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

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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 2, 2015	2015_251512_0012	T-1641-15	Resident Quality Inspection

Licensee/Titulaire de permis

BETHANY LODGE FOUNDATION
23 Second Street MARKHAM ON L3R 2C2

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

BETHANY LODGE
23 Second Street MARKHAM ON L3R 2C2

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

TILDA HUI (512), GORDANA KRSTEVSKA (600), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16 & 17, 2015.

The inspection related to the following log number was conducted concurrently: T-2132-15, follow up past due order.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), food service manager (FSM), environmental service manager (ESM), life enrichment manager (LEM), registered dietitian (RD), physiotherapist (PT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), physiotherapy assistant (PTA), life enrichment aide (LEA), cook, dietary aide (DA), housekeeping aides, residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observations in home and resident areas, observations of care delivery processes, review of the home's policies and procedures, and residents' health records.

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
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **1 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. 9. (1)	CO #001	2015_357101_0007	600

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).

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

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

Findings/Faits saillants :

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

On two identified dates and times during the inspection, the inspector observed resident #034 sitting in an identified common area and was not engaged in any activity.

Review of the current written plan of care revealed that resident #034 enjoyed identified recreational activities.

Interview with the life enrichment staff #112 indicated that the staff had documented each time he/she had offered the resident to attend an activity as indicated in the resident's written plan of care.

A review of the resident's attendance sheet for two identified months, revealed and interview with the life enrichment manager confirmed that resident #034 was not offered any activity for two weeks during the above mentioned months. [s. 6. (7)]

2. On two identified dates and times during the inspection, the inspector observed resident #035 sitting in an identified common area and was not engaged in any activity.

Review of the current written plan of care revealed that resident #035 enjoyed identified recreational activities.

Interview with the life enrichment staff #112 indicated that the staff had documented each time he/she had offered the resident to attend an activity as indicated in the resident's written plan of care.

Review of the resident's attendance sheet for two identified months revealed and interview with the life enrichment manager confirmed that resident #035 was not offered any activity in two weeks during the above mentioned months. [s. 6. (7)]

3. The licensee had failed to ensure that the provision of the care set out in the plan of care is documented.

Observations made on three identified dates, and resident interview during the same period, revealed that during the day resident #008 required staff assistance for continence care when requested. However, the resident indicated that during the night he/she was totally dependent on staff to meet his/her continence care.

Review of the resident's current written plan of care revealed the resident's continence status and the level of care and frequency required to be provided by staff. Staff were required to document each time when continence care was provided in the PSW's flow sheets. Review of the PSW flow sheets during two identified periods of time indicated that the continence care provided to resident was not documented during some of the night shifts.

Interviews with PSW staff #108, #123, and #124 indicated resident #008 was on a scheduled continence care plan, PSWs provided assistance when the resident called for assistance. The PSWs confirmed that at night, staff checked and provided continence care as needed. Interview with RPN #125 and the ADOC confirmed that staff had provided continence care to the resident during night shifts but did not consistently document as per plan of care. [s. 6. (9) 1.]

4. Review of the current written plan of care revealed that resident #005 was totally dependent on staff for care. Staff had to perform all activities of daily living (ADLs) for the resident. The resident was noted to have medical conditions that required a special care procedure whenever the resident was in bed.

Further review of the plan of care indicated that staff were required to check the resident every hour, reposition him/her every two hours and document in the PSW flow sheets.

Review of the PSW flow sheets for Turning and Repositioning during an identified period of time did not reveal any evidence that the resident was being repositioned as indicated in the plan of care on 13 identified dates during the above mentioned period of time.

Interview with staff #133 indicated and staff #131 and #134 confirmed that the resident was being repositioned every two hours. However, staff did not document each time care was provided. [s. 6. (9) 1.]

5. Record review revealed that resident #021 had been missing on an identified date and time for an identified period of time. Resident was later found in an identified area and was sent to the hospital for further assessment. The resident returned from the hospital after an identified period of time with no major injury observed. An identified intervention was implemented upon the resident's return to the home and the written plan of care was revised to include this intervention. Furthermore an identified monitoring record for hourly checks was initiated and staff had been documenting the time whenever they checked the resident.

The record review indicated that documentation for hourly checks on seven identified dates during identified periods of time were not completed.

Interview with the director of care confirmed that if the written plan of care directs staff to monitor the resident hourly, staff are expected to monitor and document the intervention in the monitoring record hourly. [s. 6. (9) 1.]

6. Review of resident #003's assessment conducted on an identified date revealed that the resident has two identified areas of altered skin integrity. The record further indicated identified treatments and interventions had been provided to the resident to manage the skin issues.

A review of a monitoring record over an identified four week period for a specific intervention revealed a lack of documentation on nine identified dates.

Interview with staff #129 indicated that if a resident is on this specific intervention, the staff should perform the intervention for the resident and document after the intervention

is done. He/she also confirmed that the record for the above mentioned dates indicated no documentation for the intervention provided.

Interview with the DOC confirmed that staff should document in the monitoring record every time after they perform the intervention for the resident. [s. 6. (9) 1.]

7. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

Record review of resident #001's assessment conducted at an identified date indicated the resident's continence status. Furthermore the assessment indicated that the resident’s continence level had deteriorated by one level over the past quarter. The interventions set out in the most recent written plan of care indicated that the resident was able to report his/her continence needs, and staff were to respond to the resident's request as soon as possible to meet his/her care needs. Review of the plan of care did not indicate that there was a deterioration in the resident's continence status and increased care needs.

Interview with the staff #135 indicated that the resident's continence level had slightly deteriorated and the resident should have been re-assessed and plan of care updated to address that change.

Interview with the DOC confirmed that when staff identify a change in a resident's level of continence, after the assessment is conducted and documented, the written plan of care should be updated to reflect the resident’s new care needs. [s. 6. (10) (b)]

8. Observation made on an identified date during the inspection, revealed that resident #006 had an identified prostectic device. However, the resident refused to wear it, and staff stored the device in an identified area in the resident's room.

Review of the current written plan of care indicated that the resident had the prostectic device and staff should clean the device at an identified frequency daily.

Interviews with PSW staff #119, #108, #120, and RPN staff #126 indicated that the resident had not worn his/her device for at least a year because the device did not fit properly. Staff indicated that the resident had some sensitivity wearing the device and therefore refused to wear it. The RPN also confirmed that the resident's current care

needs of wearing the device was not included in the written plan of care. [s. 6. (10) (b)]

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

On two identified dates and times during the inspection, resident #033 was observed sleeping in his/her room.

Record review of the most recent written plan of care revealed that resident #033 enjoyed two identified recreation programs. A review of the progress notes documented on an identified date, indicated the resident's condition limited him/her to bed which diminished his/her ability to be involved in group activities.

Interview with the life enrichment staff #112 indicated that he/she had documented each time he/she had offered the resident to attend an activity.

A review of the resident's attendance sheet for two identified months revealed, and interview with the life enrichment manager confirmed that the resident's plan of care should have been revised when the resident's needs changed and could no longer participate in the identified programs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, the provision of the care set out in the plan of care is documented, the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident has the right to be afforded privacy in treatment.

Observation made during the inspection, on an identified unit noted RPN staff #138 administering an identified medication to resident #016. After performing hand hygiene and checking on the medication order on the electronic medication administration record (eMar), the RPN proceeded to prepare the medication, and explained to the resident what he/she was going to do. Then the RPN administered the medication on an exposed part of the resident's body. The medication administration occurred in the hallway near the nursing station. One visitor walked by the resident and the RPN while the administration was taking place.

Interview with the RPN confirmed that the identified medication administration was better performed in places where privacy to treatment for the resident can be protected. Interview with the ADOC confirmed that the administration on the resident should not be performed in a public area. [s. 3. (1) 8.]

2. The licensee has failed to ensure that the resident's right to have his or her personal health information kept confidential, is fully respected and promoted.

Observation made on an identified date and time during the inspection, on an identified unit noted the eMar screen was left open on top of a medication cart in the hallway outside an identified common area, exposing private health information of resident #015. RPN staff #125 was in the common area talking to a resident at the time. The inspector waited for the RPN to come out of the common area and returned to the medication cart. The RPN confirmed that she had forgotten to close the eMar screen before she stepped away from the medication cart.

Interview with the ADOC confirmed that the RPN should have logged off from the eMar screen when stepped away from the medication cart. [s. 3. (1) 11. iv.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home and equipment are kept clean and sanitary.

Observations made on two identified dates during the inspection revealed that the inside of the toilet bowls in eight identified residents' washrooms were stained with dirt debris. Raised toilet seats were noted screwed onto these toilet bowls.

Interview with the environmental service staff #103, #104, #105 and the environmental services manager (ESM) confirmed that the above mentioned toilet bowls were stained with dirt debris. The above identified environmental service staff indicated that they did not have time daily to unscrew the raise toilet seats and clean the toilet bowls properly. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home's equipment were maintained in a safe condition and in a good state of repair.

Observations made on two identified dates during the inspection revealed that raised toilet seats in five of identified residents' washrooms were cracked and broken.

Interview with the environmental service staff #103, #104, #105 and the ESM confirmed that the above mentioned raised toilet seats installed on top of the toilet bowls were broken. The ESM indicated he/she had ordered new raised toilet seats and had informed the service provider about the poor quality of the products. [s. 15. (2) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of resident #009's progress notes revealed that the resident had multiple falls during an identified two week period. The resident was transferred to hospital after the last fall incident.

Review of the written plan of care revealed the resident had multiple falls and there was no documentation to indicate that the resident had a post fall assessment using a clinically appropriate tool that is specifically designed for falls.

Interviews with RPN staff #115 and #116 indicated the resident had a head injury routine (HIR) assessment following each fall. Interview with the PT and the DOC confirmed that the home did not have a clinically appropriate assessment instrument that is specifically designed for falls. The DOC indicated that the home is in the process of developing one. [s. 49. (2)]

2. Review of resident #004's assessment conducted on an identified date, indicated that the resident had one fall in the last 30 days and one fall in the last 180 days. Review of the resident's progress notes revealed that the resident had a fall with no injury on two identified dates. The resident was subsequently sent to the hospital six days after the last fall and was diagnosed with an injury. Record review revealed no clinically appropriate assessment instrument was completed for either fall.

Interview with physiotherapy staff#121 indicated that he/she used the common assessment instrument titled SOAP which had been recognized by the College of Physiotherapists.

Interview with the DOC confirmed that the home is working on creating a new clinically appropriate instrument for falls assessment. Before a new instrument is developed, staff are expected to complete the Resident Incident Report in point-click-care (PCC) after each fall.

Review of the Resident Incident Reports in PCC did not reveal any evidence of post-fall assessments having been conducted for the resident after the two above mentioned falls. [s. 49. (2)]

WN #5: 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, has received 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.

Observation made on an identified date during the inspection revealed resident #013 having altered skin integrity on an identified part of the body.

Review of the resident's progress notes documented on an identified date revealed resident #013 had an altered skin integrity on an identified part of the body. Further record review revealed on a second identified date, the resident sustained a different type of altered skin integrity on another identified part of the body. The record review identified no skin assessment conducted on the resident by a registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment on or after the two above mentioned dates when alteration in skin integrity were identified.

Interview with RPN staff #141 indicated that he/she did not assess the resident using a clinically appropriate assessment instrument when skin integrity was first identified. The RPN indicated the resident's identified altered skin integrity was coming and going, and they have obtained an order from the attending physician to administer a medication on as needed basis. The RPN also confirmed that he/she was not aware that the identified altered skin integrity on the resident had deteriorated. The RPN indicated that five weeks after the first date when the altered skin integrity was identified, he/she conducted a quarterly assessment for the resident and the resident's skin was intact. Interview with PSW staff #108 indicated that the PSW was not aware of any deterioration on the resident's skin.

Interview with the Quality Assurance Coordinator/Wound Care Lead confirmed that every skin impairment should be assessed using the clinically appropriate assessment instrument provided for by the home in Point Click Care (POC). [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.

Observation made on an identified date during the inspection revealed resident #013 having altered skin integrity on two identified parts of his/her body.

Review of the resident's progress notes revealed documentation on an identified date that the resident had similar type of altered skin integrity on the same two identified parts of his/her body. Further record review revealed on an identified date five weeks earlier, the resident sustained another type of altered skin integrity on a second part of his/her body.

Review of the home's policy Resident Care and Services manual, subject Skin Care and Wound Management program, revealed that under Procedure, item 4, referrals are made to RD and registered nursing staff receive order for treatment. In item 10, it was stated that all disciplines involved in the promotion of skin integrity and wound issue (included but not limited to RD, nursing and physiotherapy) are required to ensure that the plan of care is updated and reflective of resident's current condition.

Record review did not reveal any indication of an assessment of the resident by the RD on or after the two above mentioned dates when altered skin integrity was identified.

Interview with the RD confirmed that resident had not been assessed for alteration in skin integrity. Interview with the DOC confirmed that the resident should have been assessed by the RD when he/she sustained the two identified altered skin integrity. [s. 50. (2) (b) (iii)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal.

Observation made on an identified date during the inspection, revealed that pureed bread for residents on texture modified diet, tortellini and Carammila cake planned for lactose reduce diet were not available or offered to the residents with the above identified diet and texture modification.

Review of the spring/summer menu, week 2, as well as the production sheets revealed that the above mentioned menu items were planned for lunch but were not produced and not available for residents. There were no substitutions for these items observed.

Interview with dietary aide staff #100 confirmed that those items were not available during meal service on the above mentioned date. Interview with cook staff #102, confirmed that the pureed bread was not prepared for lunch, the tortellini were not ordered and the Carammilla was planned for another day. [s. 71. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that menu substitutions are documented on the production sheet.

On an identified date during the inspection, at lunch meal service, the inspector observed eggplants served as an alternate vegetable choice.

A review of the weekly spring/summer menu revealed that brussels sprout were planned as the alternate vegetable choice. Interview with the FSM confirmed that brussels sprouts were substituted with fresh eggplant.

Review of the production sheets revealed and interview with cook #147 and the FSM confirmed that the above identified substitution was not documented on the production sheets. [s. 72. (2) (g)]

2. The licensee has failed to ensure that all food were prepared using methods which preserve taste and nutritive value.

Observation made on an identified date during the inspection, revealed staff #147 when preparing a homemade potato salad, did not follow the home's recipe. An interview with staff #147 confirmed that he/she did not add vinegar, lemon juice, and sugar to the recipe. The staff also used six eggs less than required in the recipe, and added season salt that was not included in the recipe.

Review of the Homemade Potato Salad recipe indicated that the following ingredients are required to prepare the potato salad: 122 milli-litres (ml) white vinegar, 16ml lemon juice,

28ml yellow mustard, 81ml granulated sugar, ¼ teaspoon hot tabasco sauce, 122 ml oil, 16-1/4 cooked eggs, 16ml ground black pepper, 745ml mayonnaise, 446g diced frozen celery, and 243g diced frozen onions.

Observation on an identified date during the inspection, revealed the quantity of pastrami filling served contained a quarter of the required protein. Interview with staff #147 confirmed that each sandwich was spread with two teaspoons of pastrami filling instead of eight teaspoons as in a #16 scoop as required.

Record review of the plan of care of the following residents revealed and interview with the RD confirmed that:
- resident #037 is high risk due to a history of poor food intake, required 62-70g of protein daily,
- resident # 038 is high risk due to poor food and fluid intake, required 45-56g of protein daily and is a picky eater,
- resident #039 had a significant weight change, fair to poor food intake, and protein requirement is 38-47g daily,
- resident #040 is high risk due to poor food and protein requirement is 61g daily.

Interview with the RD confirmed the above mentioned residents had an order for a meat sandwich daily in addition to the menu to improve their calorie and protein intake. The RD also confirmed that the two teaspoons of meat sandwich filling only yield a quarter of the required protein amount as compare to the #16 scoop of filling. [s. 72. (3) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Interview with the Family Council representative revealed that the home conducted a family satisfaction survey in 2014 but the home did not seek the advice of the Council in developing and carrying out the 2014 family satisfaction survey.

Review of the 2014 Family Council meeting minutes indicated that there was no discussion held related to the 2014 satisfaction survey at the meetings.

Interview with the administrator confirmed that there is no evidence indicating the home had sought the advice of the Family Council in developing and carrying out the 2014 satisfaction survey. [s. 85. (3)]

2. The licensee has failed to ensure that the home seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Interview with the Resident Council representative revealed that the home conducted a family satisfaction survey in 2014 but the home did not seek the advice of the Council in developing and carrying out the 2014 satisfaction survey.

Review of the 2014 Resident Council meeting minutes indicated that there was no discussion held related to the 2014 satisfaction survey at the meetings.

Interview with the administrator confirmed that there is no evidence indicating the home had sought the advice of the Resident Council in developing and carrying out the 2014 satisfaction survey. [s. 85. (3)]

WN #9: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to informed the Director no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Record review revealed that resident #004 had a fall on an identified date with no identified injury at that time. An X-Ray was conducted 20 days later and an injury was identified and the resident was sent to the hospital for further assessment and treatment. Hospital staff called the home five days after the resident was admitted to notify the home for a change in the resident condition. The resident returned home the next day.

Record review revealed no indication that the Director was informed at any time between the above mentioned period of times for this incident that resulted in transfer to the hospital.

Interview with the DOC confirmed that the home did not informed the Director about this incident. [s. 107. (3) 4.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Observation made on an identified date and time during the inspection on an identified unit revealed the following non-medication supplies stored inside the medication cart: nine packages of hearing aid batteries, one watchmate sensor, two sunglasses, and one wrist watch.

Interview with RPN staff #116 confirmed that the above mentioned non-medication related supplies were stored inside the medication cart. Interview with the ADOC confirmed that these supplies were to be stored in areas other than the medication cart. [s. 129. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observation made on an identified date and time noted two unlabeled toothbrushes in a kidney basin on the counter of a washroom shared by two identified residents.

Interview with RPN staff #134 confirmed that the toothbrushes did belong to an identified resident, and that the toothbrushes should be labeled.

Interview with the ADOC confirmed that the toothbrushes should be labeled for the resident. [s. 229. (4)]

Issued on this 23rd day of December, 2015

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

Original report signed by the inspector.