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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2013	2013_202165_0011	H-000407-13	Resident Quality Inspection

Licensee/Titulaire de permis

BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST, SUITE 901, TORONTO, ON, M3J-2V5

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

BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3

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

TAMMY SZYMANOWSKI (165), BARBARA NAYKALYK-HUNT (146), GILLIAN TRACEY (130), LISA VINK (168)

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): July 8, 10, 11, 12, 15,16,17,18,19, 22, 23, 24, 2013

A complaint inspection was conducted concurrently with this inspection H-000311013: Findings of non-compliance are contained in this inspection report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI Coordinator, Food Service Manager (FSM), Registered Dietitian (RD), Environmental Services Manager, Recreation Manager, Associate Director of Care (ADOC), Nursing Unit Clerk Supervisor, Business Coordinator, Personal Support Workers (PSW), Registered nursing staff, Dietary staff, Housekeeping staff, family members and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all resident home areas and reviewed relevant documents including, but not limited to: policies and procedures, meeting minutes, menus, and health care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

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
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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:

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

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 2007, c. 8, s. 6 (4).
(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. (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 of the long term care home did not ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) Resident #586's plan of care did not include the planned care for the resident for the cleaning of their natural teeth. The resident indicated that they were unable to complete brushing on their own without set up and placement and staff confirmed they only provide assistance if the resident requested. The plan of care indicated that the resident required one staff extensive assist to complete personal hygiene care related to decreased range of motion, strength and mobility.
B) According to assessments and front line staff interviewed, resident #512 was usually continent of bowel. Registered staff interviewed stated that each resident should have a plan in place related to urinary and bowel continence. Staff verified that there was no bowel continence plan in place for resident #512 from July 2012, until July 2013. [s. 6. (1) (a)]

2. The plan of care did not set out clear directions to staff and others who provided direct care to the resident.

A) Resident #513 required the assistance of staff for oral hygiene. In May of 2013, a device was provided to assist the staff in the cleaning of the resident's teeth. Staff interviewed were aware of the device and it was available in the resident's room. The use of the device was not included in the plan of care as part of the oral hygiene needs of the resident.
B) The plan of care for resident #101 indicated, one staff was to provide guided support for all safe transfers, the resident did not use any assistive devices at this time, was independent with their wheelchair, able to self propel, needed cueing and directions related to impaired vision. The plan also indicated the resident was able to ambulate in the corridor and to the dining room, in their room with one staff guided support and used no assistive devices. The plan included direction for staff to ensure a clip alarm was attached and functioning when up in the wheelchair. Front line staff interviewed stated the resident was independent with ambulation. Registered staff confirmed the plan did not provide clear directions regarding the resident's mobility status.
C) The care plan focus statement for resident #512 indicated "Potential to restore function; urinary incontinence related to: Impaired Mobility, Cognitive Deficit, Physical Limitations". The goal statement indicated "Incontinence will be managed to promote independence, comfort" and the "resident will be clean and dry and odour free";

however, there were no planned interventions to support neither the focus statement nor the goals. Staff interviewed stated the resident was dependent on staff; independence could not be restored. [s. 6. (1) (c)]

3. Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were consistent with and complement each other.
A) Resident #513 had a MDS assessment completed in January 2013. The assessment identified that the resident exhibited behavioural symptoms approximately one to three times a week and resistance to care four to six times a week. The MDS assessment completed the next quarter, identified that the resident's only behaviour was now resistance to care approximately one to three times a week, a decrease in both the type of behaviours exhibited as well as the frequency. The assessment identified that the residents' behaviour status had no changes, as compared to status of 90 days ago.
B) The MDS continence assessment for resident #559, completed in October 2012, was coded zero for both bowel and bladder, indicating no episodes of incontinence; however, the 14 day observation record indicated the resident had one episode of incontinence during the observation period. The MDS continence completed the next quarter was coded zero for bowel and one for bladder, indicating incontinent bladder episode once a week or less. Section four, Change In Urinary Continence was coded zero, which would indicate the resident had no change in urinary continence status as compared to status 90 days prior. The MDS continence assessment the following quarter, was coded zero for bowel and bladder continence and indicate there had been no change in urinary continence as compared to the previous 90 days. The MDS assessment completed on the current quarterly, was coded zero for bowel and one for bladder, indicating incontinent bladder episode once a week or less. Section 4 Change In Urinary Continence was coded zero, which would indicate the resident had no change in urinary continence status as compared to status 90 days prior. Front line staff interviewed stated the resident was independent and never incontinent and the care plan indicated the resident was continent of bowel and bladder. Registered staff verified that there were coding errors on the assessments and that the assessments should have indicated "deteriorated" not "no change", when coding indicated there had been a change in continence status.
C) The plan of care for resident #528 indicated the resident was at high risk for falls however; the plan of care also indicated the resident was at moderate risk. The Falls Risk Assessment Tool completed in June 2013, asked whether the resident had

recent falls; the assessment indicated "none in the last 12 months". According to staff interviewed and the clinical record, the resident sustained falls three falls over the past 12 months.
D) The MDS assessment completed in March 2013, for resident #564, was coded as zero, no behavioural symptoms exhibited during the seven day observation period. The MDS assessment completed the following quarter was coded as one, as the resident exhibited behavioural symptoms at least one to three days during the seven day observation period. However; it was coded that there was no change in the resident's behaviour status compared to their status of 90 days ago. [s. 6. (4) (a)]

4. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
A) Resident #585's plan of care for falls indicated the resident's call bell would be within reach at all times. The resident's call bell was hanging at the point of activation however; the resident was sitting at the other end of the room in their recliner. Staff confirmed that placing the call bell within reach of the resident was a current intervention to prevent falls however; it was not placed within reach of the resident when observed.
B) The plan of care for resident #528 indicated, the resident required extensive assistance with personal hygiene and grooming, including shaving. The resident was observed and had facial hair growth. According to POC records and staff interviewed, the resident did not receive assistance with shaving as required.
C) Resident #300 had a specialized diet order. The plan of care for high nutritional risk indicated for staff to provide the specialized diet based on a specialized menu plan. Interview with the RD confirmed that the resident was to be offered the planned specialized menu first and if the resident chose not to follow it, then staff had a regular menu highlighted in the dining room that indicated what menu choices off the regular menu that the resident could be offered. The planned specialized menu was not offered to the resident during the lunch meal July 17, 2013. The resident was only offered the regular planned menu choices for entrees and desserts which did not correspond with the highlighted menu choices.
D) The plan of care for resident #523 indicated the resident was high risk for falls and required a crash mat on the floor when in bed. The resident was observed in bed on two occasions and there was no crash mat observed on the floor. Front line staff interviewed stated the resident did not have a crash mat, however, registered staff interviewed, stated the resident was high risk and required it. [s. 6. (7)]

5. The licensee did not ensure that the resident 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.
A) Resident #531's MDS assessment indicated that the resident used one side rail daily when in bed and the resident's plan of care for falls indicated that the resident required only one side rail up for bed mobility when in bed. The resident confirmed that they used two side rails up when they were in bed and that they preferred to have two side rails up. Staff interviewed confirmed that they used two side rails when the resident was in bed because the resident preferred both rails up. The resident had not been reassessed and the plan of care revised to reflect the resident's preference for both side rails.
B) The plan of care for resident #521 indicated that the resident required two staff extensive assist to complete personal hygiene care and oral care. Two staff interviewed, verified the resident required minimal assistance from one staff for oral care, not two staff as indicated on the plan.
C) The plan of care for resident #602 identified interventions that included strategies involving the resident's spouse. Staff and the resident both indicated that the resident's spouse passed away some time ago, however the plan was not revised.
D) According to the plan of care, resident #528 was at risk for falls. Staff were to leave bed rails down to prevent the resident from climbing over. The resident was observed in bed with one half bed rail raised on the right side of the bed. Staff interviewed stated the resident always had one bed rail raised however; the plan of care was not revised. [s. 6. (10) (b)]

6. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.
A) Resident #523 sustained eight recorded falls over an eight month period. According to the plan of care there were no changes made to the plan of care for falls prevention and no new strategies developed or implemented to mitigate risk, for the past nine months. This information was confirmed by staff. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are consistent with each other and to 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 the resident's care needs change, to be implemented voluntarily.

WN #2: 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 of a long term care home did not ensure that each resident of the home was 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.
A) Review of POC for resident #564 confirmed the resident did not receive two baths per week. The resident did not receive a bath for one week on two occasions, and only received one bath per week, on two occasions. During an interview the resident confirmed that they did not receive two baths per week and that they did not receive a bath which was the method of their choice. The resident's plan of care for bathing indicated that the resident would only have a bath in the car tub and the bathing schedule indicated the resident was to receive a bath using the car tub. The tub was monitored for a two week period and was noted to not be used during this time despite staffs confirmation that the tubs were operational. POC documentation confirmed that the resident received showers on three occasions during this time despite their preference for a bath.
B) Resident #535 did not receive, at a minimum, two baths per week. POC records confirmed that the resident did not receive a bath for two identified weeks, and only received one bath per week for two identified weeks. It was noted that baths were not rescheduled for another time and the resident only had one refusal noted during this time.
C) Resident #528 was observed to be unclean and ungroomed; nails were unclean and untrimmed, they were unshaven and hair did not appear clean. According to the plan of care, they were to receive a shower on Thursdays and Saturdays. The bath records indicated the resident received four showers and one bed bath over a 20 day period. There were no refusals recorded in POC or in the progress notes. Front line staff interviewed stated the resident required extensive assistance for hygiene, grooming and bathing. Staff verified the resident did not receive two baths per week during the identified time period.
D) Resident #538 reported that they did not always receive twice weekly showers on Thursdays and Sundays as scheduled which was also reported by their family member. The resident confirmed that they had not received a shower on their scheduled day because the home was short two staff members. POC records revealed that over a one month period the resident received a bath, bed bath or shower only three of the scheduled eight times and there were no refusals documented. [s. 33. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not fully respect and promote the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
A) Resident #586 stated that they had made a request to staff to use the washroom however; staff pushed their wheel chair away from the washroom and indicated to the resident that they had to wait. The resident indicated that while waiting for staff to return they had a bowel movement and had sat in it until another staff member returned approximately two hours later. The resident stated it didn't feel good, it was dried on, and that it was not very dignified. Staff interviewed confirmed that when the resident usually requested to use the bathroom other than at their toileting routine, the resident was not always taken to the toilet. Staff indicated they would tell the resident to wait closer to the next toileting time or wait until they were able to get another staff member however; they tried to stick to the schedule for the resident. The resident's plan of care for bowel continence and staff interviewed confirmed that the resident was continent of bowels.
B) Resident #538's call bell was not answered when activated for an hour during an evening in April 2013. The resident wished to be transferred to their recliner and to elevate their legs. The plan of care directed staff to ensure the resident's call bell was available and accessible; to toilet the resident at a specified hour and when requested; elevate their legs at all times due to edema; and have commonly used articles within easy reach. The resident was not toiletted at the specified hour.
ii) In May 2013, resident #538 was left siting on a commode chair for approximately 45 minutes. They did not have a call bell accessible to them, their phone was not within reach and their legs were not elevated. The resident was reported by staff to be upset, so much so that the staff called in a family member to calm the resident. The resident reported that they were yelling and banging their table in order to get help. The resident's right to be cared for in a manner consistent with their needs was not respected or promoted. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the rights of residents are fully respected and promoted including that each resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #4: 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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with all applicable requirements under the Act.

A) The policy "Wound and Care Management Program - 4.16" last revised April 2013, indicated that staff were to refer a resident with stage II skin breakdown to the RD for recommendations on supplement and laboratory investigations. This document did not include the need to have the RD assess all residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds as required in O Reg. 79/10, section 50(2)(b)(iii). Interview with the DOC confirmed that staff notify the RD only when a resident has stage II breakdown and the dietitian was not notified of all issues of altered skin integrity. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with with all applicable requirements under the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home and equipment were maintained in a safe condition and in a good state of repair.

A) A commode chair, which was missing one wheel, was observed on two occasions during the inspection, in the Willoughby Hall spa area. The chair was unstable due to the missing wheel. The Maintenance Manager observed the chair and confirmed that the chair was not in safe condition and that it should have been "tagged" and reported to the maintenance department for repair.
B) The flooring in several areas was noted to be stained or having cracked, missing or rising seams. This included flooring in a prep area of the kitchen in front of the steamer, in the nursing stations on the first floor, and the family rooms on the first and second floors. Interview with the Maintenance Manager confirmed that attempts were made to clean the staining on the family room floors, from the water coolers, without success. It has been identified that the home had quotes from vendors to replace a portion of the lounge flooring, however; there was nothing purchased at this time. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home and equipment are maintained in a safe condition and in a good state of repair, 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 resident-staff communication and response system was not easily seen, accessed and used by residents, staff and visitors at all times.

A) The bed side call bell in room 1056 could not be activated without pulling the cord out of the wall unit on two occasions during the inspection. This was observed and confirmed by the Maintenance Manager on July 17, 2013.
B) Not all call bells were easily accessed or used during the inspection. Call bell cords in ten identified rooms were noted to be in a location which could not be reached easily by a resident or could not be easily activated as they were wrapped around grab bars or were tied to the bar in a fashion that required force. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 :

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1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments were documented.

A) Resident #594 was noted to have a surface on the bed and bed rails in the raised position, which was confirmed with front line staff. Interview with the DOC identified that the resident was assessed and the bed system evaluated prior to the surface being applied to the bed. However this assessment, which included the safety and security risks/needs and behaviours specific to the resident were not documented. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessment are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee did not ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

A) Resident #003 was observed to be wearing a front fastening seat belt loosely applied, easily allowing a hand width between the residents abdomen and the belt. Staff interviewed were aware of the manufacturers specifications to apply the seat belt and confirmed that the device was a restraint. The device was not applied according to manufacturers specifications when observed. Documentation did not include all reassessment of residents who are restrained.
B) Resident #003 was observed wearing a front fastening seat belt which could not be removed on request. It was confirmed by staff that the seat belt was a restraint. Staff documented on the Restraint Flow Sheets for a two month period, the application and removal of the device as well as the monitoring and repositioning of the resident. The flow sheets for this time period, were not completed for the eight hours between 0700 and 1500 hours, for the reassessment of the resident every eight hours to confirm that the restraint was still required. Staff interviewed identified that the registered staff on the night shift (1900 - 0700 hours) only complete, the flow sheet for reassessment of the device and that this information was not recorded by the day shift (0700 - 1900 hours). [s. 30. (1) 3.]

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 no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that each resident of the home received fingernail care, including the cutting of fingernails.
A) It was observed that resident #535 did not have their fingernails trimmed. The resident's plan of care for bathing indicated the resident's nails would be manicured on bathing days. A review of POC indicated the resident received bathing on three occasions however; it indicated that nail care was not provided on these bath dates or any time over a one month period. When interviewed, the resident confirmed that they had a shower however, nails were not trimmed at this time. The resident's nails were observed to be dirty and long.
B) The plan of care for resident #523 indicated the resident was at risk for skin tears related to translucent skin, cognitive impairment, history of skin tears, bruises easily and resists care. Staff were to keep fingernails short and smooth. Nails were to be manicured on bathing days scheduled Tuesdays and Fridays. The resident was observed along with staff who verified the resident's nails were long and had ragged edges which needed to be trimmed. According to the POC records, the resident received a shower on two occasions. The records also indicated the resident did not receive nail care on one occasion, but did receive nail care on the last bathing day. The resident was observed on the last bathing day, a number of hours after receiving their shower and it was observed that the nails remained long, untrimmed with ragged edges. [s. 35. (2)]

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 each resident of the home receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee did not ensure that equipment was readily available to meet the nursing and personal care needs of residents.

Staff interview identified that the home did not consistently have a sufficient supply of toileting/hygiene slings to meet the needs of residents. The DOC confirmed the expectation that a sling be used on only one resident after laundering, due to care being provided with the device and that recently approximately ten slings were removed from circulation. Slings need to be removed from general circulation on a regular basis due to wear and as per manufacturers specifications. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #11: 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 did not ensure that the interdisciplinary falls prevention and management program developed with the aim to reduce the incidence off falls and the risk of injury, was implemented.

The home's policy "Falls Prevention Program 4.1.12" indicated the RN/RPN will complete a Falls Risk Assessment within 24 hours of admission, quarterly and after any fall; that the interdisciplinary team will complete a Risk Management report and a detailed progress note; complete a falls assessment; and each shift for 72 hours following a fall, the nurse should record in the progress notes a review of systems, noting any worsening or improvement of symptoms as well as the treatment provided. Reference to the fall should be clearly documented.
A) According to the clinical record, resident #528 sustained falls five falls over a 14 month period. According to records reviewed, Registered Staff did not consistently monitor the resident for 72 hours post fall on four of the five falls. Fall Risk Assessments were not completed on four of the five falls, and Risk Management Reports were not completed on two falls. This information was confirmed by staff.
B) Resident #523 sustained falls on at least eight occasions over a eight month period. Staff did not complete Falls Risk Assessments (FRAT) post fall on five of the eight falls. The resident was not consistently monitored for 72 hours post fall on two falls. A Risk Management Assessment was not completed post fall on one occasion.
C) A record review of resident #585 indicated that there was no post fall follow up each shift for 72 hours after the resident experienced a fall in June 2013, this was confirmed by the RPN. There was no indication in the resident's clinical health record that the family had been notified of the resident's fall. [s. 48. (1) 1.]

2. The licensee did not ensure that the pain management program developed was implemented.

The "Pain Management Policy, Section 4.14.0" indicated all residents would be assessed and/or reassessed for persistent pain, regardless of whether they were currently experiencing pain, or at risk for persistent pain due to having chronic illness consistent with pain: within seven days of admission, at least quarterly and when there was a change in the resident's health status that affected their pain. The resident's pain would be measured using standardized (reliable and validated) clinical tools.
A) Resident #521 was interviewed and stated they experience constant pain. According to the plan of care the resident has chronic pain which was managed with routine analgesics. According to the clinical record, a pain assessment using a

standardized clinical tool had not been completed for the past eleven months. This information was confirmed by Registered Staff.
B) The last two MDS assessments for resident #602 identified that the resident experienced pain daily at a mild intensity. Staff interviewed confirmed that the standardized tool to be used to assess or reassess pain would be the pain assessment tool located in point click care. The resident has not had a standardized pain assessment completed as per the home's policy in 2013, which was confirmed by the registered nurse.
C) Registered staff confirmed that resident #586 did not have a quarterly pain assessment completed for the past three quarters despite documentation that indicated the resident had daily mild pain.
D)Resident #523 was receiving a routine narcotic analgesic for chronic pain. Staff interviewed and documentation confirmed, a pain assessment had not been completed for the past eight months. [s. 48. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the falls prevention and management program is developed and implemented in the home, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.
a) Resident #523 had a skin assessment completed in October 2012, for a skin tear. The assessment indicated the area required a dressing. In April 2013, the resident had skin breakdown identified to another area. Registered staff and the DOC verified that weekly skin assessments were not completed for the affected areas.
B) Resident #528 had a physician's order in place for daily treatment to an affected area. According to registered staff, a weekly wound assessment was to be completed every Friday; registered staff confirmed a wound assessment was not completed over a six month period. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the residents who required continence care products had sufficient changes to remain clean,dry and comfortable.
A) According to the plan of care resident #100 was incontinent and required checks and changes before and after meals, evenings and on rounds during the night. During observation, the resident was toileted before lunch at approximately 1200 hours and at 1400 hours. According to staff interviewed, incontinent products were not changed until the product was at least 75% wet. At 1200 hours, the resident's brief was not 75% wet therefore reapplied. At 1400 hours the resident was checked and changed. The brief was observed to be 100% saturated with urine, was heavy in weight and maloderous. [s. 51. (2) (g)]

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 residents who are unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence and that the residents who required continence care products had sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has not responded to the resident's council concerns or recommendations in writing within 10 days.
A) Resident #200 stated that sometimes a response was received verbally from the staff representative at the next monthly meeting but there had not been written responses.
B) Resident #555 stated that sometimes no response was received but if there was, a verbal response might be delivered by the staff representative at the next month's meeting or later. This resident has not ever seen a written response.
This information was confirmed by the staff representative, the DOC and a review of the documented minutes of the meetings. [s. 57. (2)]

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 there is a response to the resident's council concerns or recommendations in writing within 10 days of receiving them, to be implemented voluntarily.

WN #15: 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:

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 did not respond in writing within 10 days of receiving advice related of concerns or recommendations from family council.
A) The Family Council president, reported that Family Council had not seen written responses from their concerns since they have been a member of Family Council for approximately five or more years. In the past, council concerns were submitted as part of the meeting minutes. The staff assistant would sometimes report back at the next monthly meeting.
B) At the June 18, 2013, meeting, a new form was initiated to present council concerns. Two written concerns were filled out for nursing and dietary however; no responses have been received by Family Council to this date, July 17, 2013. [s. 60. (2)]

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 there is a response to the family council concerns or recommendations in writing within 10 days of receiving them, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

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 each menu provided for a variety of foods.
A) During resident interviews, several residents raised concerns that veal was served too often. A review of resident council minutes indicated that residents repeatedly raised concerns that too much veal was served on the menu. A review of the home's current menu indicated that veal was served Tuesday, Friday and Sunday of week 1; Tuesday, Thursday and Saturday of week 2; and Thursday and Sunday of week 3. [s. 71. (2) (b)]

2. The licensee did not ensure that each resident was offered a minimum of three meals daily.
A) During observation, resident #592 was in bed during the lunch meal service. Staff reported that the resident remained in bed. During an interview with an inspector at 1300 hours, the resident indicated they were hungry. The inspector reported this to staff and they brought the resident to the dining room. Lunch meal service was already completed and the resident was only offered a peanut butter and jelly sandwich with a glass of milk and water. A full lunch meal was not offered. [s. 71. (3) (a)]

3. The licensee did not ensure that each resident was offered a minimum of a snack in the afternoon and evening. Several residents reported that snacks were not always offered with their beverages in the afternoon and evening nourishment pass.
A) During resident interviews on second and third floors, several residents identified that beverages were offered during afternoon and evening nourishment passes however; snacks were not always offered at these times.
B) On July 8, 2013, the inspector was interviewing resident #564 during nourishment pass and the resident was only offered a beverage. The resident later requested a snack from staff. [s. 71. (3) (c)]

4. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.
A) The home did not have a salmon sandwich on white bread with tossed salad and flavoured yogurt available for the lunch meal July 17, 2013, despite being listed on a planned menu.
B) The planned menu for the lunch meal July 19, 2013, indicated that residents who required puree textured meals were to be offered puree soup and puree bread however; resident #522 was not offered puree soup. There was no puree bread available at the point of service and was not offered to residents who required puree

texture.
C) The nourishment menu for July 23, 2013, indicated puree vanilla wafer cookies were to be available during the afternoon snack however; the planned puree snack was not available on the third floor nourishment carts. The FSM confirmed that the planned menu item was not included on the daily production sheets for that day.
D) Residents reported that on July 7, 2013, they did not receive the planned breakfast menu. The FSM confirmed that there was no cook for the breakfast meal and therefore, eggs and bacon were not available for breakfast.
E) The planned menu for July 16, 2013, indicated neapolitan ice cream was to be served for dessert however; rainbow sorbet was served instead. There was no alternate dessert available for residents who required thickened fluids and as a result resident #558 did not have an alternate choice offered.
F) The planned menu for July 17, 2013, indicated that pears were to be served for the lunch meal however; fruit cocktail was offered instead. The dietary aide confirmed that pears were not available. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each menu provides for a variety of foods, to ensure that each resident is offered a minimum of three meals daily, to ensure that each resident is offered a minimum of a snack in the afternoon and evening, and to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

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 preserve taste, nutritive value, appearance and food quality.
A) The texture of minced menu items were runny and minced to a "puree-like" texture. The minced beans for the lunch meal July 8, 2013, were runny and had to be served in a side dish to prevent running into other menu items. The minced pork and green beans for the lunch meal July 16, 2013, were runny. The dietary aide confirmed the items were minced to a "puree-like" texture. The minced chick peas for the lunch meal July 17, 2013, was runny. It was also noted that the puree chick peas had a thick dried crust around the edges. The FSM confirmed that the routine practice of textured menu items did not always include the use of thickener which contributed to the production of a "watery" product. An interview with the home's RD confirmed that a runny product would compromise the nutritive value, appearance and quality of food served.
B) The home's menu production system did not provide clear direction for staff. The production sheets for July 16, 2013, indicated for staff to provide minced and pureed ham sandwich with a mixed vegetable however; the therapeutic sheet indicated for staff to provide a pureed chef salad plate.
C) Portion sizes for the menu items served July 16, 2013, were not listed on the therapeutic sheet for staff and did not correspond with the portion sizes indicated on the production sheets. The production sheet indicated that a #10 scoop was to be used to serve puree mixed vegetable however; a #12 scoop for puree tomato was used instead, which was less in quantity. The production sheet indicated a #8 scoop was to be used to serve puree ham sandwich however; a #10 scoop was used instead, which was less in quantity. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.
A) Resident #523 was receiving a routine psychotropic medication for responsive behaviours. An assessment conducted by a Geriatric Mental Outreach specialist in March 2013, indicated the resident had an increase in behaviours, prompting changes to medications. A recommendation was made to monitor the medication for increased sedation, improved behaviours at trigger times and optimal pain control for discomfort. The DOC confirmed the home did not have a policy related to psychotropic medication use, but stated it would be the expectation for staff to monitor the effectiveness of psychotropic medication for effectiveness and changes in behaviour. Registered staff interviewed and the DOC, verified psychotropic medications were not being monitored for effectiveness, unless ordered on an as needed basis. [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #19: 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. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee did not ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A) According to the nursing schedule and staff interviewed, the DOC was the registered nurse on duty, on at least five occasions, during a 30 day period from June to July 2013. [s. 8. (3)]

WN #20: 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 plan of care for each resident was not based on, at a minimum, interdisciplinary assessment of the following with respect to the residents 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.
A) The MDS RAP assessment completed for resident #564 indicated that the resident had some paranoid behaviours. Staff identified the behaviours including triggers and reported that these behaviours were difficult to diffuse. Staff identified that the resident could become very argumentative and verbally abusive however; the resident's plan of care was not based on the assessment and did not include the resident's paranoid behaviour including the triggers and strategies to manage the behaviour. [s. 26. (3) 5.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, including the cleaning of dentures and physical assistance or cuing to help residents who cannot, for any reason, brush his or her own teeth.
A) Resident #586 and staff confirmed the resident had some natural teeth and upper and lower partial dentures. The resident indicated that they were unable to brush their natural teeth independently. The resident reported that staff did not provide oral care for their natural teeth and staff stated that they only provided assistance when the resident requested. The resident confirmed that they did not request assistance for oral care and did not receive assistance to brush their teeth. [s. 34. (1) (a)]

WN #22: 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. Copies of the most recent inspection reports were not posted.
A) Three inspection reports conducted in May 2013, that included the following: H-000263-13, H-00121-13, H-00060-13 and H-00231-13, were not posted on the bulletin board on first floor where others were posted. This information was confirmed by the administrator. [s. 79. (3) (k)]

2. Orders by an inspector or the Director that were in effect or that have been made in the last two years were not posted.
A) Two inspection reports with orders, conducted in May 2013, that included the following: H-00121-13, H-00060-13 and H-00231-13, were not posted on the bulletin board on first floor where others were posted. This information was confirmed by the administrator. [s. 79. (3) (l)]

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee did not seek the advise of Family Council in developing and carrying out the satisfaction survey, and in acting on its results.
1. Family and resident satisfaction surveys were conducted in December 2012 and January 2013. The president of Family Council stated that council had no input into the surveys nor had the Family Council seen the results. When the president was shown the summary letters of the survey results obtained from the administrator, the president stated she had not ever seen it before this date, July 17, 2013. According to the minutes of the Family Council meetings from January 2013 to present, the results of the surveys were not mentioned.
2. In an interview with the Family Council staff assistant confirmed that the advice of Family Council was not sought in either the development of the survey or the results. [s. 85. (3)]

2. The licensee did not make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. This information was confirmed by review of the minutes from January 2013, to present; the Family Council president and the staff representative. [s. 85. (4) (a)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the procedure was implemented fully for the cleaning and disinfection of resident care equipment using hospital grade disinfectant, according to manufacturer's specifications, including tub chairs and and lifts.

The tub lift chair/scale in the Orchards spa room was observed on July 8, 10 and 17, 2013. The legs of the chair and the under side of the seat were noted to be soiled with a white powder like substance. The Maintenance Manager observed the condition of the lift on July 17, 2013 and identified that it is the role of PSW staff to clean and disinfect the lift after each use. [s. 87. (2) (b)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.
a.A family member of resident #538 submitted a written letter of complaint to the home and a second letter of complaint related to a different incident to the home one month later. The complainant stated that they did not receive any sort of a response, either a resolution or an expected date of resolution or a belief that the complaint was unfounded, at the time of the inspection related to either complaint. This information was confirmed by the DOC. [s. 101. (1)]

2. The licensee did not ensure that a documented record was kept in the home that included
a. the nature of each verbal or written complaint
b. the date the complaint was received
c. the type of action taken to resolve the complaint
d. the final resolution, if any.
A written complaint was given to the home by a family member of resident #538. The home had no documented record related to the letter or the type of action taken to resolve the complaint. The DOC confirmed that they did look into the complaint and no record was available. The administrator reviewed the complaint log and confirmed this information. [s. 101. (2)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that drugs were stored in a medication cart that was secure and locked.

On July 8, 2013, at 1202 hours, the medication cart was observed to be unlocked and unattended in the hallway of Willoughby home area. The RPN was observed in the dining room, administering medications to a resident and did not have the cart in view. The RPN returned to the cart at 1205 hours and continued to administer medications. The RPN indicated that they were aware of the need to keep the cart secured, that this was their normal practice and indicated that this incident was an oversight. On July 16, 2013, at 1149 hours the medication cart was again observed unlocked and unattended in the same location. The RPN was observed returning to the unit at 1150 hours and quickly locked the medication cart in the presence of the inspector. [s. 129. (1) (a)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee did not post the most recent audited report.
A) A review of the bulletin boards in the home on July 11 ,12, 15, 16, and 17, 2013, confirmed that there was no audit posted. This information was confirmed by the administrator on July 16, 2013. [s. 225. (1) 3.]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Staff do not participate in the implementation of the infection prevention and control program.
A) On July 8, 2013, observed isolation carts outside four rooms. There was no signage to explain precautions needed in each case. Registered staff stated that signs were never used. The DOC stated that precaution signs were not used because some families thought it as a privacy issue. According to the home's Infection Prevention and Control Manual "Precautions section 02", staff were expected to utilize signage. [s. 229. (4)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

1. The licensee did not ensure that the emergency contact information was updated.
A) In the 3rd floor manual, the contact list contained the names and numbers of five former management employees but not the contact information of the current managers. The Emergency Evacuation checklist contained information regarding former personnel as being available to assist the fire department. [s. 230. (6)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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

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. 3. (1)	CO #001	2013_191107_0001	146
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2013_191107_0001	146

Issued on this 17th day of September, 2013

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

Tammy Szymanowski