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
Feb 23, 2015	2015_284545_0003	O-001473-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE GLEBE CENTRE INCORPORATED
950 BANK STREET OTTAWA ON K1S 5G6

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

GLEBE CENTRE
950 BANK STREET OTTAWA ON K1S 5G6

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

ANGELE ALBERT-RITCHIE (545), HUMPHREY JACQUES (599), KATHLEEN SMID (161), MEGAN MACPHAIL (551), RUZICA SUBOTIC-HOWELL (548)

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): January 26, 27, 28, 29, 30, February 2, 3, 4, 5 and 6, 2015

The following Complaints Inspections were conducted as part of the RQI:

1. O-001013-14
2. O-000303-14
3. O-000264-14

The following Critical Incidents Inspections were conducted as part of the RQI:
1. O-001094-14
2. O-000956-14
3. O-000557-14

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Manager of Nursing Care Operations, Coordinator Nursing Programs/RAI Back-Up, RAI Coordinator, Director of Resident Services, Director of Human Resource, Director of Quality Management, Manager of Environmental Services, Food Service Manager, Volunteer Coordinator, Social Worker, Registered Dietitian, Nutrition Care Manager, a Physician, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Care Workers (PSW), several Housekeeping Aides, two Food Services Aide, one Maintenance Staff, one Laundry staff, the President and the past President of the Family Council, two Members of the Resident Council, Residents and Family Members.

The inspectors also toured residential and non-residential areas, observed resident care and services; observed resident rooms, common areas and equipment, observed several meal and snack services, observed a medication pass including a medication room, reviewed several of the home's policies and procedures, reviewed the home's Admission Information Package, reviewed minutes for Residents' Council and Family Council, reviewed food service documentation, reviewed cleaning and maintenance schedules including daily cleaning of Residents' rooms, reviewed the resident-staff communication and response system, reviewed staff training records and reviewed Residents' Health Care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
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.

- **19 WN(s)**
- **10 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 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 the home, furnishings and equipment are kept clean and sanitary.

The following was observed in the dining room on the sixth floor on February 3, 2015:

-All thirteen table chairs have debris such as dried liquids on the seat and/or the frame
-All ten tables have debris on the legs
-One white and one pink adjustable chair used to assist residents with feeding have debris on the seat and base
-The pole between tables #3 and #4 has dried liquids on it and dark colored debris on the floor surrounding the circular base
-There is dark colored debris on the floor below the servery counter which is more prevalent in the corner where the wall meets the entry way to the servery
-The wall to the left of the server entry and the three drawers have dried liquids on them
-The half wall in the corner by table #1 contains debris [s. 15. (2) (a)]

2. On February 3, 2015, the Environmental Services Manager accompanied inspector #599 on a tour of Lindenwood Home Area situated on the second floor. The floor in the activity room was stained with white matter and the wall area underneath the hand sanitizer was dirty with dried solution. The floor in the dining room by the piano was heavily stained with brownish matter. The Environmental Services Manager agreed that the floor and walls on Lindenwood Home area have not been kept clean and sanitary.

On February 3, 2015, the Director of Care (DOC) accompanied inspector #599 on a tour of Monkwood Home Area situated on the third floor. In the storage area where resident mechanical lifts are kept; the foot rest of one sit-to-stand mechanical lift was observed to have a thick layer of dust and the frame was dirty. The DOC agreed that the mechanical lift used by Residents was dirty and had not been kept clean. [s. 15. (2) (a)]

3. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

It was observed in the home by the LCTH Inspectors that the home has a communication and response system that is commonly known as the call bell system. It was observed by the LTCH inspectors that the call bell system is available at each resident's bed and bathroom or any location used by the residents.

When the call bell system in the home is engaged a light at the entrance of the resident's room will illuminate, a sound from an annunciator panel at the nurses station will alarm along with a visual display of the location where the call bell was engaged, and a page outlining the location the call bell was engaged is sent to a pager carried by the PSWs on specific units in the home.

On January 27, 2015 at 09:52 hours Inspector #545 engaged the call bell in room L228-B bedroom and bathroom. A PSW came into the room and told the inspector that she saw the light illuminate outside the resident's room but that her pager had not activated. At 09:45 another PSW indicated that he saw the light outside the resident's room illuminate and that his pager "doesn't work well and had not activated" when the call bell was engaged. The Inspector #545 engaged the call bell and a third PSW came in right away and showed the inspector that her pager had visually displayed the location from where the signal was coming from.

On January 28, 2015 at 10:35 Inspector #545 engaged the call bell in room T507A. A PSW arrived at the room and indicated that her pager vibrated once then stopped. The PSW indicated that the pager should continue to vibrate until the call bell is canceled at the point of activation. A second PSW arrived at the room and indicated that she was alerted on her pager with only one vibration as well.

On January 28, 2015 at 09:20 Inspector #545 activated the call bell in T515-A bedroom at 09:20. A PSW came into the room and indicated that her pager went off once and never vibrated again to remind her that the call had not yet been answered.

Inspector #545 repeated the above scenario for rooms: W604B, L216A, L230A, T522A with the same result.

On January 29, 2015 Inspector #548 revisited rooms W604-A and L230-A. The call bell was engaged in the room 604-A by the inspector and the inspector noted that the light outside the door illuminated and there was an audible sound outside the resident's room. The inspector verified with a PSW, Staff #S100, if her pager had received a page indicating that the call bell from room 604-A was engaged and she stated that it had not.

Inspector #548 engaged the call bell at the resident's bed side in room L230-A. The inspector noted that the light outside the door illuminated and there was no audible sound outside the resident's room. PSW #S103 indicated that her pager had not received

a page indicating that the call bell from the room was engaged. Staff member #S103 showed the inspector that the pager did not visually display the room number on the pager. Staff member #S103 indicated that the battery was low and she would check the pager. The PSW checked the pager with the inspector present and indicated that the battery was not low on the pager. The inspector made a second attempt and engaged the call bell in room L230-A. On the second attempt the pager received the page. [s. 15. (2) (c)]

4. On January 26 2015, during the initial tour, Inspector #599 observed on the Bankwood Home Area, situated on the first floor that the wall opposite the nursing station was damaged with numerous scrape marks exposing the plaster over an area of 16 feet between rooms 114 to 115.

On February 3, 2015, the Environmental Services Manager accompanied Inspector #599 on a tour of the Bankwood Home Area. The Environmental Services Manager agreed that the wall surface was damaged and had not been kept in a good state of repair; added that the wall was painted about three months ago.

On February 3, 2015, the Director of Care (DOC) accompanied inspector #599 on a tour of the Monkwood Home Area situated on the third floor; in the common area lounge, the window blind had dried brownish stains and the wall had exposed plaster. The DOC stated that the same issue was identified during the last Resident Quality Inspection (RQI) in March 2014. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment, are kept clean and sanitary as well as in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #017 has several stage IV pressure ulcers, is diagnosed with a central nervous system condition, is wheelchair bound, and has a history of pressure ulcers.

Upon review of the Resident's RAI-MDS 2.0 assessment completed in December 2014, the presence of several stage IV pressure ulcers was noted where a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. On a specific date in June 2014, the physician prescribed dressing changes four times weekly for the stage IV pressure ulcers. In the Medication Administration Record (MAR) a note documented in June 2014 directed registered staff to complete a wound assessment every Monday for all pressure ulcers.

A review of the Treatment Administration Record (TAR) for Resident #017 was conducted by the Inspector. On a specific date in January 2015, the pressure ulcers were assessed.It was noted on the weekly Pressure Ulcer/Wound Assessment Record that between November 2014 and February 2015, the stage IV pressure ulcers were reassessed by registered staff 3 weeks out 11 weeks.

On February 5, 2015 during an interview with RPN #S123, she indicated that weekly wound assessments were conducted by the registered staff every Monday, added that the documentation would be found in the progress notes. In a review of the progress notes, weekly assessments were not found.

During an interview with the Coordinator Nursing Programs, she indicated that she was the home's Wound Care Champion. She indicated that weekly assessments for Resident #017's stage IV pressure ulcers were expected to be completed by the registered staff every Monday and documented in the Pressure Ulcer/Wound Assessment Record located in the Treatment Administration Record. In reviewing the record with the Inspector, she indicated that reassessments of the pressure ulcers was conducted 3 times over a period of 11 weeks. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #017 who was exhibiting altered skin integrity, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: 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: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the daily and weekly menus are communicated to residents.

On Monday, January 26, 2015, the meal service at lunch on the sixth floor, a designated Chinese unit was observed. At the time of the observation, the home was on week two of a three week cycle.

Noted to be posted on the wall was the Glebe Centre Chinese Lunch Menu and the Thursday, week 1 breakfast, lunch and supper meals.

According to the Chinese Lunch Menu, the residents were to be offered chicken with sweet corn, chinese greens with oyster sauce and steamed rice.

Staff member #S126, the Food Service Attendant showed Inspector #551 that the choices for this meal were tomato and rice soup, purple cabbage with bok choy or pork and potato with green onion stew, and that congee and a sandwich were available.

The lunch items offered did not match the Chinese Lunch Menu, and breakfast, lunch and supper for Thursday of week 1 were communicated when the home was on Monday of week 2 of the menu cycle. Dessert options for lunch and supper were not communicated. [s. 73. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the daily and weekly menus on the 6th floor, a designated Chinese unit, are communicated to residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the following:

•The Residents' Bill of Rights
•The duty to make mandatory reports under section 24
•The whistle-blowing protections

According to O. Reg. 79/10, s. 219 (1), the intervals for the purposes of subsection 76 (4) of the Act are annual intervals.

On February 5, 2015 the Director of Quality Management provided Inspector #161 with the content of the retraining education program that was provided by the educational consultant to all the staff in 2013. The Resident's Bill of Rights; Duty to make mandatory reports under section 24 and Whistle-blowing protections were not included in this educational program. This was verified by the Director of Quality Management who also indicated that staff were not retrained in these areas in 2014. [s. 76. (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 receive retraining annually relating to the Residents' Bill of Rights, duty to make mandatory reports under section 24 and whistle-blowing protections, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to post required information, as per s. 79 (3) c, g, h and p of the legislation.

On February 3, 2015 Inspector #161 conducted a tour of the home with the Director of Care. She confirmed that the following required information had not been posted:

- (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents
- (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
- (h) the name and telephone number of the licensee
- (p) an explanation of the protections afforded under section 26; whistle-blowing related to retaliation [s. 79. (3) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the posting of the following required information is done according to legislation: the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the 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; the name and telephone number of the licensee; and an explanation of the protections afforded under section 26; whistle-blowing related to retaliation, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures are developed and implemented to ensure there is a process to report and locate residents' lost clothing and personal items.

On January 27, 2015 during an interview with Resident #013's Power of Attorney (POA), it was indicated that the home managed the Resident's laundry and that two months ago, a large number of labelled underwear with the Resident's name, went missing. The POA indicated the missing items were reported to a nurse and to a housekeeping aide, and was told they would look into it. The POA stated that he/she never heard back from anyone and had to purchase new underwear for the Resident.

On January 29, 2015, during an interview with Laundry/Housekeeper #S110, she indicated that the home did not have a procedure or process for reporting or locating missing clothing.

During an interview with PSW #S121 and RPN #S101 on January 29, 2015, they indicated they were not aware of the missing items. The RPN indicated that nurses used to complete a "Missing Items of Significant Value Investigation" form upon hearing of a missing item but thought the form was no longer in use.

On January 30, 2015, during an interview with the Manager of Nursing Operations, she indicated that upon hearing of any missing item, the nurses on the units are expected to complete a "Missing Items of Significant Value Investigation" form then send it to herself or the Environmental Services Manager. She indicated she was not aware of the missing items as she had not received a completed form.

On January 30, 2015, during an interview with the Manager of Environmental Services, he indicated that he was not aware of the missing items, and that a form had probably not been completed by the staff. He indicated that he had recently met with the Director of Human Resources to discuss the need to develop and implement procedures to ensure that there was a process to report and locate residents' lost clothing and personal items, as presently none existed. [s. 89. (1) (a) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of laundry services, procedures are developed and implemented to ensure there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contains the following information:
-(a)procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected
-(c)measures and strategies to prevent abuse and neglect
-(e) identifies the training and retraining requirements for all staff including: (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations.

On February 3, 2015 Inspector #161 asked for and received from the Director of Care, the home's most recent policies and procedures related to the Prevention of Abuse, Neglect and Retaliation. The Director of Care provided the following: (a) Resident Abuse-Prevention, Response to Alleged Abuse and Reporting Requirement (#RCM 08-03-00) dated April 28, 2008 and; (b) Resident Abuse and Neglect, Investigation and Reporting (RC 08:03:02) dated October 2013.

On February 3, 2015 Inspector #161, the Director of Care, the Director of Quality Management and the Executive Director reviewed the above policies. The policies do not contain the following: procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; measures and strategies to prevent abuse and neglect and identifies the training and retraining requirements for all staff including: training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. This was verified by the Director of Quality Management who also indicated that the home's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents did not contain the information, as stated above. [s. 96. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contains the following information:(a) procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; (c) measures and strategies to prevent abuse and neglect; (e) identifies the training and retraining requirements for all staff including: (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

A medication pass by RN #S144 was observed on February 3, 2015 from 08:20 to 09:50.

At 08:24 Inspector #545 observed two unlabelled 30ml clear plastic cups containing powdered material placed in Resident #022's bin in the second drawer of the Medication Cart: with various crushed medications and the other with white powder. RN #S144 indicated that the Resident's medications were removed from the original package and crushed around 07:30 and placed in one 30ml clear plastic cup, and that the original labeled package had been discarded in a paper bag in the medication room. He stated that in the interest of time, he had pre-poured Resident #022's nine different medications as he wanted to ensure they would be ready when the Resident got up for breakfast:

In the second 30ml clear plastic cup, the RN indicated he had pre-poured a powder used to treat occasional constipation.

At 12:15 on the same day, the Inspector observed Resident #022 in the Dining Room eating oatmeal. RN #S144 indicated that he had poured the content of both 30ml clear plastic cups which contained the Resident's 08:00 AM medications, in the bowl of oatmeal.

During an interview with the Director of Care (DOC) on February 3, 2015, she indicated she was aware that some registered staff crushed medications ahead of time but thought they crushed the medications while the medication was still in the original labeled package. The DOC indicated that the home expects registered staff to prepare, administer and sign for medications immediately following preparation and that it was not best practice to crush medications then get rid of the the original labeled package provided by the pharmacy service provider or the Government of Ontario until administered. [s. 126.]

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 drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #9: 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.

A medication pass observation was done on February 3, 2015 from 08:20 to 09:50 with RN #S144 on the 5th floor.

In the top drawer of the Medication Cart, 3 watches were observed and in the Narcotic Box in the bottom drawer of the Medication Cart, and a $5.00 bill wrapped in a plastic sleeve with a Resident's name was observed by the Inspector.

During an interview with RN #S144, he indicated that the watches were lost items, he added that all three watches were unlabeled and were kept in the medication cart until he would have time to follow-up on the lost items. He stated that the $5.00 bill belonged to a Resident, that is was kept in the Narcotic Box as a safeguard. He indicated that he was aware that the Medication Cart and Narcotic Boxes should be used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs are stored in an area or a medication cart,
-(a)(ii) that is secure and locked; and
-(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.

On February 3, 2015 the inspector observed prescribed creams in the bed rooms of Resident #009 and #025 and prescribed creams in the top drawer of the cupboard in the bathroom of Resident #024.

In the unlocked Charting Room at the Nursing Station, a small plastic basket with prescribed creams for a number of residents was observed on top of the short filing cabinet, for example: HC 2.5% in ketoderm cream, Betaderm Cr 0.1%, HC 1% in Clotrimaderm CR.

During an interview with PSW #S147 and #S146 on February 3, 2015, they indicated that the prescribed creams were applied by the PSWs and were kept in the Resident's rooms for easy access. Both indicated that had received training on how to apply the prescribed creams to Residents.

RN #S144 indicated that the prescribed creams were left in the Charting Room so they would be easily accessible to the PSWs throughout the day. He indicated that he was aware they should be stored in a secured and locked area, but it was more convenient to leave them in an area where the staff could access. He stated that he stores the basket of prescribed creams in the Medication Room before finishing his shift.

On February 3, 2015 the DOC indicated that she was aware that staff did not always store prescribed creams in a secured and locked area, for example in the locked and secure Medication Room or the lockable Filing Cabinet in the Chart rooms. She indicated that she had on many occasion reminded staff to keep the prescribed creams in a secure and lock area.

A medication pass observation was conducted on February 3, 2015 from 08:20 to 09:50 and on February 4, 2015 at 08:45, on a specific unit.

On February 3, 2015, the following medications were observed on the top of the Medication Cart: prescribed Lactulose (1 bottle), prescribed Peg-Electrolytes (2 bottles), prescribed ACT Olopatadine 0.2% and Clearlax.

On six(6) occasions after preparing medications for Residents, the RN left the Medication Cart including the Narcotic Box and the Medication Room unlocked and unattended, for example:

-at 08:25, the RN walked into the Dining Room and administered medications to a female Resident; his back facing the Medication Cart

-at 08:26, the RN walked towards the kitchen area situated at the end of the Dining Room; the Medication Cart & Medication Room were out of his sight, he returned from the kitchen with a glass of milk which he offered to a Resident to drink with the medications, then he poured water to two other Residents at a different table

-at 08:30, the RN locked the Medication Cart and the Medication Room and left the Nursing Station area, while prescribed bottles of medications were left unlocked and unattended on top of the Medication Cart. Thirteen residents, one family member and one dietary aide were in the area; the RN returned to the Nursing Station area 5 minutes later

-at 08:40, the RN lifted the unlocked door of the Narcotic Box and removed a Lorazepam tablet to administer to a Resident, and after administering the Lorazepam, he left the Narcotic Box unlocked. The Narcotic Box contained various narcotic and controlled substance such as: Fentanyl patch 25mcg/hr, Hydromorphone 1mg, 2mg, 4mg, Hydromorph Contin 3mg and 9mg, Lenoltec No. 3 and Temazepam 30mg

-At 09:07, the RN walked away from the unlocked Medication Cart & unlocked Medication Room in the direction of the Activity Room, leaving them unattended

-At 9:19, the RN walked away to administer medications and eye drops to a female Resident in the Dining Room, his back was facing the unlocked Medication Cart and unlocked Medication Room

During an interview with RN #S144 on February 3, 2015, he indicated he felt he didn't need to always lock the Medication Cart, including the Narcotic Box and the Medication Room when administering medications to Residents in the Dining Room. He stated that he was aware that this was not best practice as he could not always see the Medication Cart and the Medication Room but due to time constraint, he didn't want to lock the room and cart, including the Narcotic Box each time he walked away from the area.

On February 4, 2015 at 08:45 Inspectors #545 and #599 observed RN #S144 administrating medications to a Resident in the Dining Room, away from the Nursing Station where the Medication Cart, including the Narcotic Box and the Medication Room were left unlocked and unattended.

On February 4, 2015 at 08:47 during a Medication Pass on different unit, the Inspector observed the Medication Cart, including the Narcotic Box in the bottom drawer of the cart, unlocked. RN #S104 indicated that she had administered Hydromorphone 1mg to a Resident at 08:43 and had kept the narcotic box unlocked following the administration of the narcotic, added that she was aware that controlled substances are stored in a separate, double-locked stationary cupboard, stored in a separate locked area within the locked medication cart.

On February 4, 2015 at 9:22 during a Medication Pass on a different unit, the Inspector observed the Medication Cart, including the Narcotic Box at the bottom of the cart, unlocked. RPN #123 indicated that she had administered Hydromorphone 1mg to a Resident at 09:08 and had kept the narcotic box unlocked following the administration of the narcotic; added that she was aware that controlled substances are stored in a separate, double-locked stationary cupboard, stored in a separate locked area within the locked medication cart.

During an interview with the DOC on February 3, 2015, she indicated that staff were taking risks in leaving the medication carts, medication rooms and narcotic boxes unlocked and that it was not best practice; added that drugs should be stored in an area or a medication cart, that is secure and locked and that narcotics and controlled substances should be kept double-locked. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, and 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 #10: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that tuberculosis screening measures are in place.

On February 3, 2015 the Director of Care indicated to Inspector #161 that the Manager of Nursing Care Operations is in charge of coordinating the home's infection prevention and control program. She indicated that each Resident is screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening are available. The Director of Care indicated that the results of the tuberculosis screening are recorded in the Resident's health care record in either Point Click Care within the Immunization tab or in the progress notes. This was verified with the Manager of Nursing Care Operations.

On February 3, 2015 a random sample of five Residents admitted after January 1, 2014 was chosen by Inspector #161 to determine if tuberculosis screening had been conducted as per the legislative requirements. A review of the five Residents' health care records indicated that 3/5 (60%) Residents had not been screened for tuberculosis. Specifically, the health care records for Residents #026, #027, and #028 did not have any documentation to indicate that tuberculosis screening had been conducted. This was confirmed by the Manager of Nursing Care Operations. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that tuberculosis screening measures are in place for Residents #026, #027, and #028, to be implemented voluntarily.

WN #11: 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. (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 written plan of care for Resident #015 sets out the planned eye care for the resident.

On January 28, 2015 yellow colored, crusty debris was observed on Resident #015's upper and lower eye lids on both eyes. Crust on the resident's eye lids continued to be observed throughout the course of the inspection.

Resident #015's health care record was reviewed and indicates that the Resident has had issues with his/her eyes since January 2014. On a specific date in January 2014, the MD prescribed eye drops to one of the eyes twice daily for seven days for an eye infection. On a specific date in February 2014, the MD noted an increase in redness and discharge due an outwardly turned or sagging lower eyelid and re-ordered a prescribed eye drops. On a specific date in March 2014, the MD noted lower lid crusting and a reddened conjunctiva and stated that he would re-order the antibiotic eye drops and noted that the resident was resistive to taking them. On a specific date in April 2014, the

MD noted lots of discharge from the specific eye and an increase in redness to the clear membrane, that coats
the inside of the eyelids. A prescribed eye drops to both eyes were ordered. Progress note entries continue to indicate ongoing issues with Resident #015's eyes but eye drops were not reordered due to Resident #015's resistiveness to them.

Staff member #142 was interviewed and stated that as part of Resident #015's care, she uses a warm cloth to soften and remove the crust from the Resident's eyes, but that it returns.

Staff member #S143 was interviewed and stated that she had been instructed to use a warm, soft washcloth to soften and remove the crust from the eyes. She indicated that she uses the flow sheets as a guide to know what care to provide to her assigned residents.

Resident #015's care plan and flow sheet do not identify that Resident #015 has issues with the eyes that lead to the accumulation of crust on the eye lids and that the Resident requires special or more frequent eye care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the provision of Resident #012's care with regards to bathing is documented.

On January 28, 2015, it was observed that Resident #012 had long, coarse facial hair.

Staff member #S140 was interviewed and stated that Resident #012's facial hair was removed with shaving cream and a disposable razor on an as needed basis on the Resident's shower days. The Resident's shower days are Tuesday and Thursday, but a shower could be given on another day depending on the Resident's mood. Staff member #S140 stated that PSWs are expected to document the provision of residents' bathing care on the flow sheet.

Resident #012's bathing flow sheets for December 2014 and January 15, 2015 were reviewed.

Out of the twenty times that Resident #012 was scheduled for bathing in December 2014 and January 2015, the provision of Resident #012's bathing care was documented five times (three times in December and twice in January); therefore 15 out of 20 care provision were not documented.

Resident #012's care plan states that the PSW/RSW initials for care delivered.

Staff member #141 was interviewed and stated that PSWs are expected to document the provision of residents' care in the flow sheets. If a resident refuses a bath/shower, PSWs are expected to report this to the registered staff who document in a progress note.

Resident #012's progress notes were reviewed, and there was no indication that bathing during this time frame was refused. [s. 6. (9) 1.]

3. The licensee has failed 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 is no longer necessary.

The Director of Care (DOC) indicated that PSW have access to a paper copy of the Plan of Care that is available in a binder at the Nursing Station.

Upon review of Resident #013's Plan of Care dated a specific date in February 2014, it was documented that the resident required setup assistance for oral care. Interventions included to ensure that the Resident's dentures were in his/her mouth & cleaned after each meals. It was also documented that staff were to remove & soak the dentures every evening. Upon review of the Resident's flow sheet for the month of January 2015, it was documented that the Resident had refused evening oral care every evening, and on three evenings, there was no documentation. An intervention under Behaviour, directed staff not to argue with Resident #013 when verbally or physically abusive.

During interviews with PSWs #S111 and #S112 on January 29, 2015, they indicated that the Resident did not want to remove the upper denture to soak it at night, but would sometime accept having the denture rinsed then the Resident would put it back into his/her mouth for the night. Both PSWs indicated that the Resident had not worn the bottom denture for a very long time. Both PSWs indicated they would not argue with the Resident. When asked if they had informed the registered nurse of Resident's refusal of care, they indicated they had not.

On January 30, 2015 during an interview with RPN #S101, she indicated she was the regular nurse on the unit and was responsible to updating the plan of care. She indicated that she was aware that the Resident used only the upper denture. She stated that she was not aware that the Resident refused evening oral care, but that if she had been

aware she would have revised the plan of care. The RPN indicated that anytime there was a change in the plan of care, the nursing staff were responsible to document in the progress notes to alert staff on other shifts, as well as sharing information during report. The RPN indicated that no information had been shared by evening staff regarding the Resident's refusal of evening oral care, most evenings in the month of January 2015.

During an interview with the Manager of Nursing Operations on January 30, 2015 she indicated that evening staff should have communicated the changes in Resident #013's care to the nursing staff so that the resident would have been reassessed and the plan of care personalized and revised to reflect the change in care needs. [s. 6. (10) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the resident-communication and response system is cancelled only at the point of activation.

It was observed in the home by the LTCH Inspectors that the home has a communication and response system that is commonly known as the call bell system. It was observed by the LTCH inspectors that the call bell system is available at each resident's bed and bathroom or any location used by the residents.

When the call bell system in the home is engaged a light at the entrance of the resident's room will illuminate, a sound from an annunciator panel at the nurses station will alarm along with a visual display of the location where the call bell was engaged, and a page outlining the location the call bell was engaged is sent to a pager carried by the PSWs on specific units in the home. It is to be noted that on the Bankwood Home Area, when engaging the call bell, a sound is heard, and that there are no pagers on this unit, a different ring is assigned to the resident bathrooms. Staff indicated that the call bells CAN be cancelled at the nursing station but staff indicate they are not suppose to do this.

It was observed by two LTCH inspectors that staff members cancelled engaged call bells. On January 27, 2015 on the 1st Floor unit, secure unit named Bankwood it was noted by Inspector #551 that a call bell was engaged. Inspector #551 observed a Registered Nurse lift the receiver from the annunciator panel and cancel the call bell. It was noted by the inspector that the call bell did not re-activate.

On January 29, 2014 during an interview the Manager of Environmental Services, he indicated that he was aware that the call bell could be cancelled from the annunciator panel by lifting its receiver. [s. 17. (1) (c)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the suspected misuse or misappropriation of Resident #011's money was reported to the Director.

During an interview with Resident #011, it was indicated to Inspector #551 that he/she had accused a staff member of stealing money. The Director of Human Resources was interviewed and stated that she led the investigation into the allegation of the missing money. The home's investigation notes were reviewed and clearly indicate that Resident #011 accused a specified staff member of theft.

The Manager of Nursing Care Operations was interviewed and stated that Resident #011's accusation of a staff member stealing money constituted suspected misuse or misappropriation and should have been reported to the Director. [s. 24. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive fingernail care, including the cutting of fingernails.

During observations on January 27, February 2 and 3, 2015, the Inspector observed Resident #014's fingernails (except for the thumb) of the right hand soiled with brownish/black matter.

Upon review of Resident #014's most recent Plan of Care, it was documented that the Resident self-disimpacted due to cognitive impairment and as part of the interventions, staff were directed to ensure that the Resident's fingernails were kept clean and short to prevent injury. Other interventions related to grooming included to ensure that nails were manicured using a file and orange stick on bath days, Tuesday or Saturday.

A review of the Flow Sheets was done. It was documented that Resident #014 was provided with a shower each Tuesday and Friday in January 2015 and on Tuesday, February 3, 2015. Hair/Nailcare was documented as provided on the Tuesdays during that period of time.

During interviews with PSW #S137 and #S138 on February 2, 2015, they indicated that the registered staff were responsible to cutting the residents' nails and they were responsible to filing the nails only. PSW #S138 indicated she used a cloth with soap and water to clean Resident's soiled nails, while PSW #S137 indicated she would probably use a wooden stick, added that she had not had to use one for a long time as Residents seldom had soiled nails.

On February 2, 2015 during an interview with RN #S104, she indicated that PSWs were expected to clean Resident #014's fingernails on shower days, either Tuesday or Friday. After assessing the Resident's fingernails of the right hand, the RN indicated that the nails were soiled and they should have been cleaned, added that nailcare frequently got overlooked by staff. The RN stated that it was especially important that this Resident's

nails be kept clean as he/she was known to self-disimpact.

On February 3 2015 at 11:30, the Inspector observed brownish/black matter under the fingernails of Resident #014. PSW #S149 indicated that he had just been directed by the registered staff to provide nailcare to the Resident. When asked if the Resident had received a shower earlier in the day, he stated that he had provided the Resident with a shower but had not done nailcare.

During an interview with the Director of Care (DOC) on February 2, 2015 she indicated that the home expected staff to provide nailcare as part of daily care, especially with Resident #014 as he/she was known to self-disimpact. [s. 35. (2)]

WN #15: 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 the planned menu items were offered and available at lunch on January 26, 2015.

On Monday, January 26, 2015, the meal service at lunch on the sixth floor, a designated Chinese unit was observed. At the time of the observation, the home was on week two of a three week cycle.

According to the Chinese Lunch Menu, the residents were to be offered chicken with sweet corn, chinese greens with oyster sauce and steamed rice.

Staff member #S126, the Food Service Attendant showed Inspector #551 that the choices for this meal were tomato and rice soup, purple cabbage with bok choy or pork and potato with green onion stew, and that congee and a sandwich were available.

The planned items according to the posted Chinese Lunch menu were not offered and available. [s. 71. (4)]

WN #16: 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,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are production sheets for all menus.

The sixth floor of the home is a designated Chinese unit. A Chinese Lunch Menu is offered Monday to Friday and is prepared by a designated cook. On the sixth floor, breakfast, supper and the lunch alternates follow the regular menu.

On January 26, 2015, it was noted that the menu items offered at lunch on the sixth floor did not match the posted Chinese Lunch Menu. On February 2, 2015, the Food Service Manager was asked for a copy of the production sheets for the sixth floor to verify what should have been prepared for lunch on January 26, 2015. The Food Service Manager stated that there were no production sheets for lunch for the sixth floor. He indicated that the cook used recipes and a chart to know how many portions of regular, minced and puree Chinese meals to produce at lunch. There is no guide that indicates which food items are to be produced or the quantities required for breakfast, supper or for the lunch alternate for the sixth floor.

On February 4, 2015, the Food Service Manager provided copies of seven therapeutic diets offered at the home. He explained that the cook uses a Therapeutic Diet Binder that lists any special food items to be prepared (that deviate from the regular menu) and a table that states how many residents consume a regular, minced or puree texture diet on each of the eight units.

There is no guide that indicates the number of each food item to be produced for any meal on any of the eight units of the home. [s. 72. (2) (c)]

WN #17: 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 seek the advice of the Residents' Council in developing and

carrying out the annual satisfaction survey.

On February 2, 2015, Resident #033, a Floor representative for the Residents' Council, stated that he/she has been participating in the Residents' Council for over twelve years and could not remember the council being asked for advice in developing and carrying out the satisfaction survey during that time.

Staff member #S136 assistant to the Resident Council stated that there is a satisfaction survey conducted annually in the home, and the Home did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

On February 3, 2015, in an interview, the Director of Quality Management informed inspector #599 that the questions were already set for a random sample of forty residents and residents were not given the opportunity to add or change questions for the satisfaction survey.

Resident #034 stated the survey was presented to the Residents' Council as a done deal, a sample of forty residents with specific questions and resident #034 was not allowed to complete a survey.

On February 3, 2015, in an interview, the Executive Director stated the Home did not seek the advice of the Residents' Council in developing and carrying out the survey. [c. 8, s. 85 (3)] [s. 85. (3)]

2. The Licensee has failed to seek the advice of the Family Council, in developing and carrying out the survey, and in acting on its results

On February 4, 2015, in an interview, the President and the past President of the Family Council stated that the satisfaction survey was presented to the Family Council and Council was informed that there would be a sample of forty residents with eight residents from five different Home areas that would be surveyed. Both the present and past President of the Family Council stated that the Home did not seek the advice of the Family Council in developing and carrying out the survey.

On February 3, 2014, in an interview, the Director of Quality Management and the Executive Director stated that the Home did not seek the advice of the Family Council in developing and carrying out the survey. [c. 8, s. 85 (3)] [s. 85. (3)]

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

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if the staff member has been trained by a member of the registered nursing staff in the administration of topicals.

The Inspector reviewed the home's Treatment Application by Health Care Aide (HCA), Policy and Procedure Number: 9-08 provided by the DOC. On page 1 of 1, it is documented that as part of the Certification requirements, a registered staff has signed the certification form after providing instruction to the HCA on the safe application of prescribed treatments (i.e. the seven rights of medication administration), demonstrated the application technique, has instructed the HCA on the documentation procedure and observed a return demonstration 3 times.

On February 3, 2015, Inspector #545 observed prescribed topical creams stored in unlocked areas such as in Residents' rooms and in a basket located in the unlocked charting room at the Nursing Station.

During interviews with PSW #S146 and PSW #147 on February 3, 2014, they indicated that they applied prescribed creams to Resident #009, #024 and #025 during morning

care and that these Residents did not self-administer the prescribed creams:

Both PSWs indicated they had been trained by a nurse on how to apply topical creams, sometime ago.

During an interview with RN #S144 on February 3, 2015 he indicated that he was the registered staff responsible for staff. He indicated that he had not provided the training in the administration of topicals to PSW #S146 and #S147 and never seen the signed certification forms to indicate they had received their certification.

On February 4, 2015 PSW #S132 and PSW #S154 indicated they also applied prescribed topical creams and that they had received training on how to apply, some time ago.

On February 03, 2015 during an interview with the Director of Care (DOC), she indicated that PSWs could apply prescribed topical creams to Residents only after being certified by a registered nurse on the process and application. The DOC indicated that the registered nurse who provided the training did not remember providing training to PSW #S132, PSW #S146 and PSW #S154. She further indicated that the home did not have documentation indicating completion of training by a registered nurse on how to apply prescribed topical creams for PSW #S132, PSW #S146 and PSW #S154. [s. 131. (4)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: there must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

The Inspector reviewed the Quality Improvement & Required Programs Checklist completed and signed by the Director of Quality Management on January 26, 2015. A note added at the top of the Checklist, indicated that the home's "Quality Program was being re-implemented as of January 2015, and would include all elements such as a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review."

During an interview with the Director of Quality Management on February 6, 2015 with Inspectors #545 and #161, she indicated that over the past year, she had been in the process of developing a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review. A review of the "Continuous Quality Improvement Program (based on Quality Management Program developed 1998)" was conducted by Inspectors #545 and #161 with the Director of Quality Management. She indicated that the written description of the system did not include policies, procedures and protocols as she was presently writing them.

During an interview with the Executive Director on February 6, 2015 he indicated to Inspector #545 that the Director of Quality Management was responsible in writing the home's CQI description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review, and that he was aware that the description was not completed at this time, as it was presently in the development phase. [s. 228. 1.]

Issued on this 9th day of March, 2015

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

Original report signed by the inspector.