, they write an order for the supplement and update the care plan, they fill out a communication form for the kitchen and the kitchen are to ensure that enough stock is sent to the nurses' station each day.

During an interview with Inspector #593 on January 21, 2016, RPN #111 reported that resident #010 does receive a nutritional supplement during the medication pass. They added that there had been occasions when the kitchen did not send adequate supply to the nurses' station therefore resident #010 did not receive their evening supplement.

A review of the MAR progress notes found 12 entries over a three week period where resident #010 did not receive their nutritional supplement with the reason documented as "medication not available". The MAR was reviewed for these dates and found corresponding documentation indicating that the supplement was not administered.

During an interview with Inspector #593 on January 21, 2016, the Director of Support Services reported that the kitchen holds the stock of the oral nutrition supplements. They added that they keep a list in the kitchen which documents the supplements all residents receive with meals or with the medication pass and it is the responsibility of the dietary staff to ensure that adequate stock is sent to the nurses' station every morning to meet these needs.

A review of the supplement list posted in the kitchen, found no documented entry for resident #010 to receive their nutritional supplement four times a day with the medication pass. [s. 68. (2) (c)]

2. The licensee has failed to ensure that the organized program of nutrition care and dietary services included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A review of resident #002, #003 and #010's food and fluid intake records for a period of

21 days during 2016 found, no intake data documented for an average of 25 meal services. There were no AM or PM nourishment pass data documented for residents #002 and #003 for this period and no intake data documented for an average of nine evening nourishment passes for all three residents.

During an interview with Inspector #593 on January 28, 2016, PSW# 117 reported that they were the PSW assigned to complete the food and fluid intake records on their shift rotation. PSW #117 further reported that there was no one assigned to this task on their days off or on the opposite shift in the evenings which is why there may be incomplete data at these times.

During an interview with Inspector #593 on January 26, 2015, the ADOC reported that the food and fluid intake records are supposed to be completed at the end of each meal period. The expectation of the home is that these records are completed for every meal period and for every resident.

A review of the home's policy #VII-I-10.00 dated January 2015, documented that all residents hydration and nutrition will be monitored and recorded daily; and the PSW's will identify all food consumed at designated times as a percentage of the whole amount of food provided at that time. [s. 68. (2) (d)]

3. The licensee has failed to ensure that there is a weight monitoring system to measure and record the monthly weight for each resident.

A review of the electronically documented weight records found that 14 residents did not have documented weights for June 2015, one resident did not have a documented weight for August 2015, three residents did not have a documented weight for September, October or November 2015 and two residents did not have a documented weight for December 2015.

During an interview with Inspector #593 on January 26, 2016, the ADOC reported that all residents are weighed at the beginning of the month by a PSW, it is then the responsibility of the registered nursing staff to input the weight data into the electronic records. The ADOC further reported that the missing weights have been completed but not entered into the electronic records and that these can be found on the hand written weight records however these documents could not be located.

A review of the home's policy #VII-G 20.80 Monitoring of Resident Weights, dated

January 2015, found that all residents will be weighed and all weights will be recorded within 48 hours of admission and monthly thereafter. The RN/RPN will record monthly weights from the PSW documentation tool into the weights and vitals system of the electronic documentation system by the 10th of every month. [s. 68. (2) (e) (i)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006, #012 and #015 as specified in the plan.

A review of resident #006's care plan found documented altered skin integrity which required daily treatment.

A review of resident #006's progress notes during the month of December, found an entry documenting the following: the treatment was not completed on a night shift as unit was understaffed and staff were unable to complete the required care.

A review of the Medication Administration Record (MAR) for December 2015, found an order for a daily treatment. It was documented on the MAR that the treatment was not

delivered. The MAR was signed by the same Registered Nurse who documented the progress note about the required care not being completed.

During an interview with Inspector #593 on January 27, 2016, the ADOC reported that the home is never short registered nursing staff and the resident should have received their treatment. They added that it is the expectation of the home that a member of the registered nursing staff completes all treatments, and it is not a good practice for those types of treatments to not be completed as per the resident's plan of care.

A health care record review was completed for resident #012. The progress notes indicated that resident #012 had three falls in a three month period. One of the progress notes pertaining to a fall indicated that the fall could have been contributed to the inappropriate footwear that the resident was wearing.

The current care plan for resident #012 under the "Falls" heading revealed that they were to wear appropriate footwear when ambulating. Under the "dressing" heading, one of the interventions was to ensure that resident #012 was wearing non-slip well fitting shoes.

Observations made throughout the Resident Quality Inspection revealed resident #012 to be wearing ill fitting shoes while ambulating.

During an interview with the RPN #108 they confirmed that resident #012 should not be wearing those particular shoes as they did not fit the resident properly.

Inspector #542 reviewed a complaint that was submitted to the Ministry indicating that a registered staff member had performed an invasive procedure to resident #015 without a physician's order.

A health care record review was completed for resident #015. The physician had written an order detailing specific instructions to manage the resident's health condition. The progress notes confirmed that on a specific day, a registered staff member had performed an invasive procedure to resident #015 without a physician's order.

During an interview with the registered staff # 101 they confirmed that they performed an invasive procedure to to resident #015 without a physician's order.

The care set out in the plan of care for resident #015 was not provided to the resident as specified in the plan as there was no physician's order for the invasive procedure. [s. 6.

(7)]

2. The licensee has failed to ensure that resident #012 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A health care record review was completed for resident #012. The current care plan indicated that resident #012 was independent for dressing and required supervision for personal hygiene care. The ADL flow sheet documentation revealed that the resident required extensive assistance for dressing and one person physical assist for personal hygiene care.

During an interview with PSW #104 they confirmed that resident #012 has not been able to complete any of their own care.

During an interview with the RAI Coordinator they confirmed that resident #012's condition had changed and that the care plan had not been reviewed or revised. [s. 6. (10) (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 the care set out in the plan of care is provided to resident #006, #012 and #015 as specified in the plan and that resident #012 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the nutrition care and dietary services policy was complied with.

A review of the monthly documented weights for resident #002 found significant weight changes between 4kg and 10kg in July 2015, September 2015, October 2015 and December 2015. There were no documented re-weighs for these months.

A review of the monthly documented weights for resident #003 found significant weight changes between 7kg and 20kg in November 2015, December 2015 and January 2016. There were no documented re-weighs for these months.

A review of the monthly documented weights for resident #010 found significant weight changes between 3kg and 33kg in July 2015, October 2015, November 2015 and December 2015. There were no documented re-weighs for these months.

During an interview with Inspector #593 on January 22, 2016, the home's Registered Dietitian (RD) reported that the monthly weights are not accurate and it was difficult to assess whether the weight difference was a true loss or gain. The RD further reported that the PSWs should be completing a re-weigh immediately if the weight was believed to be inaccurate or if there was a significant loss or gain.

During an interview with Inspector #593 on January 26, 2016, the ADOC reported that if there was a significant weight change, the PSWs should re-weigh the resident and document this. It is the responsibility of the registered nursing staff to input this data into the electronic health record system and if they notice a significant weight change, they should be requesting the PSW to complete a re-weigh of the resident.

A review of the home's policy #VII-G 20.80 Monitoring of Resident Weights, dated January 2015, found that the PSW will immediately re-weigh any resident with a weight variance from the previous month of 3kg. The Director of Support Services will monitor and address identified weight variances, consulting with nursing staff. [s. 8. (1) (a),s. 8. (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 the nutrition care and dietary services policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

During Stage 1 of the inspection, Inspector #613 observed the following residents in bed without access to their call bells.

-Resident #003 – call bell was hanging from the wall, behind the head board and lying on

the ground underneath the resident's bed.
-Resident #008 – call bell was wrapped around the left side rail and lying on the floor underneath the resident's bed.
-Resident #011 – call bell was tied around right side rail and lying on the floor underneath the resident's bed.

The residents call lights were not easily seen or accessible for each resident, staff or visitors.

The Inspector reviewed the home's policy and procedure titled, 'Call Bell Response', which identified to secure call bell cords in a safe and appropriate manner within reach by the resident at all times and to report any malfunctioning call bells immediately to direct supervisor.

During Stage 2 of the inspection, Inspector #613 observed resident #008 to be lying in their bed a various times on each day of the inspection, with their call bell system wrapped around the left side rail and lying on the floor under the bed. The call bell was not easily seen or accessible for resident, staff or visitor use during the entire inspection.

The Inspector reviewed resident #008's care plan that identified an intervention to encourage resident #008 to ask for assistance with use of call bell and to ensure that call bell was within reach at all times.

The Inspector reviewed the PSW documentation on the Daily Care Flow Sheets over an eight day period, 2016 and noted that PSWs had documented that they had checked the call bell and it was accessible to resident #008, except for one day there was no documentation for the day and evening shift.

The Inspector met with PSW #112 and RN #110 who both reported that all residents call bells are to be in reach of all residents at all times when the residents are in their rooms.

During an interview on January 28, 2016, the Executive Director/Director of Care (ED/DOC) confirmed that the expectation for all staff was to ensure that all residents' call bells are within reach at all times for all residents. The ED/DOC indicated that the call bell should have been placed in the residents reach. [s. 17. (1) (a)]

2. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by

residents.

During Stage 1 of the RQI, Inspector #593 observed the call bell in the washroom for a resident's room did not have a pull cord attached. The call bell was not accessible for resident #001.

The Inspector reviewed the home's policy and procedure titled, 'Call Bell Response', which identified for staff to secure the call bell cords in a safe and appropriate manner within reach by the resident at all times and to report any malfunctioning call bells immediately to direct supervisor.

Inspector #613 showed PSW #107 the call bell in the wash room and they stated that a pull cord should have been attached to the call bell. PSW #107 then reported this to RN #110 who also confirmed that the pull cord should have been attached to the call bell in the wash room for both residents. The RN #110 then reported the non-functioning call bell system to maintenance #113 who repaired the call bell and attached a pull cord.

The Inspector met with the ED/EDOC and informed them of the call bell in the bathroom with no cord. The ED/DOC confirmed the pull cord should have been attached to the call bell.

[s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times and that it is available in every area accessible by residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's #002, #017, #022 and #023 and #024 were bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by these residents' hygiene requirements, unless contraindicated by a medical condition.

Inspector #542 and #613 reviewed complaints that were submitted to the Ministry indicating that some residents of the home were not receiving their scheduled baths/showers twice a week due to staffing shortages.

A health care record review for resident #002 was completed. The bathing assignment sheets indicated that resident #002 was to receive their scheduled baths on Tuesdays and Saturdays. The current care plan revealed that resident #002 preferred to have a bath. The Activity of Daily Living (ADL) flow sheets that were completed by the Personal Support Workers (PSW) indicated that resident #002 received a bed bath on one of their scheduled bath days in January, 2016 contrary to what the care plan indicated.

During an interview with PSW #115 they confirmed that a bed bath was in fact provided to resident #002 on that specific day in January, 2016 as they were working short a PSW and orientating a staff member. PSW #115 stated that when they are working short they will sometimes give the residents a bed bath instead of a bath or shower as they do not have enough time.

During an interview with PSW #105 they confirmed that when the home does not have a full complement of PSW staff, they will often give the residents a bed bath instead of a bath or shower.

A further review of the ADL flow sheet documents revealed that on another day in January, 2016, resident #002 received another bed bath instead of their scheduled bath.

The health care records for resident #017 and #024 were reviewed. On a specific day in January, 2016, resident #017 and resident #024 received bed baths on their scheduled bath days according the ADL flow sheets. The current care plans for both residents did not indicate that they were to receive bed baths.

Inspector #613 reviewed the bathing assignment sheet and the Activity of Daily Living (ADL) flow sheets for residents #022 and #023 for December 2015 and January 2016. The home's nursing complement documents for December 2015 and January 2016 were also reviewed.

Upon review of the bathing assignment document, it was noted that resident #022 was to receive their scheduled baths on Sundays and Thursdays evenings. The current care plan indicated that the resident preferred to have a tub bath. The ADL flow sheets were reviewed for resident #022 and the documentation identified that on four specific days in December, 2015 there were no baths documented to support that resident #022 received their scheduled baths.

As per the documentation, resident #022 did not receive a bath for two weeks (14 days).

The ADL flow sheets for resident #022 from January 2016 were reviewed and identified that there were no baths documented for two specific days in January, 2016.

As per the documentation, resident #022 did not receive a bath for 11 days.

During an interview with PSW #120 they confirmed that resident #022 did not receive their baths during the month of December due to short staffing. They also indicated that residents were only being bathed/showered once per week in the evenings because they did not have enough staff.

Inspector #613 reviewed the bathing assignment document which, indicated that resident #023's scheduled bath days were on Sundays and Thursdays. Upon review of the ADL flow sheets for resident #023, it was noted that there was no documentation to identify that a bath had been provided over a period of 10 days in December, 2015. Resident should have received a bath twice during that period.

During an interview on January 28, 2016, the Executive Director/Director of Care (ED/DOC) confirmed that tub baths/showers are to be provided to the residents as

scheduled even if working short staffed. The ED/DOC confirmed that if a PSW did not document on the Activity of Daily Living Flow Sheets then it indicates that the tub baths/showers were not provided. [s. 33. (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 all residents are bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by these residents' hygiene requirement, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the mood and behaviour patterns and any potential behavioural triggers and variations in resident functioning at different times of the day for resident #007 were included in the plan of care.

A review of resident #007's physician's orders found an order for a medication to be restarted.

A review of resident #007's plan of care found no documentation related to the reason for the use of this medication or to monitor the resident's response for effectiveness.

A review of resident #007's progress notes found multiple entries related to the resident's mood changes over a period of eight days when the resident was re-started the specific medication.

During an interview with Inspector #593 on January 27, 2016, RN #102 reported that resident #007 was recently re-started on the medication due to their health condition as they were previously taken off the medication due to side effects. RN #102 further reported that resident #007's mood had improved since re-commencing the medication and that this intervention was not included in the residents plan of care because the medication was managing their mood.

During an interview with Inspector #593 on January 27, 2016, the ADOC reported that resident #007 was admitted from the hospital with an order this medication but they were never told the reason for the medication. The ADOC further reported that when the physician initially discontinued this order, they saw significant changes in the resident's mood and now that they were aware of the reason for the medication. They also stated that they can update the resident's care plan to include this however at this time, it was not included in the resident's plan of care. [s. 26. (3) 5.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Personal Assistance Services Device (PASD) used to assist resident #002 with a routine activity of living was included in the resident's plan of care.

Resident #002 was observed on numerous occasions during the RQI to have a PASD applied to their wheel chair.

A review of resident #002's plan of care was completed. The plan of care did not include the use of the PASD.

During an interview with PSW #115 they confirmed that the PASD was used for the resident's comfort and positioning.

A review of the home's policy titled, "Personal Assistance Service Devices (PASD's), dated July 2015 found that the registered staff will update the care plan with the interventions and monitoring of the PASD as outlined in definitions, considerations and types for the use of the PASDS. [s. 33. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was assisted with getting dressed as required and was dressed appropriately, suitable to the time of the day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate footwear.

Throughout the inspection, Inspector observed residents #004, #011 and #019 and #020 wearing pajamas during the day on various dates.

The Inspector met with PSW #112 and RN #110 who both reported to Inspector #613 that residents are permitted to wear their pajamas during the day only if they do not have any other clothes.

Inspector #613 reviewed each residents' care plans that identified they all required assistance with dressing; however, the care plan did not identify each residents' preferences to wear pajamas during the day or direction to wear pajamas due to having no other clothes.

During an interview on January 28, 2016, the Executive Director/Director of Care confirmed that their expectation was for residents to be appropriately dressed during the day and that they may wear their pajamas if it is the residents choice and if it is in their care plan. [s. 40.]

WN #11: 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 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 was posted in the home in a conspicuous and easily accessible location in a manner that complies with the requirements, established by the regulations.

During the initial tour of the home on January 18, 2016, Inspector #613 was unable to locate the posting of the Ministry of Health and Long Term Care Action Line. The Inspector met with RPN #119 who reported they did not know where the telephone number was located in the home.

The Inspector met with the Executive Director/Director of Care (ED/DOC) who confirmed the action line telephone number was not posted on the main bulletin board in the hallway, outside of the dining room. The ED/DOC reported someone must have removed it. [s. 79. (3) (f)]

2. The licensee has failed to ensure that copies of the inspection report from the past two years were posted in the home in a conspicuous and easily accessible location in a manner that complies with the requirements, established by the regulations.

During the initial tour of the home on January 18, 2016, Inspector #613 observed a binder titled, ''Compliance Inspection Reports', located at the front office. The Inspector reviewed the binder which contained only the last four inspection reports by the Ministry of Health and Long Term Care (MOHLTC), December 23, 2015 (Compliant and Critical Incident Inspection Reports), November 5, 2015 (Critical Incident Report) and November 4, 2015 (Complaint Report). The binder did not contain any other reports from the MOHLTC inspections.

The Inspector met with the Executive Director/Director of Care (ED/DOC) who confirmed that all inspection reports should be available since the home opened in May 2015 and confirmed that only the past four inspection reports were in the binder. The ED/DOC reported that these were the only reports they had received since they started their position on November 26, 2015. The ED/DOC informed the Inspector that they are unaware of the location of previous inspection reports as someone had removed them. The inspection reports were recently placed at the front desk to ensure they did not get removed. [s. 79. (3) (k)]

3. The licensee has failed to ensure that the most recent minutes of the Residents' Council meetings was posted in the home, in a conspicuous and easily accessible

location in a manner that complies with the requirements, established by the regulations.

The Inspector was unable to locate the posting of the most recent minutes of the Residents' Council meeting. Inspector #613 met with the Assistant of the Residents' Council #103 who confirmed that the minutes have not been posted. The Assistant of the Residents' Council #103 reported that the minutes would be posted on the activity bulletin board in the Activity Room once the written responses were completed.

On January 29, 2016, the most recent minutes of the Resident Council still had not been posted. [s. 79. (3) (n)]

4. The licensee has failed to ensure that the most recent minutes of the Family Council meeting were posted in the home, in a conspicuous and easily accessible location.

During an interview with Inspector #593 on January 25, 2016, the Acting President of the Family Council reported that the November, 2015 Family Council minutes were removed from the notice board in the home as they were told the content was inappropriate, they were further told not to post anything in the home unless it had been checked and approved by the Administrator of the home.

During an interview with Inspector #593 on January 26, 2016, the Program Manager S#103 reported that the November, 2015 Family Council minutes were removed by the Administrator because they felt the content of the minutes was inappropriate.

During an interview with Inspector #593 on January 26, 2016, the Administrator confirmed that the November, 2015 Family Council minutes were removed as they felt that some of the content was slanderous and incorrect. [s. 79. (3) (o)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that in development of the annual resident satisfaction survey, the advice of the Family Council was sought in developing and carrying out of the survey.

During an interview with Inspector #593 on January 25, 2016, the Acting Family Council President reported that the Family Council was not consulted with during the development of the annual resident satisfaction survey.

During an interview with Inspector #593 on January 26, 2016, the Program Manager S#103 reported that the Family Council was not involved in the development or implementation of the annual resident satisfaction survey due to an incorrect mailing address, the survey was not received by the home until seven days before it was due, therefore the home distributed the survey as quickly as possible to the residents and family members. [s. 85. (3)]

Issued on this 26th day of February, 2016

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) :	JENNIFER LAURICELLA (542), GILLIAN CHAMBERLIN (593), LISA MOORE (613)
Inspection No. / No de l'inspection :	2016_281542_0003
Log No. / Registre no:	034929-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 24, 2016
Licensee / Titulaire de permis :	AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC. 130 ELM STREET, SUDBURY, ON, P3C-1T6
LTC Home / Foyer de SLD :	CEDARWOOD LODGE 860 GREAT NORTHERN ROAD, SAULT STE. MARIE, ON, P6A-5K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rudy Putton

To AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee shall ensure there is an organized program of personal support services to meet the assessed needs of the residents, specifically related to bathing and showering.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #542 and #613 reviewed complaints that were submitted to the Ministry indicating that some residents of the home were not receiving their scheduled baths/showers twice a week due to staffing shortages.

A health care record review for resident #002 was completed. The bathing assignment sheets indicated that resident #002 was to receive their scheduled baths on Tuesdays and Saturdays. The current care plan revealed that resident #002 preferred to have a bath. The Activity of Daily Living (ADL) flow sheets that were completed by the Personal Support Workers (PSW) indicated that resident #002 received a bed bath on one of their scheduled bath days in January, 2016 contrary to what the care plan indicated.

During an interview with the scheduling clerk they confirmed that the home did not have a full complement of PSW's on the day that resident #002 received a

bed bath.

During an interview with PSW #115 they confirmed that a bed bath was in fact provided to resident #002 on that specific day in January, 2016 as they were working short a PSW and orientating a staff member. PSW #115 stated that when they are working short they will sometimes give the residents a bed bath instead of a bath or shower as they do not have enough time.

During an interview with PSW #105 they confirmed that when the home does not have a full complement of PSW staff, they will often give the residents a bed bath instead of a bath or shower.

A further review of the ADL flow sheet documents revealed that on another day in January, 2016, resident #002 received another bed bath instead of their scheduled bath. The nursing complement documents indicated that the home did not have a full complement of PSW staff working on that day.

The health care records for resident #017 and #024 were reviewed. On a specific day in January, 2016, resident #017 and resident #024 received bed baths on their scheduled bath days according the ADL flow sheets. The current care plans for both residents did not indicate that they were to receive bed baths. The nursing complement documents indicated that the home did not have a full complement of PSW staff working that day.

During an interview with the scheduling clerk they confirmed that the home did not have a full complement of PSW staff on both of the days in January where the residents did not receive their scheduled baths.

Inspector #613 reviewed the bathing assignment document and the Activity of Daily Living (ADL) flow sheets for residents #022 and #023 for December 2015 and January 2016. The home's nursing complement documents for December 2015 and January 2016 were also completed.

Upon review of the bathing assignment document, it was noted that resident #022 was to receive their scheduled baths on Sundays and Thursdays evenings. The current care plan indicated that the resident preferred to have a tub bath. The ADL flow sheets were reviewed for resident #022 and the documentation identified that on four specific days in December, 2015 there were no baths documented to support that resident #022 received their scheduled baths.

The nursing complement documents verified that the home did not have a full complement of PSW staff working on those specific evening shifts.

As per the documentation, resident #022 did not receive a bath for two weeks (14 days).

The ADL flow sheets for resident #022 from January 2016 were reviewed and identified that there were no baths documented for two specific days in January, 2016. The nursing complement staffing documents verified that the home did not have a full complement of PSW staff on those days.

As per the documentation, resident #022 did not receive a bath for 11 days.

During an interview with PSW #120 they confirmed that resident #022 did not receive their baths during the month of December due to short staffing. They also indicated that residents were only being bathed/showered once per week in the evenings because they did not have enough staff.

Inspector #613 reviewed the bathing assignment document which, indicated that resident #023's scheduled bath days were on Sundays and Thursdays. Upon review of the ADL flow sheets for resident #023, it was noted that there was no documentation to identify that a bath had been provided over a period of 10 days in December, 2015. Resident should have received a bath twice during that period.

During an interview on January 28, 2016, the Executive Director/Director of Care (ED/DOC) confirmed that tub baths/showers are to be provided to the residents as scheduled even if working short staffed. The ED/DOC confirmed that if a PSW did not document on the Activity of Daily Living Flow Sheets then it indicates that the tub baths/showers were not provided.

The decision to issue a compliance order was based on the severity, potential for minimal harm and the scope which was a pattern of residents not receiving their scheduled baths/showers due to staffing shortages. (542)

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 : Mar 07, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
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.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance to ensure that an interdisciplinary continence care and bowel management program is developed and implemented that includes, but is not limited to the following;

a) To ensure that incontinent residents receive an assessment, utilizing a clinically appropriate assessment tool.

b) Ensure that proper equipment and supplies are available to manage or assist residents with continence care and bowel management

c) To ensure all incontinent residents have an individualized plan of care to promote and manage bowel and bladder continence based on the appropriate assessment and that this plan is implemented.

d) Ensure that all residents that require continence care products have sufficient changes to remain clean, dry and comfortable.

This plan shall be submitted in writing to Jennifer Lauricella , Long Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email Jennifer.Lauricella@ontario.ca. The plan must be submitted by March 11, 2016 and fully implemented by March 25, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary continence care and bowel management program was developed that promoted continence and ensured that residents were clean, dry and comfortable.

During the Resident Quality Inspection (RQI), resident #016 was observed by Inspector #542 to be incontinent, on three separate occasions over a five day period. The current care plan revealed that resident #016 required assistance for toileting and that they were continent of their bowels and frequently incontinent of bladder.

On January 18, 2016, resident #012 was observed to be incontinent with feces. The current care plan indicated that resident #012 was continent of bladder and bowels and was independent for toileting. The ADL flow sheets indicated that the resident required extensive assistance for toileting and was incontinent of

bladder.

During an interview with PSW #115 they confirmed that the residents of the home were not on any specific toileting plans.

On January 25, 2016, Inspector #542 overheard PSW #104 ask another staff member to assist them with transferring resident #018 from their wheel chair to the bed pan as the resident needed to use the bathroom. Inspector #542 spoke with PSW #104 who indicated that resident #018 cannot be transferred to the toilet as the home lacks the proper equipment.

On January 26, 2016, Inspector #542 overheard resident #018 requesting to use the bathroom. PSW #105 then asked RPN #116 to assist with transferring resident #018 from their wheel chair and onto the bedpan. Inspector #542 asked the PSW #105 why the resident could not be transferred to the toilet. PSW #105 stated that resident #018 could not use the toilet because they do not have the required equipment for resident #018 to use the toilet. RPN #116 confirmed that the home does not have enough of the proper equipment to safely toilet residents and that is why some of them are placed on bed pans. Resident #018 informed this Inspector that they would like to use the toilet instead of the bed pan.

During an interview with RN #110 they confirmed that the home does not have enough of the proper equipment to meet the toileting needs of certain residents.

During an interview with the Assistant Director of Care (ADOC) they stated that the home did not have the proper equipment for resident #018 to use for toileting purposes.

A health care record review was completed for resident #012. A continence care assessment was completed in May, 2015 and it was documented that the resident was continent of bladder and bowel. The current care plan accessible to the direct care team identified the resident as being independent for toilet use and continent of bladder and bowels. The documentation on the Activity of Daily Living (ADL) flow sheets over a five day period indicated that resident #012 required extensive assistance from staff for their toileting needs and was incontinent.

During an interview with PSW #104 and PSW #105 they confirmed that the

resident has been incontinent for quite some time now.

During an interview with the RAI Coordinator they confirmed that the home should have completed a continence care assessment for the resident since their condition changed.

During an interview with the Executive Director/Director of Care and the Assistant Director of Care they confirmed that the home does not have a Continence Care and Bowel Program implemented at this time.

The decision to issue this compliance order was based on the severity which indicates a potential for actual harm to the residents, the scope which presented as a pattern as numerous residents were affected due to the home not having a continence care and bowel management program.
(542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 25, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the Nutrition and Hydration Program includes;

a) A plan to ensure that all ordered nutritional supplements are available and provided to the required residents and staff are aware of the ordered supplements.

b) A system to monitor and evaluate the food and fluid intake of all residents.

c) A weight monitoring system to measure and record monthly weight for each resident, this includes the necessary re-weighs according to the home's policies.

This plan shall be submitted in writing to Jennifer Lauricella , Long Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email Jennifer.Lauricella@ontario.ca. The plan must be submitted by March 11, 2016 and fully implemented by March 25, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that interventions to mitigate and manage nutrition and hydration risks were implemented for resident #006 and resident #010.

The licensee has failed to ensure that interventions to mitigate and manage nutrition and hydration risks were implemented for resident #006 and resident #010.

A review of resident #006's care plan found that the resident was a nutrition risk, had altered skin integrity and had an intervention of a nutritional supplement ordered four times a day with the medication pass to manage this.

A review of the physician's order for resident #006 found the nutritional supplement order four times a day with medication pass and signed by the Registered Dietitian (RD).

The Medication Administration Record (MAR) was reviewed for resident #006. There was no order entered for the nutritional supplement for three months after the original order.

During an interview with Inspector #593 on January 22, 2016, the RD reported that resident #006 should have been receiving the nutritional supplement four times a day as part of the medication pass. They further added that when they order a nutrition supplement, they write an order for the supplement and update the care plan and then it is up to the registered staff to carry the order to the MAR and ensure that the resident is receiving the supplement.

During an interview with Inspector #593 on January 21, 2016, RPN #111 reported that resident #006 does not receive any oral nutrition supplements as part of the medication pass and there was no order for any supplements for this resident.

During an interview with Inspector #593 on January 26, 2016, the Assistant Director of Care (ADOC) reported that resident #006 has been receiving the nutritional supplement in the morning from dietary staff. The ADOC added that resident #006 has only been receiving this in the morning and was not aware that it was ordered more frequently than this.

A review of resident #010's care plan found that the resident was a nutrition risk with altered skin integrity and had an intervention of a nutritional supplement four times a day with the medication pass to manage this.

A review of the physician's orders for resident #010 found an order for the nutritional supplement four times a day with the medication pass dated and signed by the Registered Dietitian (RD).

The Medication Administration Record (MAR) was reviewed for resident #010. There was an order entered for the nutritional supplement four times a day.

During an interview with Inspector #593 on January 22, 2016, the RD reported that resident #010 should be receiving the nutritional supplement four times a day as part of the medication pass. They further added that when they order an oral nutrition supplement, they write an order for the supplement and update the care plan, they fill out a communication form for the kitchen and the kitchen are to ensure that enough stock is sent to the nurses' station each day.

During an interview with Inspector #593 on January 21, 2016, RPN #111 reported that resident #010 does receive a nutritional supplement during the

medication pass. They added that there had been occasions when the kitchen did not send adequate supply to the nurses' station therefore resident #010 did not receive their evening supplement.

A review of the MAR progress notes found 12 entries over a three week period where resident #010 did not receive their nutritional supplement with the reason documented as "medication not available". The MAR was reviewed for these dates and found corresponding documentation indicating that the supplement was not administered.

During an interview with Inspector #593 on January 21, 2016, the Director of Support Services reported that the kitchen holds the stock of the oral nutrition supplements. They added that they keep a list in the kitchen which documents the supplements all residents receive with meals or with the medication pass and it is the responsibility of the dietary staff to ensure that adequate stock is sent to the nurses' station every morning to meet these needs.

A review of the supplement list posted in the kitchen, found no documented entry for resident #010 to receive their nutritional supplement four times a day with the medication pass. (593)

2. The licensee has failed to ensure that the organized program of nutrition care and dietary services included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

A review of resident #002, #003 and #010's food and fluid intake records for a period of 21 days during 2016 found, no intake data documented for an average of 25 meal services. There were no AM or PM nourishment pass data documented for residents #002 and #003 for this period and no intake data documented for an average of nine evening nourishment passes for all three residents.

During an interview with Inspector #593 on January 28, 2016, PSW# 117 reported that they were the PSW assigned to complete the food and fluid intake records on their shift rotation. PSW #117 further reported that there was no one assigned to this task on their days off or on the opposite shift in the evenings which is why there may be incomplete data at these times.

During an interview with Inspector #593 on January 26, 2015, the ADOC

reported that the food and fluid intake records are supposed to be completed at the end of each meal period. The expectation of the home is that these records are completed for every meal period and for every resident.

A review of the home's policy #VII-I-10.00 dated January 2015, documented that all residents hydration and nutrition will be monitored and recorded daily; and the PSW's will identify all food consumed at designated times as a percentage of the whole amount of food provided at that time. [s. 68. (2) (d)] (593)

3. The licensee has failed to ensure that there is a weight monitoring system to measure and record the monthly weight for each resident.

A review of the electronically documented weight records found that 14 residents did not have documented weights for June 2015, one resident did not have a documented weight for August 2015, three residents did not have a documented weight for September, October or November 2015 and two residents did not have a documented weight for December 2015.

During an interview with Inspector #593 on January 26, 2016, the ADOC reported that all residents are weighed at the beginning of the month by a PSW, it is then the responsibility of the registered nursing staff to input the weight data into the electronic records. The ADOC further reported that the missing weights have been completed but not entered into the electronic records and that these can be found on the hand written weight records however these documents could not be located.

A review of the home's policy #VII-G 20.80 Monitoring of Resident Weights, dated January 2015, found that all residents will be weighed and all weights will be recorded within 48 hours of admission and monthly thereafter. The RN/RPN will record monthly weights from the PSW documentation tool into the weights and vitals system of the electronic documentation system by the 10th of every month. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 25, 2016

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

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 24th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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