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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 3, 2012	2012_202165_0004	H-002083-12	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE BRANT CENTRE
1182 NORTHSHORE BLVD. EAST, BURLINGTON, ON, L7S-1C5

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

TAMMY SZYMANOWSKI (165), LALEH NEWELL (147), SHARLEE MCNALLY (141)

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 30, 31, November 1, 2, 6, 7, 8, 9, 13, 14, 15, 2012.

Complaint Inspections H-001434-12, H-001544-12, H-000972-12, H-001862-12

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Practical Nurse (RPN), Registered Nurse (RN), Personal Support Workers (PSW), Cooks, Dietary aides, Food Service Manager (FSM), Environmental Manager, Recreation Manager, Business Manager, families and residents.

During the course of the inspection, the inspector(s) reviewed clinical health records, reviewed policies and procedures, toured home, observed care, food production and meal service.

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

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]

2. Resident #523 was not afforded privacy in treatment for their personal needs. The resident was observed on November 8, 2012, during noon medication pass to have a medical test completed by the registered staff while sitting outside the dining rooom in the presence of other residents. [s. 3. (1) 8.]

3. Resident #523 was observed November 8, 2012 to have a medication administered by injection outside of the dining room with other residents present. [s. 3. (1) 8.]

4. Resident #523 was observed November 15, 2012 to have a medication administered by injection outside of the dining room with other residents present. [s. 3. (1) 8.]

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 rights of residents were fully respected and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that sets out the planned care for the resident.
Resident #494 and #582's plan of care did not include the need for finger nail care requirements including the frequency of need and the behaviours associated with the need. The DOC confirmed the home did not have a policy or procedure related to frequency of finger nail care and this need should be identified in the resident plan of care. [s. 6. (1) (a)]

2. Resident #582's plan of care did not set out the planned care to manage the residents behaviour.
Staff confirmed that the resident exhibited behaviour towards staff however; registered staff confirmed that the resident's behaviours and strategies for staff to manage the behaviour were not included in the resident's plan of care. [s. 6. (1) (a)]

3. The licensee of the long term care home did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
The nutritional assessment and diet list indicated resident #675 was to receive a regular diet with with special interventions. The resident's plan of care indicated the resident was to receive a specialized diet. The cook confirmed that staff follow a therapeutic menu for the resident and the Food Service Manager provided an individualized menu that staff were expected to follow. [s. 6. (1) (c)]

4. The licensee did not ensure the plan of care was based on an assessment of resident's needs and preferences. [s. 6. (2)]

5. Resident #552 expressed a preference time for showers to be completed. Staff confirmed knowledge of the resident's preference however, the resident's plan of care did not identify the resident's preference for time of showers. [s. 6. (2)]

6. Resident #552's plan of care was not based on an assessment of the resident's needs. The resident was observed utilizing two forms of mechanical restraints when up in a wheelchair. The written plan of care updated in September 2012 did not include the use of the mechanical restraints. Staff confirmed that the restraint had been initiated approximately 4 weeks previous to the observation to assist in minimizing falls from the wheelchair. Resident records and the DOC confirmed that an assessment was not completed prior to initiating the new restraint. [s. 6. (2)]

7. Resident #552's plan of care was not based on an assessment of the resident's needs.
There was no documented evidence of an assessment completed to determine if the 1/2 length bed rails for the resident were a Personal Assistance Service Devices (PASD) or a restraint. The plan of care identified the resident used 2 1/2 bed rails when in bed as a strategy for risk of falls but did not identify the bed rails as a PASD or a restraint. [s. 6. (2)]

8. Resident #605's plan of care was not based on an assessment of the resident's needs.
There was no documented evidence of an assessment completed to determine if the 1/2 length bed rails for the resident were a Personal Assistance Service Devices (PASD) or a restraint. The plan of care identified the resident used 2 1/2 bed rails when in bed as a strategy for risk of falls but did not identify the bed rails as a PASD or a restraint. [s. 6. (2)]

9. The licensee did not ensure the care set out in the plan of care was provided to resident #101 as specified in the plan.
The resident's plan of care indicated staff were to provide a specialized diet for the resident. The planned menu for November 6, 2012 indicated the resident was to receive specific portions and menu items according to the specialized diet however, regular portions and menu items that were contraindicated in the diet were served instead. Staff confirmed that the resident did not receive the menu items identified in the planned menu. The resident also received a beverage that was contraindicated in the diet for morning nourishment November 6, 2012.[s. 6. (7)]

10. The licensee did not ensure the care set out in the plan of care was provided to resident #552 as specified in the plan.
The resident's plan of care for falls included the strategy for a chair alarm to be used in bed and when the resident was up in a recliner. The resident was observed by the inspector sitting in the recliner chair without the use of a chair alarm. Staff confirmed the chair alarm had not been in place. The DOC confirmed she was not aware the resident was in need of a chair alarm. The resident had a history of multiple falls from the chair and bed. [s. 6. (7)]

11. The licensee did not ensure the care set out in the plan of care was provided to

resident #115 as specified in the plan.
The resident's plan of care indicated for staff to encourage fluid intake however; the resident only received 125ml of thickened juice for the lunch meal October 30, 2012. [s. 6. (7)]

12. The licensee did not ensure that resident #605 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.
a)The resident was identified in the Functional/Rehab Potential Resident Assessment Protocols (RAPS) of October 2, 2012 needing 2 staff to perform the activity of dressing. Staff confirmed the resident needed 2 staff to perform dressing due to the resident's decreasing physical abilities however; the resident's current plan of care did not identify the need to have 2 staff to perform the activity of dressing.
b)Physiotherapy last assessment completed in October 2012 identified resident #605 could still weight bear. Staff confirmed the resident required to be transferred to bed using a mechanical lift for approximately 4 to 6 weeks, as the resident was no longer able to weight bear however; the resident's current plan of care identified the resident was a 2 person assistance side by side for all transfers. [s. 6. (10) (b)]

13. The licensee did not ensure that resident #545 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.
The resident had a significant change in condition and had a physicians order for clear fluids. The home's dietitian confirmed she was not aware that the resident's care needs changed and the plan of care was not reviewed and revised to reflect the resident's current care needs. [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 there was a written plan of care for each resident that sets out the planned care for the resident; to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary; to ensure that the care set out in the plan of care was provided to residents as specified in the plan; to ensure that that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; to ensure that the plan of care was based on an assessment of resident's needs and preferences., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and implemented in accordance with all applicable requirements under the Act. [s. 8. (1)]

2. The home's policy and procedure for "Physical Restraints" ((LTCE-CNS-H-4) and "PASD" (LTCE-CNS-H -3) did not include the procedure for assessments, consents, and care planning for the use of 1/2 and 1/4 length bed rails for residents when in bed. The DOC confirmed that the home did not have a policy for identifying the purpose of 1/2 and 1/4 length bed rails. [s. 8. (1)]

3. The home failed to ensure 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 is complied with. [s. 8. (1) (b)]

4. The home did not comply with their Head Injury Routine policy (LTCE-CNS_G_5). The home's policy and procedure for Head Injury Routine stated that all residents who may have sustained an injury to their head as a result of a fall or other such incident where the head may have come in contact with a hard surface would have a head injury routine initiated and once initiated would continue for 72 hours unless it was ordered discontinued by the physician.
Resident #552 had a fall in October, 2012 that resulted in injury. Staff confirmed that head injury routine had not been completed as per policy as the resident had a specific physician order for routine to be followed for head injuries. Review of the physician order identified the order was completed in April, 2011 but the quarterly medical reviews completed subsequent to this date did not contain the identified order. Review of the resident's records did not indicate that a head injury routine as per the home's policy or the physician order was completed. The DOC confirmed the physician order was not current. [s. 8. (1) (b)]

5. The home did not comply with their Medication Administration policy (LTCE-CNS-F-1).
The home's policy and procedure Medication Administration stated registered staff would administer a resident's medication, observe the resident taking the medication and then return to the Medication Cart and initial for the administration of each medication given before proceeding to the next resident.
On November 8, 2012 at 1200 hours an inspector observed a registered staff sign for

the administration of medications for multiple residents prior to the administration of any of the medication. The registered staff confirmed they had signed the Medication Administration Record indicating medication had been administered for multiple residents prior to administering the medication. [s. 8. (1) (b)]

6. The home did not comply with their Resident Safety-Door Alarms, Nurse Call System and Rounds policy (LTCE-CNS-G-12). The home's stated care staff were responsible to ensure the resident had the call bell readily available when they were in bed or in the washroom.
Resident #605 stated when staff assist them to the bathroom to do care at the sink the staff leave and return later to mobilize the resident out of the bathroom. The resident stated they cannot use the call bell system to summon staff as the cord to the call bell was too short to reach the sink area. Observation by the inspector of the resident's bathroom identified that the call bell cord was not long enough to extend to the resident when at the sink. [s. 8. (1) (b)]

7. The home did not comply with their Drug Inventory Management policy (05-02-20). The home's policy stated expired medications must be identified, destroyed and disposed of.
a)During the inspection period outdated government medications including Senekot (expiry date January 2011), Aruzine Suppository (expiry date April 2012) were observed in the medication storage area. Apo K 600mg (expiry date August 2012) was observed in the medication room storage cupboard in one home area. The DOC confirmed the medications were outdated and should have been destroyed and disposed of. [s. 8. (1) (b)]

8. The home did not comply with their Admission policy (4.1.6). Review of the home's Admission policy indicated the home was to ensure that the Agreement of Accommodation contracts were appropriately signed and dated and that there were no delays in having this Agreement signed.
Resident #118's business file on November 13, 2012, revealed that the resident's Agreement of Accommodation contract was signed by the resident's Power of Attorney, however the contract was not signed by the home. The Business Manager stated the contracts were reviewed and signed on an annual basis at the resident's care conference meeting. The resident's clinical record indicated the resident's last care conference was held in June, 2012. [s. 8. (1) (b)]

9. The home's policy "Pain" (LTCE-CNS-E-4) stated staff would complete a Comprehensive Pain Assessment Tool when a resident reported new pain that was not episodic in nature.
a)Resident #552 had a fall in October, 2012 which resulted in a laceration to the forehead. Clinical health records indicated the resident received pain medication as needed over the following four days for expressed pain. Further review identified that the last pain assessment was completed in September, 2012. There was no record that an assessment of the pain was completed at the time of newly expressed pain. [s. 8. (1) (b)]

10. The home did not comply with their Personal Clothing-Missing policy. Review of the home's policy titled Personal Clothing-Missing the home was to ensure that the staff on all the units were to complete the Missing Clothing Report Form - NSEM/Form - E-01.01.05 and that an immediate search of the home areas would be initiated. Resident #603 stated that several items of clothing were missing in the past few months and reported to the home. Review of the Missing Clothing Forms for the past year did not indicate the home had documented these items were missing and that an immediate search of the home areas had been initiated. [s. 8. (1) (b)]

11. The home did not comply with their Personal Clothing-Missing policy. Review of the home's policy titled Personal Clothing-Missing the home was to ensure that the staff on all the units were to complete the Missing Clothing Report Form - NSEM/Form - E-01.01.05 and that an immediate search of the home areas would be initiated. Resident #675 stated an article of clothing that had been given as a gift had gone missing and was reported to the home. Review of the Missing Clothing Forms for the past year did not indicate the home had documented these items were missing and that an immediate search of the home areas had been initiated. [s. 8. (1) (b)]

12. The home did not comply with their Hydration policy (NHS-X-18). The procedure directed staff to provide each resident with 125ml of milk and water, 180ml of tea/coffee and 180ml of soup for the lunch meal service however; residents were not always offered the planned fluid.
Resident #117 received 125ml thickened milk and water, 180ml of pureed soup and resident #111 received 125ml thickened juice and water, 180ml of pureed soup on November 6, 2012 however, both residents were not offered thickened coffee or tea. [s. 8. (1) (b)]

13. The home did not comply with their Hydration policy (NHS-X-18). The procedure directed staff to provide each resident with 125ml of milk and water, 180ml of tea/coffee and 180ml of soup for the lunch meal service however; residents were not always offered the planned fluid.
Resident #115 received 125ml thickened juice and 180ml of pureed soup on October 30, 2012 however, the resident was not offered water/milk or tea/coffee. The home's dietitian confirmed that residents who require thickened fluids were to receive two thickened fluids and thickened coffee or tea. [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 to ensure 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 is complied with., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. Without restricting the generality of subsection (1), the licensee did not ensure that every resident was provided with food and fluids that were safe, adequate in quantity, nutritious and varied. [s. 11. (2)]

2. All residents were not provided food and fluids that were safe.
During the lunch meal on November 6, 2012, resident #111 was being fed soup and the resident was observed coughing. The Dietary aide confirmed pureed soup was served to all residents who required thickened fluids and that the soup was not altered in consistency. The cook confirmed that the puree soup sent to the home area was of nectar consistency however; review of the resident's records identified the resident was to receive honey thickened consistency. The Food Service Manager confirmed that there were thirteen residents that required nectar thickened fluids and eight residents that required honey thickened fluids however, it was confirmed that both nectar and honey thickened soup was not sent to five of the seven floors that required both consistencies. [s. 11. (2)]

3. All residents were not provided food and fluids that were adequate in quantity.
During November 6, 2012 lunch meal service, the home did not have enough menu items for all residents who chose the cottage cheese fruit plate to have the quantities as outlined in the planned menu. The home area ran short of menu items twice during meal service resulting in some residents receiving smaller quantities. Resident #119 was served only 1 slice of pear and 2 slices of peaches for the fruit plate however, the menu indicated 2 ounces of each pears and peaches were to be served. Staff confirmed that the portions were smaller because they ran short of these menu items. [s. 11. (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 every resident is provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions. Manufacturer's instructions for belt application for proper positioning stated for the seat belt to be effective, the belt must be not too loose to allow client to slide under belt and leave just enough space for two fingers to fit between the belt and pelvic crest.
a)November 14, 2012 10:45 hours resident #675 had a seat belt applied loosely leaving 5 inches from the resident's pelvic crest to the seat belt. The RPN confirmed that the seat belt was applied too loose for the resident and more than two fingers were able to fit between the belt and pelvic crest of the resident. The RPN confirmed that the resident had a history of sliding out of the chair.
b)November 14, 2012 11:15 hours resident # 120, 121, 122, 123, and 124 were identified as having their seat belts applied too loose leaving 2-5 inches from the resident's pelvic crest to the seat belt. The Administrator of the home confirmed that the seat belts were applied too loose and more than two fingers were able to fit between the resident's pelvic crest and the seat belts.
c)November 14, 2012 11:25 hours resident #113 was identified as having their seat belt applied to loose leaving 2 inches from the resident's pelvic crest and the seat belt. The PSW stated that the seat belt which was applied with the 2 inch space between the resident's pelvic crest and the seat belt was a normal application however, the PSW stated that the seat belt could be applied a little tighter. [s. 23.]

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 all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #6: 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 did not ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.
Resident #494 was observed on October 31, 2012 to have dirty finger nails with encrusted black debris. The staff confirmed that the resident finger nails were routinely cleaned on bath days and more frequently due to the residents behaviours. The resident Daily Flow Sheets for November 2012 documented that the resident received a tub bath or bed bath on three occasions but according to documentation finger nails were only cleaned once. [s. 30. (2)]

2. Resident #582 was observed having dirty finger nails with encrusted debris on several occasions during the inspection period. The staff confirmed that the resident had behaviours and that the resident's finger nails were routinely cleaned on bath days. The resident Daily Flow Sheets for October 2012 documented that the resident received a tub or bed bath on nine occasions but according to documentation finger nails were only cleaned twice. Documentation indicated the resident refused nail cleaning on one occasion. [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 #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. (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. (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 did not ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.
a)Food items were prepared to far in advance of the dinner meal service. November 6, 2012 the cook confirmed at 15:10 hours that all the regular and textured entrees, and the textured vegetables were cooked and holding for the dinner meal service at 17:00 hours.
b)On November 7, 2012 at 14:30 hours, the cook confirmed that the textured modified vegetables were already prepared and placed in hot holding greater than two and a half hours prior to meal service. The puree mashed potatoes, minced and pureed sausage, pureed fish and rice were prepared by 15:00 hours and the oven roasted potatoes were prepared and placed in holding by 15:15 hours. The Food Service Manager confirmed that some menu items are cooked too far in advance compromising quality and temperature. At least eight residents voiced complaints regarding the quality of food.
c)Standardized recipes were not consistently followed. Staff did not follow recipes for thickened soup. The recipe indicated for staff to prepare nectar and honey thickened consistency for soup however, staff confirmed that only nectar thickened soup was prepared on November 6, 2012.
d)The renal menu indicated a green salad was to be prepared. Staff confirmed that iceburg and romaine lettuce were prepared as the salad. There was no standardized recipe and the Food Service Manager confirmed it was a prepared product consisting of iceburg lettuce, radishes and carrots. It was confirmed with dietary staff that the green salad prepared November 6, 2012 contained lettuce only and did not include any radishes or carrots. [s. 72. (3) (a)]

2. The licensee did not ensure that all food and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.
a)November 7, 2012 the cook confirmed that the prepared roasted lamb for the dinner meal the next day had been cooked and taken out of the oven at 13:00 hours. The lamb roasts were still covered and sitting on a cart in the main kitchen at 15:30 hours. Temperatures taken by the inspector confirmed that temperatures ranged from 146.2-150.5 degrees fahrenheit two and a half hours after the roasts were taken from the oven. The recipe for roasted lamb directed staff to cool the product to 140-70 degrees fahrenheit within two hours. It was confirmed with the Food Service Manager that the method of cooling this product did not meet the Hazard Analysis Critical Control Point

identified on the recipe. [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 to ensure that all food and fluids in the food production system are prepared, stored and served using methods to to prevent adulteration, contamination and food borne illness, preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

2. On November 8, 2012 at 1200 hours the inspector observed the medication cart to be in the common hallway outside the nursing station on one home area. The RPN was administering medications to residents and walking away from the cart. On inspection of the cart it was identified the catch on the control substance bin lid was in locked position but not secured and the lid had the ability to be opened without the use of a key. The RPN dispensing medication confirmed the lid was not secured. [s. 129. (1) (b)]

3. On November 9, 2012 at 1130 hours the inspector observed in the presence of the DOC the medication cart in the medication room on another home area. The cart was unlocked and the controlled substance bin lid was in locked position but not secured and the lid had the ability to be opened without the use of a key. [s. 129. (1) (b)]

4. Controlled substances that were scheduled for destruction were stored in a locked filing cabinet in the DOC's office. It was observed during the course of the inspection period that the door to the DOC's office was left unlocked and unoccupied on multiple occasions during the day resulting in the substances not to be double locked. The DOC confirmed the control substances in her office were not consistently double locked. [s. 129. (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 to ensure that 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, to be implemented voluntarily.

WN #9: 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 home failed to ensure that all staff participate in the implementation of the program.
The Infection Control Lead confirmed that the home's infection control practice was to ensure that clean linen carts were covered by staff when left unattended. It was observed on multiple occasions during the inspection period that the clean linen carts on the units were left uncovered and unattended by the staff. [s. 229. (4)]

2. The Infection Control Lead confirmed that blue wash clothes can not be used repeatedly for hand hygiene during meal service. It was observed in the dining rooms on multiple occasions during the inspection period that staff were reusing wet blue washcloths at the servery for hand hygiene between serving the residents. [s. 229. (4)]

3. The DOC confirmed that aero chambers were to be cleaned routinely however, there was no assigned job routine for the completion of cleaning the aero chambers. Four individual resident's aero chambers and masks on different medication carts were observed during the inspection period to be excessively soiled with debris and staff confirmed the observations. [s. 229. (4)]

Additional Required Actions:

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

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure the policy was complied with. The home's policy "Physical Restraints" LTCE-CNS-H-4 indicated in the procedure for staff that restraints must be applied according to manufacturer's specifications, in such a way that they ensure the resident's safety while maintaining comfort.
a)Personal Support Workers, Registered Staff and the Administrator confirmed that seat belts for at least seven residents were not applied according to manufacturer's specifications. The policy references staff to follow manufacturer's specifications however, the manufacturer's specifications were not available in the home for staff to reference when requested by the inspector November 14, 2012. [s. 29. (1) (b)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that resident #552 was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
a) The resident was observed on multiple occasions during the inspection period to be in a wheel chair with a restraint in place. Staff confirmed the restraint had been initiated approximately 4 weeks prior to the inspection period. Review of the resident's plan of care did not identify the use, the purpose or the strategies of the restraint. The DOC confirmed this was a restraint for this resident as a strategy to minimize falls.
b) The resident did not have a physician order for the use of the restraint. [s. 30. (1) 3.]

WN #12: 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 did not ensure that each resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures. [s. 34. (1) (a)]

2. Resident #552's plan of care provided specific strategies for staff to assist the resident to complete oral care. The resident's Daily Flow Sheets indicated residents oral care was provided with extensive assistance by one staff to complete oral care twice daily. The resident was observed on October 30, 2012 and on November 8 and 14, 2012 by the inspector to have extensive build up of food debris and plague on the lower teeth both between the teeth and at the gum line. On November 14, 2012 staff confirmed that the resident completed her own oral care without extensive assistance. Staff also confirmed on observation that there was excessive build up of debris on the resident's teeth. [s. 34. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure resident #552 exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. The home's policy and procedure for "Skin and Wound" (LTCE-CNS-1-3) stated resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would receive a skin assessment by a member of the registered nursing staff using the Pressure Sore Risk Assessment in Point Click Care.
a)Resident #552 had a fall in October, 2012 which resulted in a laceration. Review of the resident records did not identify a skin assessment was completed using Pressure Sore Risk Assessment in Point Click Care. The DOC confirmed that a skin assessment had not been completed using the appropriate template. [s. 50. (2) (b) (i)]

2. The licensee did not ensure resident #552 exhibiting a laceration was reassessed at least weekly by a member of the registered nursing staff.
a)Resident records indicated the resident sustained a laceration in October, 2012. Resident records did not identify that weekly monitoring of the wound was completed for three subsequent weeks until the laceration was healed. Staff confirmed that the resident was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

WN #14: 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 did not ensure that the planned menu items were offered and available at each meal and snack.
a)November 6, 2012 during the lunch meal service resident #114 was not offered a choice of dessert. The resident was provided a dessert however, was not offered the alternate choice. Dietary staff confirmed that there was no alternate choice remaining to offer the resident. [s. 71. (4)]

2. During the lunch meal service October 30, 2012 resident #115 was provided a lunch meal tray however, dessert was not offered to the resident. [s. 71. (4)]

WN #15: 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:
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).

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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee of the long term did not ensure that the home had a dining and snack service that included, 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.
a)On November 6, 2012 one dining room ran out of teaspoons required for residents to safely eat and drink comfortably. Resident #116 received a tablespoon to eat the main entree and all residents were provided tablespoons to eat their dessert. The dietary aide confirmed that teaspoons were not available during the meal service and the Food Service Manager confirmed that the expectation was that only teaspoons were to be provided for residents. [s. 73. (1) 9.]

2. The licensee of the long term care home did not ensure that the home had a dining and snack service that included, at a minimum, appropriate furnishings and equipment in resident dining area, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.
a)Resident #582 was placed at a table that was too high for the resident. The resident had to raise their arm up to be able to reach the plate. The Food Service Manager confirmed that the table was not of appropriate height for the resident. [s. 73. (1) 11.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by

Findings/Faits saillants :

1. The licensee did not ensure that the admission package of information provided included the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy.
a)The staff confirmed that this information was not included as part of the admission package provided to the resident and/or Substitute Decision Maker. [s. 78. (2) (g)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3

Findings/Faits saillants :

1. The licensee did not ensure that required information related to the policy to minimize the restraining of residents was posted and communicated, as well as information about how a copy of the policy can be obtained.
a)The home did not have their policy for minimizing restraints posted in the home. The Administrator confirmed the policy was not posted. [s. 79. (3) (g)]

2. The licensee did not ensure that required information related to explanation of evacuation procedures was posted in the home in a conspicuous and easily accessible location.
a)The home did not have evacuation procedures posted in the home in a conspicuous location that would be easily accessible by visitors or residents. The Administrator confirmed that evacuation procedures were not posted in conspicuous locations for easy access. [s. 79. (3) (j)]

WN #18: 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 failed to ensure that the advice of the Family and Residents' Council were sought in developing and carrying out the survey and in acting on its results. The Administrator, President and members of the Family Council confirmed that Family Council was not consulted in the development and carrying out of the satisfaction survey and acting on its results. [s. 85. (3)]

2. The Administrator and President of Residents' Council confirm that Residents' Council was not consulted in the development and carrying out of the satisfaction survey and acting on its results. [s. 85. (3)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure there was, at least quarterly, a documented reassessment of each resident's drug regime.
a)The Physicians Order Reviews in one home area on November 15, 2012 identified that 10 of 25 residents did not have their reviews scheduled for November 1, 2012, completed. Review of 2012 Physicians Order Reviews for 2 of the 10 residents on the home area and 2 residents on another home area identified that previous reviews were not completed by physicians for 2-3 weeks after the scheduled date of effect. The DOC confirmed not all physicians in the home completed their review within the time frames identified. [s. 134. (c)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the admission package of information provided included information on the ability to retain a physician or RN (EC) to perform the required services.
a)The staff confirmed that this information was not included as part of the admission package provided to the resident and/or Substitute Decision Maker. [s. 224. (1) 1.]

Issued on this 17th day of December, 2012

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

T Bzymanowski