Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 7, 8, 9, 10, 13, 16, 17, 21, 22, 23, 24, 27, 28, 29, Mar 1, 2, 5, 6, 7, 9, 15, 16, 28, Apr 13, May 1, Jun 6, Aug 9, 30, Sep 26, 2012	2012_105130_0002	Resident Quality Inspection

Licensee/Titulaire de permis

WATERDOWN LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

ALEXANDER PLACE
329 Parkside Drive, P. O. Box 50, Waterdown, ON, L0R-2H0

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

GILLIAN HUNTER (130), MICHELLE WARRENER (107), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Food Services Manager, Life Enrichment Coordinator, administrative support staff, registered staff, personal support workers, dietary staff, recreation staff, residents and families related to H-000214-12.

During the course of the inspection, the inspector(s) Interviewed staff, residents and families, reviewed health records, policies and procedures, protocols, observed resident care, meal service and food production.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Trust Accounts

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the outcomes and the effectiveness of the care set out on the recreation plan of the care for an identified resident were documented. a) Documentation did not include a RAP (Resident Assessment Protocol) Summary, nor a progress note summary of the effectiveness of the plan of care over the quarter during the RAI -MDS assessment completed in 2012. The RAP summary for a specific date in 2011 states not "N/A" and does not evaluate the effectiveness of the plan of care. Interview with the Recreation Manager confirmed that a RAP summary or progress note was required to document the outcomes of care and confirmed that the documentation related to the outcome and effectiveness of the plan was not completed.
(b)Measurable goals were not identified for the recreation plan of care. Evaluation of the effectiveness of the plan of care is difficult due to the general nature of the goals.
2. The licensee did not ensure that the care set out in the plan of care was provided as specified in the plan.

(a) Residents receiving a pureed menu who chose the fish at the lunch meal February 8, 2012 received tartar sauce which was not consistent with the residents' diet orders. Staff confirmed that tartar sauce was not appropriate for the pureed menu (chunky texture).
b) Staff serving an identified resident at the lunch meal provided soup to the resident without first checking the resident's diet list. The resident was given soup that was contrary to the resident's plan of care. The soup was then removed from the resident after the resident had started eating it.
c) An identified resident required thickened fluids, however, additional thickener was added to the resident's soup and it was served at the wrong consistency at the lunch meal February 8, 2011.
(d) The plan of care for an identified resident stated staff were to use an assistive device to effectively communicate with the resident. Staff interviewed confirmed that the resident's assistive device had been broken for quite some time and had not been replaced. Staff were using an alternate method for communication, however, when attempted by the Inspector, the resident stated the alternate method of communication was ineffective.
(e)The care set out in the plan of care for an identified resident was not provided to the resident as specified in the plan. The resident's plan of care stated the resident liked to receive 1:1 visits/interaction in the resident's room to promote social stimulation and would receive this via Activity staff, family members, friends and volunteer visits. Staff interview identified that all 1:1 visits would be recorded on the resident's participation record. Staff stated the Activity staff try to provide about one to two 1:1 activities with the resident per month, documented as 1:1 or as an other specific activity on the participation record. Documentation on the resident's attendance record did not reflect that 1:1 visits occurred and other specific activity was only recorded once in the three month period from over a three month time period. The resident was not routinely receiving 1:1 visits/activities.
(f)The plan of care for an identified resident indicated that the resident was to be served meals first in the dining room, as the resident eats very slowly. The resident was not served the lunch meal first on February 21, 2012. The resident's two table mates were provided their meal first at 1229 hours with staff providing assistance to them however, instead of serving the resident next, the staff member served another table and did not provide the resident the meal until 1238 hours. The plan of care indicated the resident required extensive assistance with one staff to feed part of the meal however, the resident did not receive extensive assistance with one staff feeding part of the lunch meals February 8 and February 21, 2012.
3. The licensee did not ensure that the plan of care was revised when the care set out in the plan was not effective.

a) The resident assessment instrument-minimum data set (RAI-MDS) assessment for an identified resident, completed in 2012, identified that activity staff would continue to visit the resident 1:1 and invite the resident to programs using a communication tool, when possible. The plan of care was not evaluated for effectiveness and the plan of care was not revised based on recreation attendance records that demonstrated the resident attended only one 1:1 program and 11 total programs over a four month period.
b) The recreation plan of care identified the use of a communication tool with an identified resident, however, the plan was not revised when the communication tool was broken and a replacement communication tool was not provided.
(c) The activities resident assessment protocol (RAP) for an identified resident completed in 2012 stated that the home would continue providing 1:1 visits to the resident as the resident enjoyed them, however, recreation attendance records demonstrated that the resident had one 1:1 visit over a four month period. Staff interviewed confirmed the resident was not routinely receiving 1:1 programming and the resident's plan of care was not revised in relation to the 1:1 programming. The Activities RAP summary completed on an identified date in 2012 also identified that the resident spent the afternoon resting in bed and often refused invitations to activities stating the resident was uninterested in the activities offered. The resident's plan of care was not revised to ensure activities of interest were offered to the resident

and to ensure adequate programming was offered during hours the resident was awake.
4. The licensee did not ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

(a) The plan of care for an identified resident indicated under the toileting program that the resident required limited assistance of one staff for toileting every am, pm and before bed, before and after meals and as needed, however, under the incontinent program the plan directed staff to assist the resident with toileting and peri care upon rising and after lunch on day shift, after dinner and then change her brief once more on the evening shift and as required (prn). Staff interviewed report the resident was toileted upon rising and again after breakfast and after lunch and when the resident requested assistance.
5. The licensee did not ensure that residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents' care needs change or when care set out in the plan was no longer necessary.

(a)Personal support workers and registered staff interviewed confirmed that an identified resident had poor oral intake prior to being sent to hospital in 2012. Food records indicated the resident had intake of 50% or less for 13/36 meals and refused 19/36 meals over a two week period in 2012. Registered staff confirmed that residents who consume < 50% of their meals for 3 consecutive days were to be referred to the dietary department. The registered staff confirmed that a nutrition referral for reassessment was not initiated for the resident and there was no reassessment completed despite the resident's poor oral intake prior to being hospitalized in 2012. Documentation from hospital indicated that speech-language pathology (SLP) was unable to complete an assessment in hospital, however, did provide care directions to the home related to feeding. Personal support workers and registered nursing staff confirmed that the resident was refusing to eat meals and take fluids since the return to the home however, there was no referral initiated to the dietitian for reassessment of nutrition and hydration and the resident's plan of care was not revised to reflect the resident's current condition including SLP guidelines.

(b) In 2012, the plan of care for an identified resident had not been updated since the resident's return from hospital. Personal support workers interviewed reported they were not sure why there was personal protective equipment outside the resident's room nor could they confirm why there was contact precaution signage on the resident's room door. Staff on duty were unclear whether or not to don gowns when entering the resident's room to provide fluids. The registered staff on duty was interviewed and could not confirm whether or not the resident in fact had an infection because she was new to the unit and there was no documentation in the plan of care to indicate the resident had an infection requiring precautions. Staff interviewed report the resident had refused food and all medication for three days, since returning from hospital, was refusing to get out of bed and was refusing all care, returned from hospital with excoriated buttocks and was experiencing other symptoms. The ADOC admitted the resident required end of life care and that the home's chaplain had been alerted to the resident's change in condition. The ADOC and registered staff admitted the resident's plan of care had not been updated since returning from hospital, despite changes in her condition and care requirements.
6. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborate with each other.

(a)The RAI-MDS assessment coding, completed for an identified resident in 2011 and 2012 identified the resident had specific problems related to communication. Staff interviewed confirmed the RAI-MDS assessments were not consistent with the status of the resident and information provided in the plan of care.

(b) The oral health screening form for an identified resident in 2011 indicated that the resident's dentures were not worn and were not labelled. The RAI-MDS assessment completed the same day indicated the resident wore dentures. Staff interviewed identified that the resident had always worn dentures and they were not able to explain the reason for the discrepancy between the assessments.
7. The licensee did not ensure that the care set out in the plan of care for an identified resident was based on an assessment of the needs and preferences of that resident. The resident sustained falls with injuries in 2011 and 2012. A falls risk assessment completed in 2011 indicated the resident had a history of falls and was at high risk. A falls risk assessment completed in 2012 indicated the resident was at moderate risk. Staff interviewed and records verified that there were no planned interventions and/or strategies in place to manage the identified risk in the plan of care despite

the assessments related to falls.
8. The licensee did not ensure that there was a written plan of care that sets out the planned care for the resident.

(a) There was no documentation for an identified resident related to oral care and hygiene that set out the planned care for the resident. Written direction related to the wearing of dentures and the oral care required was not provided to staff caring for the resident. Staff interviewed confirmed that written direction related to oral care were not provided to staff caring for the resident.

(b) An identified resident sustained falls with injuries in 2011 and 2012. A falls assessment completed in 2012 indicated the resident had a history of multiple falls and was 'high risk" to fall again, however, there were no written goals or planned interventions and/or strategies to manage the falls risk.

(c) According to two staff interviewed, the plan of care for an identified resident indicated the resident required a specific safety device to alert staff of any movement when in bed. Staff stated the safety device had a different sound than the call bell in order to alert staff to respond immediately. Staff also stated that because the resident was unable to activate a push call bell, a safety device was required at all times. The resident also required two bed rails raised when in bed. The plan of care for this resident did not identify the need for specific safety devices nor the need for two bed rails raised when in bed. At least one staff who provided care to this resident was not aware of the need for specific safety devices. (130)

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 a written plan of care for each resident that sets out, the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that residents at risk of altered skin integrity received skin assessments by a member of the registered nursing staff, upon any return of the resident from hospital. Three identified residents returned from hospital in 2011; none of the identified residents had a skin assessment completed. According to their plans of care, the identified residents were known to be at risk for impaired skin integrity prior to their hospital admissions.

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 every resident at risk for altered skin integrity receives a skin assessment by a member of the registered nursing staff upon return from hospital., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following subsections:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service Provider shall use the funding allocated for an Envelope for the use set out in the Applicable Policy". The Long-Term Care Homes Nursing and Personal Care (NPC) Envelope Section 1. b) reads, "Direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene services, administration of medication, and nursing care."

(a) Nursing staff (personal support workers) were observed completing laundry duties (folding towels and linens) on February 27 and 28, 2012. Staff interviewed verified that they were required to fold laundry (towels) every other day and when they have extra time.

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 licensee complies with the conditions to which the licensee is subject, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following subsections:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program;
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities;
(e) the provision of information to residents about community activities that may be of interest to them; and
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the recreation program included activities that were of a frequency and type to benefit all residents of the home and reflect their interests.
a) An identified resident was observed sitting in the Activity room, alone, for most of the day on multiple occasions during this review. Staff confirmed that the resident rarely attended the activation programs as they were not appropriate for the resident due to existing disabilities. Staff also confirmed the resident was not receiving 1:1 programing. Attendance records identified the resident attended a limited number of programs over the course of a few months during an identified time frame. The resident's plan of care indicated the resident preferred 1:1 activities, however, only one 1:1 activity was provided to the resident over several months. The Activities RAP, completed in 2012, stated that due to lack of interest and disabilities the resident only attended a few of the activities offered.

b) Activities outlined on the Recreation calendar (four months of schedules were reviewed) were repetitive and did not consistently vary from month to month. Staff interview confirmed that the schedule was not consistently being revised due to staffing issues.
c) During this inspection, inspectors observed multiple residents routinely sitting in front of the tv in lounges and residents were sleeping or not engaged in the programming.
d) Interview with the President of the Residents' Council identified that the home's programs often do not meet her interests. The President also expressed ongoing concerns (and stated she had discussion with other residents) about residents sitting around the hallways with nothing to do or sitting in the tv room when they could not hear or understand the program.
e) Family Council meeting minutes indicated that residents wanted increased programming on evenings in home area #4. The Recreation Manager was not aware of this request and the activation schedule was not revised in relation to this request.
f) An identified resident stated that the organized programming did not meet the resident's interests, that there was limited programming on the weekends, and that the resident did not routinely attend activities. According to recreation attendance records, the resident attended a limited number programs over the course of a few months, did not attend programming on Sundays, and attended only a few programs on Saturdays. Staff interviewed confirmed that the resident was in bed during the afternoon, which was when most of the activity programming was offered and staff confirmed they did not provide a lot of 1:1 programming for this resident. The resident attended only one program in January 2012 and has not attended a recreation program since January 28, 2012.
g) An identified resident stated that the activities did not meet the resident's interests and were not of a frequency that were acceptable to the resident (not enough), and that on Saturdays the activity programs did not meet the resident's interests. The resident has attended only five activities over the last three months on Saturdays.

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 recreation and social activities program for the home includes a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and their interests, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production system were 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.
Not all food and fluids were prepared and served using methods which preserved taste, nutritive value, appearance and food quality at the lunch meals February 8, 22, and dinner meal February 22, 2012:

a) Numerous residents requiring texture modified menus were served their foods all stirred together or mixed together on the spoon, which did not preserve taste, appearance and food quality. The regular textured meals were served separately. Pureed fish (hot), pasta salad (cold), and zucchini were mixed together, and minced texture and pureed texture chicken curry, broccoli and rice meals were stirred together. Staff assisting the residents to eat did not identify this as a problem when interviewed. Management staff confirmed that stirring foods together was not part of the identified residents' plans of care and was not an acceptable practice at the home.
b) Residents receiving the pureed thickened bean soup had thickened milk added to their soup to cool it down, resulting in differences in taste, volume, nutritive value and food quality. Residents receiving the regular soup did not have milk added. Management staff interviewed confirmed that staff were not to add thickened milk to the pureed soup.
c) Foods served to residents were prepared too far in advance of meal service, resulting in reduced nutritive value, food quality and potential for food borne illness. Some examples: The pureed pork chops were placed into the oven at 1300 hours for the 1800 hours dinner meal and texture modified at 1353 hours. The pureed meat was panned using deep containers and then placed into the refrigerator for cooling. The pureed pork chops were held in the danger zone for over 2.5 hours and then reheated (reduces nutritive value) prior to the dinner meal. The recipe for the pureed pork stated 1 hour for cooking and to texture modify within 1 hour of service for optimal food safety and nutrient retention.
The chicken curry was prepared a day in advance, however, was reheated at 1340 hours and hot held for dinner. The recipe for the chicken curry stated to prepare same day and hot hold for a maximum of 2 hours.
The minced and pureed turnip and broccoli were finished cooking at 1400 hours for the dinner meal. The vegetables were placed into deep containers and placed into the refrigerator until 1600 hours for reheating. This method of preparation did not preserve nutritive value and flavour (double exposure to heat). The Home's policy related to Food Production stated staff were to prepare vegetables as close to serving time as possible.
Rice was placed into the steam table on the first floor at 1400 hours for the supper meal, which may dry out the rice. The Nutra Services policy and Job Description for the Head Cook identified the supper meal preparation was to begin at 1400 hours.
d) Foods prepared and served did not always follow the planned recipes, resulting in reduced flavour, nutritive value, appearance and food quality. Some examples: the recipe for buttered turnip contained butter and seasoning, however, the prepared product was turnip only; the recipe for pureed Hawaiian pork uses the same pork as the Regular texture (cooked in sauce), however, the pureed pork was prepared separately and cooked without sauce prior to pureeing.
e) Not all recipes enhanced nutritive value and flavour. Many of the recipes had very limited spices and flavouring and resident interviews identified that food was not flavourful. Some examples: sausage on a bun did not include condiments, plain omelet was eggs and milk without seasonings, oven roasted potatoes contain oil and potatoes without seasonings. Recipes for pureed texture items were made with the addition of water only, resulting in reduced flavour, and they did not enhance nutrient density. Some examples: bread, beef pot pie, tuna sandwich, vegetables, submarine sandwich, fish cakes, pasta salad, Swiss steak, herbed baked chicken, and Hawaiian cod, prepared with added water. Staff stated that residents do not seem to like the pureed bread and it was not well received.

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 food and fluids in the food production system is 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Not all foods were served at a temperature that was both safe and palatable to residents.
a) Resident interviews identified numerous concerns with cold food, especially when being served towards the end of the meal. Review of food temperature records for February 2012 indicated that many food temperatures dropped significantly from the start to the end of meal service (20 - 30 degrees Celsius).
b) The Home's policy stated that food was to be served at a minimum of 60 degrees Celsius (C), however, foods were served below 60 degrees C at several identified meals (as per the temperature monitoring records) and documentation did not reflect that remedial action was taken.
c) At the observed lunch meal February 22, 2012, foods were placed into very deep pans that were were not sitting very far down into the wells of the steam table. Temperatures recorded for the pureed pot pie fell below 60 C at the end of the meal, and the temperature of the pureed vegetables dropped 20 degrees C from the beginning to the end of the meal.
d) Not all foods were placed into the steam table at the supper meal February 22, 2012, resulting in food temperatures below 60 C. Curried chicken and pureed pork were left sitting on the counter for the entire supper meal and did not have an end of the meal temperature recorded in the Home's monitoring records. The food was then taken upstairs to be served in the second floor dining room in case of shortages. The minced curried chicken was probed at 54.6 C and the pureed pork probed at 45.1 C.
e) Food temperatures were not recorded February 4, 2012 dining room 1/2 and February 6, 2012 dining room 1/2 and 3/4 due to staffing shortages.

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 has a dining and snack service that includes, food and fluids being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
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.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The plan of care for an identified resident was not based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident. The resident stated feeling unhappy with the time of day staff wake the resident (0600 hours) on bath days. Staff interviewed confirmed they woke the resident early on bath days and that they were aware the resident preferred to sleep in, however, they had to wake the resident early due to the bathing schedule. Interview with Management confirmed that the bathing schedule was determined through attrition and not through an assessment of the resident's sleep patterns and preferences.

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 plan of care is based on, at a minimum, interdisciplinary assessment with respect to the resident's sleep patterns and rest routines., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee did not consult regularly with the Family Council, and in any case at least every three months as evidenced by interview with the Family Council President. The President stated the Licensee meets with the Council annually to discuss financial reports, and interview with the Administrator reflected twice yearly consultation with the Council. [LTCHA, 2007, S.O. 2007, c.8, s. 67]

WN #9: 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 subsections:

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);
(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;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(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 did not document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. Interview with both the Administrator and Family Council President confirmed that the results of the satisfaction survey were not brought to the Family Council during the 2011 calendar year.[LTCHA, 2007, S.O. 2007, c.8, s. 85(4)(a)]
2. The licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. Interview with the Family Council President confirmed that the Council had not been consulted in developing the satisfaction survey. [LTHCA, 2007, S.O. 2007, c.8, s. 85(3)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following subsections:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee does not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations. Interview with the Family Council President confirmed that concerns are not consistently responded to in writing, and not within 10 days. One example: January 4, 2012 meeting family members suggested that entertainment such as Jola (accordion player) and the Karaoke could be moved to the weekends rather than during the week as there are usually no entertainment activities held on weekends. This concern/suggestion was not responded to in writing. Concerns related to evening and weekend activities were also voiced by residents during this inspection and in the November 2, 2011 Family Council meeting minutes.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee did not ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Family Council. Interview with the President of the Family Council identified that this information was not provided to the Council.
2. The home did not maintain a record of the communication made to the Residents' Council, Family Council, and the staff of the home regarding the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents. Meeting minutes from the Residents' Council and Family Council did not reflect communication of quality initiatives and the Administrator of the home confirmed that a written record of the communication to Family and Residents' Councils was not completed.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following subsections:

s. 241. (7) The licensee shall,
(a) provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident;
(b) where the licensee has deposited in a trust account money received from any person on behalf of a resident, make part or all of the money available to the resident or a person acting on behalf of the resident,
(i) in accordance with the instructions of the resident or a person acting on behalf of the resident in respect of the property the resident or the person is legally authorized to manage, and
(ii) upon the resident, or the person acting on behalf of the resident, signing an acknowledgement that the resident, or the person acting on behalf of the resident, received the funds;
(c) maintain a separate ledger for each trust account showing all deposits to and withdrawals from the trust account, the name of the resident for whom the deposit or withdrawal is made and the date of each deposit or withdrawal;
(d) maintain a separate book of account for each resident for whom money is deposited in a trust account;
(e) on the written demand of a resident, or a person acting on behalf of a resident, make the residents' book of account referred to in clause (d) available for inspection by the resident or the person during any business day;
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and
(g) with respect to each resident for whom money is deposited in a trust account, retain for a period of not less than seven years,
(i) the books of account, ledgers, deposit books, deposit slips, pass-books, monthly bank statements, cheque books and cancelled cheques applicable to the trust account,
(ii) the written instructions and authorizations and acknowledgements of receipt of funds of the resident and the person acting on behalf of the resident, and
(iii) the written receipts and statements provided to the resident, or a person acting on behalf of a resident. O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee did not provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement. The home's administrative assistant confirmed that an identified resident did not receive a quarterly itemized written statement respecting the money held by the licensee in trust for the resident.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the following was complied with in respect of the dietary services and hydration program required under section 11 of the Act: 3. The program must be evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices. The home had a hydration policy as required under section 11 of the Act. The revised hydration policy (nutrition/hydration section in the resident care manual/nutrition manual) dated August 2009 which indicated residents are not referred until their fluid intake was less than 50% of their fluid requirement for 3 consecutive days. This was not in accordance with evidenced-based practices or prevailing practices in regards to referring and assessing adequate fluid intake and monitoring risk for dehydration. The home was unable to provide evidence-based practices or prevailing practices to support their policy.
2. The licensee of the home did not ensure that actions taken with respect to an identified resident, under the recreation program, including interventions and the resident's response to interventions, were documented.
The resident identified a preference to attend spiritual services and stated staff were not routinely taking the resident to the program. Over an identified period of time documentation did not include spiritual services on on a number of identified dates. Interview with the Recreation Manager indicated the resident sometimes refused the service or had the service offered in the resident's room, however, this was not documented.

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 every required program is evaluated and updated annually in accordance with evidenced-based practiced and, if there are none, in accordance with prevailing practices, and also to ensure any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee did not ensure that here was a written record relating to each evaluation of the staffing plan under clause (3) (e) that included 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 home's Administrator confirmed that the home evaluated the staffing plan however, did not keep a written record 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.

WN #15: 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 subsections:

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).

Findings/Faits saillants :

1. The licensee did not ensure that the nutrition and hydration program included the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration. The home's dietitian confirmed that she was not involved with the development of policies relating to nutrition care and dietary services and hydration. The Food Service Supervisor confirmed that the yearly education day attended by the food service supervisor and dietitian was to receive education on the policies rather than to participate in the development of policies. It was confirmed that any policy changes were completed corporately.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

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 did not ensure that the planned menu items were offered and available at each meal and snack. Not all residents were offered the planned menu items at the lunch meal February 21, and supper meal February 22, 2012.
a) Bread and pureed bread were not offered to residents during the observed lunch and supper meals. The planned menu stated that whole wheat bread / pureed bread was to be offered at lunch and dinner, unless bread, wraps, rolls/buns, garlic sticks, fruit loaf, muffins, cornbread or t-biscuits were part of the meal. The therapeutic menu for the first choice lunch entree February 21, and for the supper meal February 22, 2012 stated bread and pureed bread was to be offered as part of the meal (1 slice/#16 scoop). Staff serving the supper meal stated bread was available, however, not offered unless residents asked for it. Residents being assisted with eating were not offered bread with their meal (confirmed by staff feeding residents). The Food Services Manager confirmed the expectation was for staff to offer bread to all residents at meals unless bread was served as part of the meal.
b) The planned menu for February 22, 2012 supper meal stated pureed noodles were to be prepared and offered to residents receiving the first choice pureed menu. Staff serving the meal confirmed that the pureed noodles were not prepared nor offered to residents. The substitution offered to residents was from a different food group, resulting in differences in nutritional value from the planned menu.
c) Portion size of the pureed chicken curry served to residents at the supper meal February 22, 2012 was less than the planned menu. The Food Service Manager identified the error half way through the meal and it was corrected.

WN #17: 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 subsections:

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).

Findings/Faits saillants :

1. The licensee of the home did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act and complied with.

(a)The home's procedure in the skin breakdown policy(clinical practices section of the nutrition manual) indicated that the nursing department would notify the dietary department of any residents experiencing skin breakdown (stage 2 or higher) however; this was not in accordance with the applicable requirement set out in regulation 50(2)(b)(iii) which indicated that every licensee of a long term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 implemented.

(b)The home did not comply with their meal intake (poor)- referral policy (nutrition/hydration section of the resident care manual/nutrition manual) that indicated when a resident is identified as consuming less than 50% of their meals in a 24 hour period for three consecutive days a referral would be made to the food services supervisor and a plan would be developed using a multidisciplinary approach and if necessary a referral to the dietitian would be initiated. An identified resident had intake of 50% or less for 14 consecutive meals over a one week period in 2012 however; registered staff confirmed that the home did not initiate a referral to the food service supervisor, there was no plan developed using a multidisciplinary approach and no referral to the dietitian.
(c) The home's policy (Skin & Wounds, section skin assessments and skin care procedures) indicated, for residents at risk for skin integrity issues, a head to toe skin assessment would be completed on return from hospital after 8 hours and following leave of absences greater than 24 hours. The Registered Nurse on duty would complete a skin assessment, using the "Braden scale" on point click care at the time of the resident's readmission. An identified resident was admitted to hospital for a period of time in 2011. The resident did not have a Braden Scale completed upon returning from hospital and did not have a head to toe assessment completed. A second identified resident was admitted to hospital for a period of time in 2011. The resident did not have a Braden Scale completed upon return and did not have a head to toe assessment completed until 2012. A third identified resident was admitted to hospital for a period of time in 2011. The resident did not have a Braden scale completed upon returning from hospital and did not have a head to toe assessment completed. According to their plans of care, each of the identified residents were known to be at risk for impaired skin integrity, prior to their hospital admissions. Staff confirmed these assessments were not completed in accordance with the home's policy.

Issued on this 28th day of September, 2012

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