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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2017	2017_420643_0013	013526-17	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
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

ADAM DICKEY (643), ANGIE KING (644), FAYLYN KERR-STEWART (664), NATALIE MOLIN (652), SIMAR KAUR (654), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 4-7, 10-14, 17-21, 24-28, 31, August 1-4, 8-11, 2017.

The following critical incident intakes were inspected concurrently with the Resident Quality Inspection (RQI):
#016523-16, #019576-16, #024262-16 and #025176-16 related to alleged abuse;
#006798-17 and #007232-17 related to responsive behaviours;
#003738-17 related to unknown injuries;

#020712-16, #031589-16 and #004541-17 related to falls prevention and management; and
#031748-16 related to safe and secure home.

The following complaints were inspected concurrently with the RQI:
#028846-16 related to alleged neglect, falls prevention and management, and continence care,
#031774-16 and 005736-17 related to sufficient staffing,
#004477-17 and #008952-17 related to unknown injuries,
#010261-17 related to alleged abuse, menu planning and medication administration,
#011173-17 related to falls prevention and management,
#011529-17 related to skin and wound care, restraints, transferring and positioning, falls prevention and management, nutrition and hydration, continence care and infection prevention and control,
#013777-17, #009881-17 and #009880-17 related to alleged abuse and resident rights,
#014355-17 related to menu planning, and
#014604-17 related to hospitalization and change in condition.

The following compliance order follow-ups were inspected concurrently with the RQI:
#002322-17 related to neglect, and
#002328-17 related to pain management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Nursing (DON), Medical Doctor (MD), Nurse Managers (NM), Acting Nurse Manager (ANM), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Social Worker, Nutrition Managers, Building Services Manager, Practical Care Assistants (PCA), Heavy Duty Cleaner, Food Service Workers, Resident Services Manager, Recreation Services Assistant, Senior Clerk, Support Assistant "C", private sitters, volunteers, residents, family members, Substitute Decision Makers (SDM), Residents' Council and Family Council Representatives.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff

training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
8 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_302600_0015	643
O.Reg 79/10 s. 52. (2)	CO #002	2016_302600_0015	643

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. (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. (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 there is a written plan of care for each resident that sets out, the planned care for the resident.

A Critical incident system report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to an alleged abuse reported by resident #031's substitute decision maker (SDM). The MOHLTC also received a complaint from resident #031's SDM, related to the same incident. An additional complaint was received from resident #031's SDM in relation to resident #031's injuries of unknown cause.

Review of the CIR revealed that on an identified date, resident #031's SDM reported to the home that resident #031 had specified injuries.

Review of complaints revealed that resident #031's SDM stated that the resident was observed having specified injuries on the above mentioned identified date, and he/she was concerned for the resident. Additionally, resident #031's SDM stated that there had been many incidents and he/she was very worried.

Review of an assessment for resident #031, revealed that the resident exhibited specified responsive behaviours during the observation period prior to the assessment.

In an interview, resident #031's SDM stated that resident #031 has been neglected

because he/she found the resident was in bed one day when visiting.

In interviews, Personal Care Assistant (PCA) #133 and Registered Practical Nurse (RPN) #160 stated that resident #031 exhibited specified responsive behaviours. PCA #133 and RPN #160 also stated that resident #031 required supervision and encouragement to eat and remain in the dining area. PCA #133 and RPN #160 further stated that a specified intervention was used by staff to prevent altercations between resident #031 and other residents in the dining area. RPN #160 stated that the decision of implementing the specified intervention for resident #031 was made during one of the care conferences, and resident #031's SDM was present at the care conference and was aware of the decision.

In interview, Behavioural Support Ontario (BSO) RPN #164 stated that resident #031 may exhibit identified responsive behaviours in the dining area, and the specified intervention can prevent the risk of resident #031 harming him/herself or other residents.

Observations by the inspector over a three day period, revealed that resident #031 was in the dining area at identified times assisted by staff for eating.

Review of resident #031's health record and progress notes failed to reveal the documentation of the care conference indicating the above mentioned specified intervention.

Review of resident #031's written plan of care failed to reveal the above mentioned intervention for the resident's responsive behaviour.

In interview, Nurse Manager (NM) #130 stated that when an intervention is found effective, staff are expected to discuss the strategy with BSO team, develop the plan of care in collaboration with the BSO team, and include the intervention in the written plan of care. NM #130 confirmed that resident #031's written plan of care should have been updated to reflect the above mentioned intervention for the resident's responsive behaviour. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided as specified in the plan.

A complaint was received by the MOHLTC related to staff not providing resident #001

with enough food and/or fluids.

A review of resident #001's plan of care revealed he/she was to receive a specified volume of fluid at meals. A physician's order also indicated the resident is to receive the specified volume of fluids at meals and a specified volume of fluids at snack passes.

A review of the diet list in the unit servery indicated resident #001 is to receive the specified volume of fluids at meals.

Observations by the inspector revealed that resident did not receive the specified fluids as ordered. Additional observations of snack passes, revealed resident #001 did not receive the specified volume of fluids.

In an interview with PCA #124, he/she stated that resident #001 did not receive the specified volume of fluid at an identified meal service.

An interview with Food Service Worker (FSW) #125 revealed that he/she was responsible for serving fluids at the meal and was not aware that resident #001 is to receive the specified volume of fluids at meals.

In an interview, Nutrition Manager #120, stated that it was the FSW's responsibility to serve fluids as written on the diet list, and it was the home's expectation that staff comply with and serve prescribed fluids to resident #001.

The licensee has failed to ensure resident #001 received prescribed fluids as noted in the 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 with ensuring that the written plan of care for each resident sets out the planned care for the resident; and that the care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

As required by Regulation O. Reg. 79/10, s. 114. (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the home's medication policy titled Medication Management, Policy Narcotic and Controlled Medications, Section 01-General Information, number MM-0106-00, published date April 1, 2016, Policy Procedure section Documentation and Monitoring, #10 stated that at shift change, one nurse from the outgoing shift and another nurse from the oncoming shift, will count narcotics and controlled medications and document the count by utilizing the Combined Monitored Medication Record With Shift Count.

Record Review of the Narcotic and Control Drug count sheets by the Inspector on an identified date, revealed RPN #131 and RPN #132 had completed a Narcotic and Control Drug count at an identified time for end of shift with a documented time five and one half hours later than signed for.

A review of the individual resident’s Medical Pharmacies Narcotic and Controlled Combined Monitored Medication Record by the Inspector revealed the shift count was done at above mentioned identified time by the RPNs and they had documented, signed off for the departing nurse medication counts five and one half hours prior to end of shift for five identified residents.

Interviews with RPN #131 and RPN #132 revealed that they had administered their scheduled narcotic and control medications and would not be administering again therefore completed the shift count. Both RPNs stated they should not have completed the shift count until the end of their shift with the oncoming nurse.

Interviews with Director of Nursing (DON) and NM #103 stated that it was the home's expectation to have two nurses at shift change complete the count of the narcotic medications, and sign on the count sheet after conducting the count. The DON and NM #103 further confirmed that staff # 131 and #132 did not comply with the home’s Narcotic Control policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring the required medication management policy is complied with,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #019 was protected from abuse.

A CIR was submitted to the MOHLTC, related to a witnessed incident of resident to resident abuse involving residents #012 and #019. Review of the CIR revealed that resident #012 was witnessed by RSA #141 abusing resident #019. A second CIR was submitted fifteen days later related to a subsequent incident of resident to resident abuse involving residents #012 and #019. Review of the CIR revealed that a PCA responding to resident #019's call bell found resident #012 in resident #019's room with resident #019.

Review of resident #012's health records revealed he/she had identified diagnoses, and a history of exhibiting responsive behaviours toward the staff. Review of progress notes revealed resident #012 exhibited identified responsive behaviours on six occasions over a ten day period prior to the first incident. Progress notes revealed resident #012 also had a history of entering co-resident rooms.

Review of resident #012's written plan of care, revealed staff were instructed to place him/her away from co-residents when in a specified common area. Staff were also instructed to check resident #012's whereabouts especially on identified shifts.

Review of a progress note revealed RSA #141 reported to acting nurse manager (ANM) #180 that he/she had witnessed resident #012 abusing resident #019. The progress note further revealed that resident #019 was very upset by the incident and asking why did resident #012 do this to him/her.

In an interview, RSA #141 stated that he/she had heard resident #019 saying "stop" when RSA #141 saw resident #012 abusing resident #019. RSA #141 further stated that resident #019 was upset and distraught at the time of the incident. RSA #141 stated he/she called to ANM #180 who came onto the scene and witnessed the end of the incident.

In an interview, ANM #180 stated that he/she had heard RSA #141 trying to stop resident #012, who was abusing resident #019. ANM #180 further stated that resident #019 was upset by the incident and was being reassured by RSA #141. ANM #180 stated that resident #012 and #019 were immediately separated and the incident was reported to police.

Review of progress notes revealed resident #012 was found in resident #019's room abusing resident #019. Resident #019 activated the call bell and resident #012 was removed from the room by the assigned PCA and redirected to his/her room. The progress notes further revealed that resident #012 was asked what he/she was doing in resident #019's room and could not explain his/her presence there.

In an interview, PCA #144 stated that he/she had answered resident #019's call bell and found resident #019 alongside resident #012's bed. PCA #144 further stated that resident #012 was abusing resident #019. PCA #144 stated that the staff were aware of resident #012's history of responsive behaviours and had been instructed to keep an eye on him/her as there was a previous incident. PCA #144 further stated that resident #012 had a history of entering a co-resident's room in the past.

In interviews, RPN #172 and RN #173 stated that staff were aware of resident #012's responsive behaviours and were monitoring him/her closely. RPN #172 further stated that resident #012 was on modified dementia observation system (DOS) monitoring, though staff did not believe that resident #012 would go to resident #019's room as they were not located close together.

In an interview, ANM #180 stated that strategies had been established to monitor resident #012 related to his/her recent behavioural history. ANM #180 further stated that

resident #012 was placed in an identified area so that staff could monitor him/her to make sure that resident #012 was not seated near resident #019. ANM #180 stated that in these incidents resident #012 had demonstrated specified responsive behaviours toward resident #019, and that resident #019 had not consented and was upset by the incidents.

In an interview, the DON acknowledged that in these incidents that the home had failed to protect resident #019 from abuse. [s. 19. (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 with ensuring that residents are protected from abuse by anyone,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIR was submitted to the MOHLTC on an identified date, related to an incident of alleged abuse of resident #021 which occurred two days prior. The CIR indicated that resident #030's family member had witnessed resident #021's family member abusing resident #021. Staff overheard the family members arguing and were informed by resident #030's family member of the allegation of abuse of resident #021.

Review of the home's policy RC-0305-00 titled zero tolerance of abuse and neglect published August 1, 2016, revealed that it is the responsibility of registered staff to inform the nurse manager(NM) or RN in charge (RNIC) immediately once an allegation suspicion or witnessed incident of abuse has been made. This includes informing the on-call manager. Management level staff would then immediately notify the MOHLTC that an alleged, suspected, or witnessed incident of abuse or neglect has become known.

Review of resident #021's progress notes revealed that on the day prior to the above mentioned incident, PCA #145 had witnessed resident #021's family member abusing resident #021. PCA #145 reported this to RPN #146 who assessed the resident for injury.

In an interview, RPN #146 stated that he/she had received the report from PCA #145, and entered a progress note detailing the report. RPN #146 further stated that he/she did not report this to anyone, as there was no injury and based on the family involvement with resident #021's care did not suspect abuse of the resident. RPN #146 stated that the PCA's report would be considered an allegation of abuse and according to the process in the home was expected to report to the RN in charge or Nurse Manager.

Review of resident #021's progress notes revealed that at an identified date and time, RN #147 had responded to loud noise in the hallway while he/she was assisting residents with feeding in the dining room. The progress note indicated that RN #147 saw resident #021's family member arguing with resident #030's family member and had intervened in the incident. The progress note indicated that resident #030's family member stated that she had witnessed resident #021's family member abusing resident #021, though this was not witnessed by staff. Progress note written by RPN #146 indicated that he/she and RN #147 had checked resident #021's skin and no new injuries were noted. RPN #146 informed resident #021's SDM about the incident.

In an interview, RN #147 stated that a family member of another resident had said resident #021's family member had abused resident #021. RN #147 further stated that he/she documented in resident #021's chart, but did not report the allegation of abuse of resident #021 as it was not witnessed by staff. RN #147 stated that the process in the home when receiving allegations of abuse of a resident would be to report the RN in charge and not just make a progress note entry.

In an interview, Nurse Manager #103 stated that the process in the home was for

registered staff to report to the RN in charge or Nurse Manager any allegations of abuse of a resident. NM #013 further stated that these allegations would be reported to the DON. NM #103 stated that on the day prior to submitting the CIR he/she had received the report of an incident between family members of residents #021 and #030 daughter that had occurred the previous day. NM #103 further stated that he/she was not aware of the incident that was reported by PCA #145 to RPN #146. NM #103 stated that he/she had reported to NM #122 who was covering for the DON at the time about the incident that occurred between the family members of residents #021 and #030 on the day the CIR was submitted. NM #103 was told by NM #122 to submit the CIS report as there were allegations of abuse of resident #021. NM #103 stated he/she had not reported to the DON immediately as per the home's policy, and that RPN #146, RN #147 had both failed to comply with the home's zero tolerance of abuse policy related to immediate reporting of allegations of abuse of a resident. [s. 20. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #012 demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A CIR was submitted to the MOHLTC, related to a witnessed incident of resident to resident abuse involving residents #012 and #019. Review of the CIR revealed that resident #012 was witnessed by RSA #141 exhibiting an identified behaviour toward co-resident #019. A second CIR #M504-000025 was submitted fifteen days later related to a subsequent incident of resident to resident abuse involving residents #012 and #019.

Review of resident #012's health records revealed he/she had identified diagnoses, and a history of exhibiting responsive behaviours toward the staff. Review of progress notes revealed resident #012 exhibited identified responsive behaviours on six occasions over a ten day period prior to the first incident. Progress notes revealed resident #012 also had a history of entering co-resident rooms.

Record review of the home's policy #RC-0517-07 titled "Behavioural Response-Care Strategies: Modified Dementia Observation System" dated March 1, 2015, indicated the DOS is used as a component of the assessment for new or escalating behaviours in order to gain a better insight and understanding of the time, pattern and antecedents leading to behavioural response when the root cause or triggers are difficult to identify.

Review of resident #012's progress notes and interviews with RPN #164 and RPN #176, who were members of the Behavioural Supports Ontario (BSO) team, revealed that resident #012 had been placed on DOS monitoring over a three week period. Review of the DOS monitoring records for resident #012 revealed that there were entries missing for eighteen days.

In an interview, the DON stated that it was the expectation of the home to complete the DOS monitoring records hourly during the monitoring period to identify any patterns or triggers to a resident's behaviour. The DON acknowledged that the DOS monitoring records for resident #012 were not completed as per the expectations of the home.

The home is not in compliance with documenting resident #033's responses to interventions related to his/her responsive behaviours. [s. 53. (4) (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 with ensuring that for residents demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented,, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods and fluids in the food production system are prepared, stored and served using methods to prevent adulteration, contamination and food-borne illness.

a. Observations by the inspector in an identified unit dining room revealed PCA #133 serving dessert choices of berry mousse and peaches. PCA #133 took a two-tiered cart with covered, pre portioned desserts in dishes and began to present the dishes to residents. PCA #133 was observed presenting dessert choices closely in front of three residents who all chose peaches. PCA#133 returned to the cart to get another portion of peaches each time, though he/she had presented the same potion of berry mousse to all three residents. The fourth resident selected the berry mousse and was given the portion that PCA #133 had presented to all three prior residents.

In an interview, Nutrition Manager #120 stated that it was the expectation of the home to have dessert choices presented as show plates then providing residents with a portion that was taken from the covered tray on the cart. He/she further stated that it was not the proper practice in the home for desserts to be presented uncovered to residents then subsequently served to another resident. Nutrition Manager #120 acknowledged that this method of serving desserts did not effectively prevent adulteration, contamination and food-borne illness.

b. Observations by the inspector in the fourth floor unit dining room revealed Food Service Worker (FSW) #134 serving dessert choices of chocolate cookie and applesauce to residents from a two tiered cart with covered trays. FSW #134 was observed presenting the dessert choices by placing both options onto the surface of the dining table in front of the resident to choose. The resident chose a cookie and FSW #134 returned to the cart and placed the applesauce that was not chosen back onto the tray and took the cart to the next table. FSW #134 was then observed presenting the same applesauce to a subsequent resident who chose the applesauce.

In an interview, Nutrition Manager #121 stated that it was the expectation of the home for the food service workers to offer the dessert choices from the cart and place the chosen dessert on the table for the resident. Nutrition Manager #121 further stated that this method was used in order to prevent contamination of the dessert. Nutrition Manager #121 acknowledged that the method in which FSW #134 was serving the dessert choices did not effectively prevent adulteration, contamination and food-borne illness. [s. 72. (3) (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 with ensuring that all foods and fluids in the food production system are prepared, stored and served using methods to prevent adulteration, contamination and food-borne illness,, to be implemented voluntarily.

WN #7: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The license has failed to ensure that the dining and snack service included proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Observations by the inspector in an identified unit dining room at an identified date and time, revealed resident #013 being assisted with feeding by RN #101. Resident #013 was seated tilted back in a wheelchair while being assisted with feeding.

Resident #013's feeding position was brought to the attention of Registered Dietitian (RD) #102 who stated that this was not a safe feeding position for resident #013. RD #102 stated that it was the expectation of the home that residents be positioned as close to 90 degrees as possible.

Review of resident #013's written plan of care revealed that he/she is totally dependent on staff and required the assistance of one staff member for feeding due to impaired cognition. Staff are instructed to sit to feed, make eye contact with him/her and that resident #013 should be sitting in upright position.

Observations by the inspector at an identified date and time revealed PCA #135 standing in front of resident #013 while spooning food into the resident's mouth. Upon the inspector's entrance into the dining room PCA #135 was told by a student RPN to sit down. Resident #013 was observed to be seated in a tilted position in his/her wheelchair at the time.

In an interview, RPN #128 stated that residents should be seated in an upright position while being assisted with feeding. RPN #128 further stated that staff should never stand while assisting a resident with feeding, and that the staff and resident should be sitting at eye level to reduce the risk of aspiration.

In an interview, the DON stated it was the expectation of the home for residents to be seated upright while being assisted with feeding. The DON further stated that staff members should be seated facing the resident not feeding from a standing position. The DON stated that the importance of this positioning was to facilitate swallowing and to prevent the resident from choking. The DON acknowledged that resident #013 was not positioned safely while being assisted with feeding as observed by the inspector. [s. 73. (1) 10.]

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 with ensuring that the dining and snack service includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #8: 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

Observations by the inspector in an identified unit dining room at an identified date and time revealed FSW #125 removed dirty dishes and utensils from table #9 and placed them in a receptacle located on a cart. The FSW then proceeded into the servery to commence serving additional foods without performing hand hygiene.

In an interview, FSW #125 confirmed that he/she did not perform hand hygiene after clearing the dirty the dishes from table #9. The FSW was unable to indicate that it was the home's practice to perform hand hygiene following the removal of dirty dishes.

During an interview with Nutrition Manager #120, he/she indicated the DA is to comply with hand hygiene practice after disposing of dirty dishes. NM #120 stated the home's practice is to complete hand hygiene after removing dirty dishes to prevent the spread of

infection.

The licensee failed to ensure that FSW #125 participated in the implementation of the infection prevention and control program. [s. 229. (4)]

2. The licensee has failed to ensure that on every shift symptoms indicating the presence of infection in residents are recorded and that immediate action is taken as required.

a. Review of resident #003's progress notes revealed that on an identified date resident #003 presented with cold symptoms and elevated temperature which was treated with an identified medication. Resident #003 was placed on droplet precautions and was assessed by the MD on the following day, when a x-ray and identified medication were ordered. Resident #003's symptoms continued to be monitored each shift. Resident #003 was sent to the hospital eight days after initial symptoms were observed for assessment of his/her ongoing symptoms.

In an interview, RN #108 stated that registered staff are required to monitor and document residents showing symptoms of infection on each shift. He/she further stated that this documentation would be entered into the 24-hour report for the shift as well as the resident's progress notes.

Review of resident #003's progress notes and 24-hour shift reports from the third floor unit failed to reveal documentation of symptom monitoring for six shifts prior to being sent to hospital.

b. Review of resident #009's progress notes revealed that on an identified date, he/she had been noted to have an occasional congested cough. Vital signs were assessed for resident #009 and at an identified time he/she was noted to have an elevated temperature and an identified medication was given with good effect. Resident #009's symptoms were monitored throughout the night showing continued symptoms. On the following day, resident #009 continued to have a dry cough and elevated temperature and an identified medication was administered and isolation precautions were initiated. Respiratory outbreak was declared in the home. Resident #009's symptoms continued to be monitored for two weeks.

In an interview, RPN #107 stated that when residents are showing signs and symptoms in an outbreak situation the resident would be placed on a line list to be monitored each shift. RPN #107 further stated that the residents symptoms should be documented in the

chart on the progress notes as well as on the 24-hour report.

Review of resident #009's progress notes and 24-hour reports for the third floor unit failed to reveal documentation from four shifts over the two week period.

In an interview, Nurse Manager (NM) #103 who was the lead for Infection Prevention and Control stated that it was the expectation of the home for residents showing symptoms of infection to be monitored on each shift. NM #103 further stated that this symptom monitoring should be documented in the progress notes of the affected resident and confirmed infections should be documented in the 24 hour reports so that he/she could monitor for disease outbreaks. NM #103 acknowledged that licensee had failed to ensure that on every shift symptoms indicating the presence of infection for residents #003 and #009 were recorded. [s. 229. (5) (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 with ensuring that staff participate in the implementation of the infection prevention and control program; and ensuring that on every shift symptoms indicating the presence of infection in residents are recorded and that immediate action is taken as required, to be implemented voluntarily.

Issued on this 28th day of September, 2017

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

Original report signed by the inspector.