Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2014	2014_237500_0022	T-124-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

BENDALE ACRES
2920 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 2T8

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

NITAL SHETH (500), JOANNE ZAHUR (589), SLAVICA VUCKO (210)

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): October 28, 29, 30, 31, November 3, 4, 5, 6, 7, 10, 2014.

Additional inspections related to complaints: T-769-13, T-770-13, T-879-14, T-701-14, T-1073-14, T-1296-14, T-777-13, T-779-13, T-773-13, and T-1065-14, and critical incidents: T-978-14, T-611-14, and T-771-13, and follow up T-278-14 were also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with administrator, assistant administrator, acting director of nursing (DON), nutrition managers, acting manager building services, manager clinical nutrition, nurse managers (NM), manager resident services, registered nurses (RNs), registered practical nurses (RPN), personal care aides (PCAs), food service workers (FSWs), cook, residents, families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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During the course of this inspection, Non-Compliances were issued.
20 WN(s)
8 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2013_049143_0058	500

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Health record review indicated that resident #24 requires the physical assistance of two staff for all transfers and toileting activities.

Interview with an identified PCA revealed that resident #24 was toileted, transferred and repositioned in the wheelchair with one person physical assistance on an identified day, and the resident fell and sustained a bruised right eye and a laceration to the head requiring staples.

An interview with resident #24 revealed that the identified PCA completed the transfer, toileting and positioning activities unassisted by another staff member.

An interview with the DON confirmed that the identified PCA did not provide care to resident #24 as specified in the written plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 :

1. The licensee has failed to 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.

A review of Nursing and Personal Care Record for Food and Fluid intake (NPCR) for the month of June and July 2014, revealed that there is no documentation for breakfast and lunch intake for one day in June, two days in July 2014; for supplement intake at meals for the month of June 2014 and one day in July, 2014: for snack intake on eight days in June, and two days in July 2014: for fluid intake at snacks on ten days in June, 2014; and, for supplement intake at snacks on four days in June 2014.

A review of a plan of care revealed that the resident was on a nutritional supplement three times a day with meals and snacks.

Interview with the fourth floor nurse manager and manager clinical nutrition confirmed that the staff did not follow the policy and procedure for the NPCR documentation. [s. 30. (2)]

2. Review of the clinical record and interview with registered nursing staff indicated that during the second and last week in September 2014, and the first, third and last week in October 2014, resident #42 had only one bath a week. Review of the care plan indicated the resident refuses care such as showers, meals, clothes changes, medications and blood work. Certain interventions are described to be implemented such as: provide emotional support to resident as needed, provide a consistent care giver, keep environmental distractions to a minimum, inform family and MD when an inappropriate behaviour is noted, determine what triggers or leads up to behaviour and, distract resident if possible when the behaviour occurs.

Interview with a registered nursing staff indicated when the resident refuses the bath it must be documented in the nursing and personal care record and reported to the registered staff in order for different interventions to be implemented, and for efficacy to be evaluated and documented in the progress notes.

Review of the nursing and personal care record and interview with NM for resident #42 confirmed the refused baths in September and October 2014 were not reported to the registered nursing staff and documented as per the home's practice. [s. 30. (2)]

3. Review of the written plan of care for resident #43 indicated the resident resists care (refuses medications). The interventions described are: provide emotional support to the

resident as needed, remove the resident from public area when behaviour is disruptive or unacceptable, provide PRN (as necessary) identified medication as needed, keep environmental distractions to a minimum, and provide a consistent care giver.

Review of the nursing and personal care records and interview with registered nursing staff confirmed it was not documented that the resident had a bath two times a week during the second, third and last week in September 2014, and if he/she refused the care, which interventions were implemented. [s. 30. (2)]

4. Review of the written plan of care for resident #44 indicated the resident refuses showers, meals, to attend physiotherapy programs and to change his/her clothes. The interventions described were: remove the resident from public area when behaviour is disruptive or unacceptable, provide emotional support to the resident as needed, provide a consistent care giver, use gentle approach when washing the hair because he/she does not like his/her hair getting wet, explain to the resident that his/her clothes need to be changed and consult behavioural support team and social worker as needed.

Review of the nursing and personal care records and interview with registered nursing staff confirmed it was not documented that the resident had a bath two times a week in September 2014, and during the first, second and third week in October 2014, nor if he/she refused the care for which interventions were implemented. [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 assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Review of the nursing and personal care record for resident #20 indicated during the week from 25 to 30 September, 2014, he/she did not have a bath two times a week. In October 2014, during the 2nd, 3rd anfd 4th weeks the resident received one bath per week. Interview with the resident indicated that he/she receives a bed bath and confirmed that he/she was not offered a bath two times a week on several occasions. The resident indicated that when the bath was not offered to him/her nobody explained the reason. [s. 33. (1)]

2. Review of the nursing and personal care records for bathing for residents on the sixth floor for September and October 2014, indicated in September 2014, the bath record was not signed by PCAs as performed on 96 occasions, and in October 2014, on 54 occasions.

Interview with registered nursing staff and PCAs indicated it was not possible that so many baths were not given and that maybe they were not documented. If the home was short of staff, residents were offered a bath on the next day when more staff was available.

Interview with a PCA indicated resident #41 gets showers regularly, two times a week and he/she would not be happy if he/she missed the shower. Interview with resident #41 indicated it has happened that he/she missed showers sometimes because of the short staffing in the home.

Review of the nursing and personal care record and interview with the resident confirmed resident #41 did not receive a shower two times during the last week in September 2014. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

Interviews with an identified PCA and resident #24 reflect that on an identified day the PCA transferred the resident unassisted and used the back of the resident's pants to reposition him/her in the wheelchair. This subsequently resulted in resident #24 falling forward onto the floor, hitting his/her head and sustaining a bruised right eye and a laceration to the head that required staples.

Health record review reflected that resident #24 requires the assistance of two staff for all transfers, positioning and toileting activities.

An interview with the DON confirms that the identified PCA did not follow the care plan as outlined related to the transferring care needs of a two-staff assist and that the use of the resident's pants is not an acceptable positioning technique. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents., to be implemented voluntarily.

WN #5: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel continence based on the assessment of the resident.

Review of the clinical record for resident #10 and interview with registered nursing staff indicated the resident did not have a bowel movement for three consecutive days in June 2014. The resident had less than 50% food and fluid intake in the second half of June 2014. His/her health status deteriorated and the resident passed away in July 2014.

The home's policy for constipation management for clients at risk for constipation indicated that if a resident does not have a bowel movement for one day, additional fluids are to be provided. If there is no bowel movement on the second day, the resident is to be given prune juice, and additional fluids (for a minimum of 1.5l/day) and to be monitored. If the resident does not have a bowel movement on the third day, prune juice is to be given and a laxative is ordered (as needed). Staff are to ensure the resident is toileted to assist with bowel evacuation, and to encourage exercise as per the care plan.

Review of the clinical record and interview with the registered nursing staff confirmed that when resident #10 had constipation he/she did not have an individualized plan of care to promote and manage bowel and continence based on the resident's assessment. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and continence based on the assessment, and that plan is implemented., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that immediate action is taken to deal with pests.

Observation conducted on November 6, 2014, at 10.40 a.m., in the kitchen revealed that there are live cockroaches. The inspector observed roaches in the spice storage area, on the glue pads in the dry storage area, in the utensils storage area close to the dry storage, underneath the sink in Meals and Wheels cook area. There was a live cockroach on the floor near the entrance door of the milk and juice fridge.

Interview with the dietary staff confirmed that they see cockroaches every day in the kitchen.

Interview with the nutrition manager and acting manager building services confirmed that the kitchen was flushed by pest control 3 weeks before and every week gel and sprays are applied by the pest control as required in identified areas.

A review of pest sighting report sheets revealed that the staff reported cockroaches in the 6th floor dining room, on 6th floor hallways on October 13, 2014, on the show plate at meal time on November 3, 2014, in the cafeteria on October 16, 2014, and second floor servery on October 20, 2014. These identified areas were not treated immediately by the pest control according to the report sheets. [s. 88. (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 immediate action is taken to deal with pests, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, falls prevention and management training is provided to all staff who provide direct care to residents.

A review of the training record for falls prevention and management revealed that 9% of the direct care staff did not receive training in falls prevention and management in 2013.

Interview with the acting director of nursing confirmed that training has not been offered to all staff who provide direct care to the residents as required. [s. 221. (1) 1.]

2. The licensee has failed to ensure that direct care staff are provided training in skin and wound care.

Review of the education records and interview with DON indicated in 2013, 80% registered nursing staff and 91% PCAs were not provided training in skin and wound care.

Record review and interview with DON confirmed not all direct care staff received training in skin and wound care. [s. 221. (1) 2.]

3. The licensee has failed to ensure that the licensee provided training related to continence care and bowel management to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs.

Review of the training record for 2013 indicated 89% of direct care staff and 93% of registered nursing staff were not provided training in continence care and bowel management.

Acting DON confirmed that not all staff who provide direct care to residents were provided training in continence care and bowel management. [s. 221. (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 for the purposes of paragraph 6 of subsection 76 (7) of the Act, falls prevention and management, skin and wound care, and continence care and bowel management training are provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges

The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.

2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.

3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.

4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.

5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.

6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.

7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.

8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee failed to ensure that the following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.

Review of the clinical records and interview with registered nursing staff and DON indicated that resident #17 uses the identified product to be applied on the buttocks every second day.

Interview with the NM from fourth floor confirmed that the family is paying for the product once it is ordered from the pharmacy. Further, during the interview, the NM confirmed that other family members pay for the dressing products, for instance resident #5 pays for the identified product $60.00/box of 10 sheets and resident #42 pays for other identified product $12.00 per tube. The NM and DOC confirmed it has been a rule for a few years that all residents pay for these supplies. The home does not provide these type of supplies and no other substitutes have been considered by the home as a replacement. [s. 245. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following charges that are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act, to be implemented voluntarily.

WN #9: 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 has failed to ensure that the resident's right to be properly fed in a manner consistent with his or her needs is fully respected and promoted.

Interview with the family member confirmed that on an identified day in October 2013, resident #17 was not fed by the home until 1.30 p.m.

A review of a plan of care revealed that there was a note made by the RPN indicating the staff usually first serve the dining room and than provide tray services in the resident rooms.

Interview with nurse manager confirmed that 1.30 p.m is too late for providing tray services. It is inappropriate and he/she can see poor co-ordination of the staff on that day. The home does not have anybody having room service at 1.30 pm. [s. 3. (1) 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the home's policy for wound and skin management is complied with.

Review of the policy "Skin Care and Wound Prevention and Management" dated October 1, 2010, indicates a purpose to initiate prompt, appropriate interdisciplinary skin care and wound prevention and management based on evidence and best practice. In the section for "Team Members-Roles and Responsibilities", the skin care coordinator and the NM 's role is to collaborate with the interdisciplinary team to coordinate skin and wound prevention and management strategies to act as a resource to unit teams on prevention and effective skin and wound prevention and management best practices, and to liaise with community resources to provide the best possible care to a resident with a wound.

Review of the clinical record for resident #17 and interview with registered nursing staff indicated the resident had a stage 2 wound on the buttocks for two years and it is not healed yet. Review of the treatment administration record for August, and September 2014 indicated an identified product to be applied on buttocks every second day. In September 2014, the treatment was changed. The wound was to be cleansed with an identified product first then other product to be applied every 2 days and as needed. The assessment form indicated the wound is not healed yet.

Interview with the skin care coordinator indicated if a resident has a stage 3 or 4 wound or a long- standing non-healing wound, the resident should be referred to community services such as the nurse practitioner or the wound care nurse from St. Elizabeth for further assessment.

Review of the resident's record and interview with registered nursing staff confirmed the resident was not referred to community services for further skin assessments according to the policy. [s. 8. (1) (b)]

WN #11: 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 has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, 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.

Record review of resident #5's plan of care revealed that the resident was assessed by dental services in 2012. There is no documentation available in the plan of care indicating that the resident was offered an annual dental assessment in 2013. [s. 34. (1) (c)]

2. Record review of resident #7's plan of care revealed that the resident was assessed by the dental services in 2010. There is no documentation available in the plan of care indicating that the resident was offered an annual dental assessment in 2011, 2012, and in 2013.

Interview with the registered nursing staff confirmed that he/she could not find any documentation whether the above mentioned residents has received offers for annual dental assessments in the above mentioned years.

Interview with the nurse manager indicated that the annual dental assessment was offered to the resident in 2013, however was not able to present any supporting document.

A review of a home's policy #NU-0501-02, titled Mouth Care, reviewed December 01, 2013, indicates "Dental assessment and preventive services shall be offered annually". [s. 34. (1) (c)]

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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

Interview with registered nursing staff indicated that whenever a resident has impaired skin integrity, a skin assessment should be performed and documented on a head to toe skin assessment form and the weekly skin assessments documented on a weekly ulcer/wound assessment record form.

Review of the nursing and personal care records and interview with registered nursing staff indicated resident #11 started having an open coccyx area in June 2014. A review of the physician's order from April 2014 indicated an identified product was to be applied to coccyx area during diaper change till healed.

Review of the medication administration record for May 2013 indicated the resident had an identified product applied to the coccyx open area at diaper change until the wound healed in May, 2014.

Review of the clinical record and interview with registered nursing staff confirmed, when

the resident exhibited altered skin integrity in April 2014, a skin assessment was not performed by a member of the registered nursing staff, using a clinically appropriate instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration implemented.

Review of the clinical record and interview with the registered nursing staff indicated resident #11 has impaired skin integrity on the coccyx since April 2014 and treatment was initiated. A referral was sent to the RD in May 2014 for weight loss but not for the skin problems. The RD assessed the resident for the skin problems in June 2014 and ordered a supplement, three times a day.

Review of the clinical record and interview with registered nursing staff confirmed the RD was not notified about the skin problems of resident #11 from April 2014 until June 2014 . [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown or wounds has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the clinical record and interview with registered nursing staff indicated that in July 8, 2013, resident #19 had an ileostomy insertion and started having skin problems in the peri-stoma area. In August 2013, he/she was sent to hospital again for assessment of the peri-stoma area. The ET nurse assessed the resident in August 2013 and October 2013 and at the last assessment, he/she recommended a ring to be applied in order to prevent leaking from the stoma and skin irritation.

Review of the clinical record and interview with the registered nursing staff confirmed that the altered skin integrity around the stoma was not reassessed at least weekly since August 2013. [s. 50. (2) (b) (iv)]

4. Review of the clinical record and interview with registered nursing staff indicated that resident #17 has a stage 2 pressure ulcer that has not healed in the last two years until the present moment.

Review of the clinical record and interview with registered nursing staff confirmed the weekly skin assessments were not completed on a weekly basis in August, September and October 2014. [s. 50. (2) (b) (iv)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee responds to the Residents' Council in writing within 10 days of receiving the advice.

Interview with the president of the Residents' Council confirmed that concerns raised by the Residents' Council receives response at the next meeting, which is usually every month and is not always in writing.

Interview with the assistant of the Residents' Council confirmed that the home does not initiate a Residents' Council follow-up form for each concern raised by the Residents' Council and the response is not always in writing and not within 10 days as the Residents' Council meets only every month. [s. 57. (2)]

WN #14: 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 has failed to ensure that if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), that the licensee responds to the Family Council in writing within 10 days of receiving the advice.

Review of the Family Council's minutes from January to October 2014 and interview with the president of the Family Council confirmed that the home was not providing a written response for any concern raised by the Family Council within 10 days until September 2014 when they started using the Family Council follow- up forms. [s. 60. (2)]

WN #15: 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).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed 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.

Observation conducted on October 28, 2014, at 12.30 p.m., in the second floor dining room revealed that there was a cup of unthickened water lying in front of resident #25.

A review of the plan of care of the resident revealed that the resident is on pureed-texture foods and nectar-thick fluids.

Interview with the private care giver who was feeding the resident confirmed that he/she used regular consistency water and added it into the resident's pureed textured soup to make it colder.

Interview with the charge nurse and nutrition manager confirmed that adding cold water to the pureed soup by the private care giver was not an appropriate action as it altered the taste, texture, and the quality of the soup. [s. 72. (3) (a)]

2. Observation conducted on October 28, 2014, at 12.30 p.m., in the second floor dining room revealed that the dietary aide used #10 scoop instead of #12 for pureed tossed salad, #16 instead of #12 for minced tossed salad, #12 instead of #16 for pureed peaches and pureed pears.

Interview with the dietary aide confirmed that he/she should use the appropriate size of scoop to serve foods to the residents, as indicated in the therapeutic menu.

Interview with the registered nursing staff and nutrition manager confirmed that use of inappropriate scoop size altered the quantity and nutritive value of the foods. [s. 72. (3) (a)]

3. The licensee has failed to ensure that the staff of the home comply with a cleaning schedule for all the equipment.

Observation conducted on November 6, 2014, at 10.40 a.m., in the kitchen, revealed that the fridge and freezer were not clean. Food crumbs were found on the floor close to the walls and in the corners of the dry storage. Sticky greasy dirt was found on the handles, walls and inner areas of the steamer. The dish washing area was not clean. The bottom shelves and drawers of the preparation tables were not cleaned. The hot food carts were found with the sticky greasy material on the walls and in the inner areas. The hand washing sink in front of the steamer was not clean.

Interview with the nutrition manager confirmed that the home has a cleaning schedule, however the staff do not comply with the schedule. [s. 72. (7) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (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: 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. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.

Interview with the President of the Residents' Council confirmed that the home has standard meal and snack times.

Interview with the nutrition manager confirmed that the home did not review meal and snack times with the Residents' Council but the home did review it with the Residents' Council during the inspection after being notified by the inspector. [s. 73. (1) 2.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Observation conducted on October 28, 2014, at 12.30 p.m., in the second floor dining room revealed that residents #21 and #26 were not provided rimmed plates at lunch. Residents #22 and #23 were not provided nosey cups.

A review of the plan of care of residents #21 and #26 indicated that residents should be provided with rimmed plates and residents #22 and #23 should be provided with nosey cups.

Interview with the FSW confirmed that he/she should provide the above-mentioned assistive devices for the above-mentioned residents as indicated in their plan of care.

Interview with the nutrition manager confirmed that above-mentioned residents should be provided assistive devices as indicated in their plan of care at meal times. [s. 73. (1) 9.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report informing the Director of an incident includes the outcome or current status of the individual or individuals who were involved in the incident.

Review of a critical incident report submitted to the director on May 2, 2014, for resident #21 and #25 revealed that the report was not amended related to the outcome or current status of the individual or individuals who were involved in the incident. During this inspection the Nurse Manager did complete the requested amendment on November 6, 2014.

Interviews with the Nurse Manager and the DON confirmed that the critical incident form for resident #21 and #25 was not amended when requested. [s. 107. (4) 3.]

2. The licensee has failed to ensure that the written report informing the Director of an incident includes whether an inspector had been contacted, and if so, the date of the contact and the name of the inspector.

Record review of a critical incident report failed to reveal that an inspector had been notified at the time of an incident related to sexual inappropriateness by resident #21.

Interviews with the Nurse Manager and the DON confirmed that the home failed to notify the Director as required by the Long-Term Care Home Act and Ontario Regulation 79/10. [s. 107. (4) 5.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Review of the clinical record and interview with the DON indicated that on an identified day resident #15 was given six identified medications from another resident and was sent to hospital for assessment. A critical incident report was submitted to the MOHLTC Director. The resident came back to the home the next morning with no side effects.

Observation of residents on the 5th floor, interview with registered nursing staff and DON confirmed that after the incident the home has implemented new interventions to prevent this type of incident from reoccurring. [s. 131. (1)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the clinical record and interview with registered nursing staff indicated resident #16 came back to the home from hospital on an identified day. The identified medication was confirmed with the physician and ordered from the pharmacy. The medication was started to be given to the resident the next day, in the morning. Interview with registered nursing staff and review of the clinical records and drug record book indicated on the evening of that day, the medication was not taken from the emergency box in order to be given to the resident.

The resident was prescribed on an identified day, an identified medication, twice daily for 10 days. The medication was ordered from the pharmacy the same day and was received in the home on the same day, in the evening. According to the physician's order and registered nursing staff interview the medication should be given the same day, and if it did not come from the pharmacy the same day, it was available in the emergency box. Review of the medication administration record and emergency medications supply indicated the medication was not signed as being given in the evening of the identified day, but it was started the next morning. Review of the 24-hour nursing report indicated notes by the evening nurse that the resident started on an identified medication at bed time, but according to registered nursing staff the nursing report is not the place where the medication administration is recorded.

On two occasions a medication was not given to the resident in accordance to the directions for use specified by the prescriber. [s. 131. (2)]

WN #19: 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 has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the requirement to communicate the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents to the Family Council of the home on an ongoing basis.

Interview with the president of the Family Council confirmed that the home staffing structure changed over two years and it was not communicated to the Family Council.

Interview with the administrator confirmed that the Family Council did not permit him/her to make presentations in their meetings (which was confirmed by the president of the Family Council) to share some of the information. Therefore it is difficult for the home to communicate some information to the Family Council. The home was not able to provide any supporting documentation of communicating this information with the Family Council. [s. 228. 3.]

WN #20: 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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program by labeling residents' personal care items.

Observations conducted on October 28, 29 and November 7, 2014, in shared resident bathrooms revealed unlabelled personal care items consisting of toothbrushes, toothpaste, deodorant, urinals, denture cup and bar soap.

An interview with the Infection Prevention and Control lead confirmed that the above identified personal care items should have been labelled with the resident names. [s. 229. (4)]

2. The licensee has failed to ensure that there is access to hand hygiene agents at point of care in resident rooms.

Observations conducted during inspection revealed that resident rooms were not equipped with hand hygiene agents at point of care.

An interview with Infection Prevention and Control lead confirmed that only a few rooms in an identified home area had hand hygiene agents at point of care and that the home was in the process of planning the installation and availability of hand hygiene agents in remaining resident rooms with their head office. [s. 229. (9)]

Issued on this 9th day of January, 2015

[redacted]

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

Original report signed by the inspector.