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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 18, 2014	2014_312503_0014	T-016-14	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

COLEMAN CARE CENTRE
140 CUNDLES ROAD WEST, BARRIE, ON, L4N-9X8

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

LAURA BROWN-HUESKEN (503), ARIEL JONES (566), SLAVICA VUCKO (210), VALERIE JOHNSTON (202)

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): May 22, 23, 26, 27, 28, 29, 30, June 2, 3, 4, 5, 6, and 9, 2014.

During the course of the inspection, the following complaint inspection was completed: T-454-13.

During the course of the inspection, the inspector(s) spoke with general manager (GM), director of care (DOC), director of food services (DFS), director of recreation services (DRS), neighbourhood coordinators, registered dietitian (RD), physiotherapist (PT), physiotherapy assistant (PTA), RAI coordinator, registered nursing staff, personal support workers (PSW), recreation aides, dietary aides, cook, environmental services/housekeeper, Residents' Council president, family members, and residents.

During the course of the inspection, the inspector(s) conducted tour of all home areas, observed meal and snack service, reviewed clinical records, observed provision of care, reviewed Residents' Council minutes, home's policies related to food services, lift and transfer, immunizations, infection control, restraints, abuse, accommodation services, reviewed the complaint log, maintenance records, and housekeeping records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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 failed to ensure the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

A review of resident 0022's written plan of care under the Activities of Daily Living (ADL) assistance section identified that the resident toilets independently and requires no help or oversight, and no physical help from staff. The urinary/bowel elimination section indicated that the resident uses pads/briefs as a personal preference and for protection of stress related incontinence, that the resident is occasionally incontinent of urine, and that staff are to provide skin care/pericare as required. The lack of skin integrity section indicated that the PSWs are to attempt to assist with pericare, and the resident's continence care product is to be changed every 4 hours and as needed. Further record review of resident 0022's flow sheets revealed that, on average, the resident uses two continence care products daily. Day shift PSW staff reported that the resident is provided one continence care product in the morning and that the

resident will be questioned about the need for more products during the shift. The evening PSW reported the resident is provided with one continence care product and will receive further assistance when requested. An interview with the neighbourhood coordinator confirmed that the resident uses a continence care product, which is not changed every four hours, and that resident 0022's written plan of care should be updated to provide clear directions to staff regarding the resident's continence care needs. [s. 6. (1) (c)]

2. The licensee failed to ensure the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Review of the clinical record and interviews with a PSW and RAI coordinator indicated resident 0031 was not assessed for his/her preferred method for bathing. RAI coordinator stated that there is a form which the resident or the Substitute Decision Maker (SDM) would sign indicating the preferred bathing method (sponge bath, shower or tub bath) and it was introduced few months ago. The form is to be completed on admission or at the yearly care conference; however, the RAI coordinator confirmed it had not been completed for all of the residents. In addition, a PSW indicated in an interview that the type of bath is dependent upon the bath schedule. [s. 6. (2)]

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

The written plan of care for resident 3578 directs staff to provide physiotherapy treatments three times weekly. A review of clinical documentation for the resident revealed that he/she only received physiotherapy treatments once per week for three identified weeks, and twice per week for five identified weeks.

The written plan of care for resident 3577 directs staff to provide physiotherapy treatments two to three times weekly. A review of clinical documentation for the resident revealed that he/she did not receive physiotherapy treatments for two identified weeks, and only received physiotherapy treatments once per week for five identified weeks.

The written plan of care for resident 3595 directs staff to provide physiotherapy treatments two to three times weekly. A review of clinical documentation for the resident revealed that he/she did not receive physiotherapy treatments for one

identified week, and only received physiotherapy treatments once per week for three identified weeks. [s. 6. (7)]

4. The written plan of care for resident 3589 directs staff to provide physiotherapy treatments two to three times weekly. A review of clinical documentation for the resident revealed that he/she only received physiotherapy treatments once per week for three identified weeks, and he/she did not receive any treatment during two identified weeks.

The written plan of care for resident 3591 directs staff to provide physiotherapy treatments three times weekly. A review of clinical documentation for the resident revealed that he/she did not receive treatment three times a week at all during an identified two month time period. He/she did not receive physiotherapy treatments during three identified weeks, he/she received physiotherapy treatments once per week for three identified weeks, and twice per week for three identified weeks.

An interview with the home’s PTA revealed that care may not be provided as per care plan due to a heavy work load and staff shortages. An interview with the home’s PT confirmed that treatments for resident 3578, 3577, 3595, 3589 and 3591 were not provided as per the written plan of care. [s. 6. (7)]

5. The care plan for resident 3583 directs staff to provide the resident with an individualized snack to be provided during the afternoon snack related to the management of a disease. During the afternoon snack on an identified date, the resident was observed to be provided with some of the individualized snack. An interview with an identified PSW revealed that the individualized snack had not been available for the resident on the snack cart and had to be retrieved from the kitchen for the resident. An interview with the home’s RD revealed that the individualized snack should have been labeled and available on the cart for the resident. The RD and DFS confirmed the resident had not received the interventions as per his/her care plan. [s. 6. (7)]

6. Review of the clinical record and interview with RAI coordinator indicated the SDM of resident 3624 signed a form on an identified date, indicating the resident’s preferred bathing method to be tub bath. Review of the flow sheets and interview with a PSW indicated the resident was scheduled to have bath twice a week, on identified days. Review of the bath record for a seven week time period, indicated resident had shower on one bathing day and tub bath on the other bathing day, with one exception

noted. A review of the written plan of care indicated the resident was totally dependent on two staff to provide bathing twice a week. Interview with a PSW indicated on an identified date the resident received shower by one PSW while the second PSW was in the same bath room but giving tub bath to another resident. The same day, it was noted that the resident had an identified injury. The care set out in the plan of care, tub bath by two people, was not provided to resident 3624, as specified in the plan. [s. 6. (7)]

7. The licensee failed to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every 6 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 written plan of care for resident 3577 directs staff to place two bed rails up while resident is in bed as a physical restraint. The interventions section of the care plan further directs staff to ensure that a lap belt is secure but not too tight while in wheelchair. The resident was observed to be seated in his/her wheelchair on an identified day, with the lap belt applied. The order for a lap belt restraint for resident 3577 was discontinued on an identified date. The charge nurse confirmed that the resident should not have been restrained with the lap belt and that the written plan of care had not be revised to reflect the change in the restraint order. [s. 6. (10) (b)]

8. The licensee failed to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every 6 months and at any other time when the resident's care needs change or care set out in the plan has not been effective.

On an identified date a quarterly nutritional assessment was conducted for resident 3595 by the home’s RD. The resident was noted to be at high nutritional risk. The assessment identifies the resident as having experienced an undesired weight loss and that the weight was below the identified goal weight range for the resident. The identified plan for the resident was to achieve weight maintenance for which a nutritional supplement was added to the plan of care. In an interview, the home’s RD revealed that the care set out in the plan of care had not been effective as the resident continued to lose weight. The home’s policy 07-01, titled Role of the Director of Food Services (DFS)/ Assistant Director of Food Services (ADFS) & Registered Dietitian (RD) reviewed January 2014, indicated that the RD will complete monthly assessments on all high risk residents and document the assessment in the resident's progress notes. The RD revealed the resident had not been reassessed for an identified two month period and that the care plan had not been reviewed and revised

during that time despite the ineffective interventions. [s. 6. (10) (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 care set out in the plan of care is provided to the resident as specified in the plan and that the written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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 failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

On June 2, 2014, the call bells at the the bedsides of resident 3604 and 3578 were found to be non-functional. The charge nurse verified that these call bells were not functional due to a malfunction of the panel that they were attached to. The nurse notified maintenance immediately and the panel was fixed restoring the function of the call bells. [s. 17. (1) (b)]

2. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed used by residents.

Observations conducted on May 22 and 23, 2014, of residents 3596, 3589, 3591, 3577, 3578, 3604 found that the residents did not have call bells installed at their bedsides. The charge nurse confirmed that the resident did not have a call bell, and the call bells were subsequently installed at each resident's bedside. [s. 17. (1) (d)]

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 is equipped with a resident-staff communication and response system that is available at each bed used by residents and that the resident-staff communication and response system is on at all times, to be implemented voluntarily.

WN #3: 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,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provides for preparation of all menu items according to the planned menu.

The lunch meal preparation was observed on June 5, 2014. The cook poured baked beans directly from the can into the serving containers. Review of the standardized recipe of the baked beans included the addition of onion, ketchup, mustard, brown sugar and Worcestershire sauce to the canned baked beans. After cooking the cheddar cheese soup, the cook was observed to place the soup into the blender altering the texture of the soup. Review of the standardized recipe of the soup did not call for the soup to be pureed. The cook confirmed that both recipes were not prepared according to the standardized recipes. The cook was observed to add a powder thickener to the pureed Oktoberfest sausage prior to service. The cook revealed in an interview that milk had not been added to the pureed sausage during its preparation and that the item was not prepared according to the standardized recipe. A review of the standardized recipe did not include addition of the thickener. The DFS confirmed that the cooks are directed to follow the standardized recipes and that the menu had not been prepared according to the planned menu as the recipes had not been followed. [s. 72. (2) (d)]

2. The licensee failed to ensure that the food production system provides for preparation of all menu items according to the planned menu.

During an observation of the lunch meal service on May 22, 2014, resident 3594 was served the puree texture carrots. The resident’s plan of care identified the resident required thickened fluids as well as a mechanically altered diet. The carrots had separated into solids and thin fluids on the resident’s plate. A review of the standardized recipe for the carrots revealed that the carrots were to be a pudding-like consistency. The DFS confirmed that the carrots were not prepared according to the standardized recipe as part of the home's planned menu and that the mixed consistencies within the product were unsafe for the resident. [s. 72. (2) (d)]

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 all menu items are prepared according to the planned menu, to be implemented voluntarily.

WN #4: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, a process to ensure that food service workers and other staff assisting residents as aware of the residents' diets, special needs and preferences.

During the lunch meal service on May 22, 2014, an identified PSW was observed

serving the residents dessert. Prior to the service of the dessert, the dietary aide serving lunch had removed the diet roster from the dining room. The PSW was not observed to consult a dietary roster while serving the desserts. The PSW indicated that he/she was a long term employee of the home and that he/she knew the diets of each of the residents. He/she further indicated that there was no tool available for use in verifying the residents' diet orders. An interview with the DOC confirmed that there is no process in place during the dessert service to ensure that the staff assisting residents are aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

2. The licensee failed to ensure that the home has a dining and snack service that includes at a minimum course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During the lunch meal service on May 22, 2014, residents 3581, 3621, 0011 and 0012 were observed to be served the dessert course while they were consuming their entrees. None of the residents were observed to have indicated this as a preference. Review of the clinical records for the residents revealed that the residents had not been assessed to require service of multiple courses at one time. The home's Meal Time Responsibilities policy 08-22, reviewed January 2014, indicated that residents will be offered their meal course by course unless otherwise indicated by the resident or by the resident's assessed needs. The DFS confirmed that the residents should not have been served dessert until their entrées were completed and that the residents had not been provided course by course meal service. [s. 73. (1) 8.]

3. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During the lunch meal service on May 22, 2014, resident 3617 was observed to be receiving feeding assistance from a recreation aide. The resident was fed both the soup and the puree texture entrée and vegetables with a tablespoon. In an interview the recreation aide revealed that he/she had not received training on proper feeding techniques and was unaware of any safety risks associated with using tablespoons to feed residents. Interviews with the DFS and DOC confirmed that proper feeding techniques include the use of teaspoons to provide feeding assistance to residents and that resident 3617 had not been fed using proper techniques. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a process to ensure that food service workers and other staff assisting residents as aware of the residents' diets, special needs and preferences, to be implemented voluntarily.

WN #5: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of

his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,

v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents’ Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is promoted and respected.

Resident 3632 reported in interviews an incident where a PSW was rude to the resident. Family and staff interviews confirmed that there was an incident involving a PSW's approach to the resident during care, whereupon the resident's right to choose to stay in his/her room during meal time was not respected. This incident was reported to management by another staff member. An interview with the DOC and GM confirmed that the PSW had general performance issues related to resident centered care, and was disciplined for violation of residents' rights. A record review confirmed that the PSW received a Team Member Disciplinary Note on December 23, 2013. [s. 3. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Mechanical lifts (LTC) policy is complied with.

A review of the policy Mechanical lifts (LTC), dated February 2013, paragraph 2, states all mechanical lifts require two care-givers. Paragraph 4 states new team members will be educated on mechanical lifts upon hire, and will be certified annually by the Program for Active Living (PAL) kinesiologist or designate in order to ensure that their skills and knowledge are kept up to date. All team members must be trained by the PAL kinesiologist or designate on the proper use of mechanical lifts prior to using the lifts with any resident. The section "procedure -mechanical lift from

paragraph 1 states the procedure requires two team members, one on either side of the bed. One is the Leader and the other is the assistant. Paragraph 15, states one team member gently turns the lift while the other team member guides both the resident and the lift. When positioned over the chair, the lead team member lowers the resident using the handset and the assistant team member supports the resident into the chair. Ensure that the resident is positioned in the chair properly before removing the sling and lift.

Review of the policy Mechanical Lifts, toileting using mechanical lifts, tab 04-66-A, page 7, indicated that kinesiologist must assess the resident for ability to use the hygiene/toileting sling as it is not appropriate/safe for all residents. A form called PAL transfer/lift decision, tab 04-66, page 3, is part of the policy and consists of the documentation for the lift decision such as the sling size for mechanical lift (small, medium, large, extra-large) and if the resident is appropriate for toileting sling.
A review of the written plan of care in relation to transfer of resident 3624 indicated the resident required total assistance by two people while transferring with the mechanical lift related to physical limitations.

On an identified date, the resident was transferred using the mechanical lift for a shower. Staff noted during the shower that the resident's left shoulder was injured. The resident was later diagnosed with an identified injury.

Interview with PSWs indicated that they decide whether to use either a regular sling or a hygiene sling to transfer the resident. The resident was not assessed by a kinesiologist for the use of the hygiene sling as per the home's policy and the PAL transfer/lift decision form could not be located for this resident.

Interview with PSWs, maintenance care partner, environmental staff, nursing staff and GM indicated that when PSWs do not have the second team member to assist close to them while transferring a resident with mechanical lift or they are busy with another resident in another room, they can call staff who is available in the hallway (such as maintenance, environmental staff, nursing staff) to "spot" them while a PSW is performing the procedure of transferring with the mechanical lift. A resident could be already attached on the mechanical lift with the sling by one PSW.

Interview with maintenance and environmental staff confirmed that it happened two times in 2013 that they were present as a second person in the room while a PSW was performing the transfer of the resident with a mechanical lift. They said that they

usually do not touch the resident, the sling or guide/set up the lift. They are in the room to "spot" as a second person just in case something happens. The maintenance care partner stated he/she did not have training in transfers with mechanical lifts in 2013 but he/she has general knowledge in mechanical lifts. The environmental staff stated he/she did not have the on-line training for transfers with mechanical lifts in 2013 but he/she was present at the presentation because it was his/her wish to learn more. They both stated that the training for transfers with mechanical lifts is not mandatory for them and they were not certified annually by the PAL as per the home's policy.

Interview with GM confirmed that the practice of “spotting” is not written. [s. 8. (1) (b)]

2. The licensee failed to ensure that the home’s Immunization Administration policy 01 -04, reviewed January 2014, was complied with.

The home’s Immunization Administration policy 01-04, reviewed January 2014, indicated that all team members and contract employees are to be offered the tetanus diphtheria booster. A review of the employee files for the three most recent hires revealed that the tetanus diphtheria booster had not been offered. The lead nurse for infection control and the DOC confirmed that the tetanus diphtheria booster has not been offered to team members and contract employees as per the home’s policy. [s. 8. (1) (b)]

WN #7: 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 failed to ensure that the home, furnishings and equipment are kept

clean and sanitary.

On May 23, 2014, a strong, lingering urine odour was noted in the resident bathrooms of rooms 53 and 56, and the raised toilet seat in room 56 was observed to be unclean. On further observation of both resident bathrooms, the lingering odours remained on May 28 and 30, 2014, and the raised toilet seat in room 56 was also observed to be unclean on May 30, 2014. Record review of Housekeeping Check Sheets indicated that these resident rooms were cleaned daily between May 12 and June 1, 2014. An interview with the housekeeper and GM confirmed that it is the responsibility of housekeeping staff to address strong, lingering odours within the home, and that the daily cleaning schedule included cleaning residents' bathrooms. Interviews with both the housekeeper and maintenance technician confirmed the strong, lingering odours in the bathroom of rooms 53 and 56.
In an interview, resident 3622 revealed that the floors in the home are often unclean. On May 30, 2014, the floors in the resident's room were noted to be unclean in both the bedroom and bathroom, with tracked dirt and urine, respectively. Record review of Housekeeping Check Sheets indicated that this room was cleaned daily between May 12 and June 1, 2014. An interview with the housekeeper and GM confirmed that it is the responsibility of housekeeping staff to ensure floors are kept clean in both resident rooms and common areas, even if that means cleaning them more than once per day. An interview with the housekeeper and maintenance technician confirmed that the floor in the resident's room was unclean. [s. 15. (2) (a)]

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

The following observations were completed by the inspector on May 23, May 26, and May 28, 2014:
In the East tub room:
-Two holes in the ceramic wall tiles
-Dark markings on the floor between tub and wall
-Wallpaper pulling down from ceiling approximately four to six inches across top edge of wall with patchwork applied to ceiling related to water damage
-Lower edge of wall paper lifting along length of tub in the same area.
In the West tub room:
-Yellowish stained grout on wall tiles and broken ceramic wall tiles
-Shelf surface worn and particle board exposed
-Discolouration of floor around tub area

-Paint around tub drain chipped and enamel of tub discoloured
-Chipped door surface with exposed particle board.
A review of the maintenance logs failed to reveal that the above areas requiring repair had been recorded on the Maintenance and Safety Task Sheets for the common tub rooms. The maintenance technician confirmed the above noted areas required repair. [s. 15. (2) (c)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A record review revealed that the Residents' Council Concern forms dated March 31, 2014, and April 28, 2014, addressed to the dietary department were not forwarded from the recreation aid (acting Residents' Council assistant) to the GM or DFS for a response following receipt of the concern. An interview with the DFS confirmed that he/she did not receive any Residents' Council Concern forms in March or April, 2014, and therefore the requests were not fulfilled or responded to until the following Residents' Council meeting. A review of the Residents' Council meeting facilitation policy indicated that the Residents' Council assistant will supply the GM with a copy of the Residents' Council minutes each month, and the GM or designate will be responsible for replying in writing to the Residents' Council concerns within ten days. Interviews with the DRS and GM confirmed that the licensee's duty to respond was not fulfilled. The acting Residents' Council assistant neglected to forward on the concerns/recommendations raised by the Residents' Council on March 31, 2014, and April 28, 2014, and as such, they were not received by the appropriate department heads and Residents' Council was not provided with response within 10 days. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home’s menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the homes menu cycle includes choices of entrees, vegetables and desserts at lunch and dinner.

The lunch menu for Wednesday June 5, 2014, provided two choices for the home’s residents; a yogurt fruit plate served with banana bread or an Oktoberfest sausage with mustard on a whole wheat bun served with baked beans. Neither of the two choices provided a vegetable. The home’s Menu Planning policy 06-33, reviewed January 2014, indicated the home’s menu will provide choices for entrees, vegetables, and desserts. The DFS confirmed that the lunch menu on June 5, 2014, did not provide a choice of vegetables. [s. 71. (1) (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is restrained by a physical device under section 31 of the Act that the staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

On May 30, 2014, resident 3577 was observed to be seated in his/her wheelchair with the seat belt applied. The charge nurse indicated that resident 3577 does not require a seat belt restraint and removed the restraint immediately. A review of the clinical record revealed that the resident had previously required a seat belt as a restraint, but that this order was discontinued on an identified date, due to the restraint no longer being required. [s. 110. (2) 1.]

2. The licensee failed to ensure that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of the staff as authorized by a member of the registered nursing staff for that purpose.

The care of plan for resident 3578 indicated that the resident is to be restrained with a seat belt while in his/her wheelchair and with full bed rails on all sides of the bed while the resident is in bed. The care plan further directed staff to monitor the resident hourly while the resident is restrained. Interviews with identified PSWs and the charge nurse revealed that the resident should be restrained at all times, monitored hourly and that this monitoring is to be documented hourly on the restraint monitoring chart. There was no documentation on the restraint monitoring chart for following time periods:
- May 8, 2014, from 6:00a.m. to 1:00p.m.
- May 13, 2014, from 12:00a.m. to 5:00a.m.
- May 14, 15, 16 2014, from 2:00p.m. to 9:00p.m.
- May 18, 2014, from 6:00a.m. to 11:00p.m.
- May 19, 2014, from 12:00a.m. to 9:00p.m.
- May 22, 2014, from 6:00a.m. to 11:00p.m.
- May 23, 2014, from 12:00a.m. to 5:00a.m.
- May 24, 25, 26, 2014 from 5:00a.m. to 1:00p.m.

The DOC confirmed that the resident should be monitored hourly at all times related to the resident’s restraints and that this monitoring should be documented on the restraint monitoring chart. [s. 110. (2) 3.]

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

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded schedules posted on the Ministry website.

A review of the clinical record for resident 3578 revealed that his/her last tetanus and diphtheria booster was administered greater than 10 years ago. The home's Immunization Administration policy 01-04, reviewed January 2014, stated that the Tetanus Diphtheria Booster is to be offered to all residents every 10 years. The lead nurse for infection control and the DOC confirmed that the resident had not been offered the tetanus diphtheria booster in the past 10 years. [s. 229. (10) 3.]

Issued on this 6th day of August, 2014

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