Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 21, 2015	2015_377502_0016	T-1653-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (no.1) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

CRAIGLEE NURSING HOME
102 CRAIGLEE DRIVE SCARBOROUGH ON M1N 2M7

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

JULIENNE NGONLOGA (502), SHIHANA RUMZI (604), SOFIA DASILVA (567)

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): August 10, 11, 12, 13, 17, 18, 19, 20, 21, 24, 25 and 26, 2015.

Inspector Juliet Manderson-Gray (607)was part of the inspection team. Findings identified for non-compliances related to LTCHA r.221(1), s.57(2), s.60(2), s.76(4); for resident #007 related to LTCHA r.30(2) and for resident #009 related to LTCHA r.33(1) were collected by Inspector #607.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), registered nurses (RNs) registered practical nurses (RPNs), personal support workers (PSWs), Ward Clerk , dietary manager (DM), registered dietitian (RD), dietary aides, cooks, maintenance lead, housekeeping aides, residents, substitute decision makers (SDMs) and family members of residents.

The inspectors also conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following intakes were conducted concurrently with the Resident Quality Inspection: T-4061-15, T-19223-15, T-001018-15, T- 019102-15, T-002997-15 and T-002184-15.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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.
- **15 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 230. (7)	CO #001	2015_357101_0003	502

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

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

Specifically failed to comply with the following:

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Review of resident #005's written plan of care revealed the resident was continent of bowel and bladder. Review of the home's assessment record for a specified date, revealed the resident used a specified incontinence product during the days, evenings and nights. Review of the plan of care did not reveal a use of any incontinence product.

Interview with an identified staff member revealed the resident was continent of bowel and bladder and was independent with respect to toileting. The identified staff further revealed the resident wore a specified incontinence product when he/she goes out.

Interview with resident #005 confirmed he/she had been wearing a specified

incontinence product since he/she was admitted to the home.

Interview with an identified nursing staff revealed the resident wore only the specified incontinence product when he/she went out, and indicated that the use of incontinence products should be included in the resident’s care plan. After speaking with resident #005, an identified staff confirmed the resident wears a specified incontinence product and confirmed he/she would speak to the registered staff about changing the plan of care.

Interview with the DOC confirmed the plan of care should reflect the use of incontinence products. [s. 6. (1) (c)]

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

Review of resident #023’s plan of care, for a specified date, identified the resident as having responsive behaviour. On a specified date, resident #023 exhibited a specified responsive behaviour toward another resident and the police was involved. The intervention in place to address the resident's responsive behaviour were to carried out until discontinued by Behavioral Support Ontario (BSO).

A review of the DOS records for resident #023 for a specified period of time, revealed the resident was observed every hour instead of 30 minutes.

An interview with an identified staff members and DOC confirmed the home did not follow the plan of care directing staff to observe the identified resident every 30 minutes. [s. 6. (7)]

3. The licensee has failed to ensure that staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Review of the plan of care for resident #024 for a specified date, identified the resident as having responsive behaviour. Interventions were put in place to address the resident's responsive behaviour.

Interview with the staff assigned to monitor resident #024 revealed he/she was from a specified agency and confirmed he/she was not aware of the interventions set out in the

resident's plan of care and did not have access to it.

Interview with an identified nursing staff and the DOC confirmed the agency staff did not have access to the resident's plan of care and the interventions were not reviewed with the identified staff before they start providing care to resident #024's. [s. 6. (8)]

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

On a specified date, resident #021 sustained a fall with no injuries noted during the post fall assessment.

Review of the progress notes revealed on a specified date after the fall the resident was found to exhibit specified symptoms. The resident was transferred to the hospital a day after the fall for further assessment, and returned the following day with specified medical condition. The family agreed to have the resident on palliative care. Resident passed away two days after the fall.

Review of resident #021's Post Fall Assessments for specified dates, revealed interventions were recommended to reduce the risk of fall, however those recommended interventions were not included in resident #021's plan of care for a specified date.

Interview with the DOC indicated when Post Fall Assessments are completed, the interventions should have been added to the resident's plan of care, and confirmed resident #021's the plan of care was not updated with the above mentioned interventions. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
-there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
-the care set out in the plan of care is provided to the resident as specified in the plan,
-that staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient and immediate access to it, and
-that the resident 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy and procedure put in place is complied with.

Review of the home's "Individual Narcotic Medications Record/Count" policy directs staff to sign immediately on the Individual controlled and Narcotic Drug Form each time a narcotic is administered. Include the date, time, amount given, amount wasted, and new quantity/balance remaining.

Review of the "Individual Controlled and Narcotic Drug Form" revealed six resident's controlled medication was administered but new quantity/balance remaining was not recorded consistently on specified dates for identified residents.

Interviews with an identified nursing staff, ADOC and DOC confirmed the controlled medication quantity on hand or balance was not recorded consistently once the medication was administered. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there any policy and procedure put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

On August 11, 2015, at 3:00 p.m., inspectors #502 and #607 observed windows opened greater than 15 centimeters in identified residents' rooms. There were residents present in the rooms when the windows were observed. The windows in an identified room overlooked the parking lot, one floor below and was located next to resident #016 who was identified by staff as having a specified responsive behaviour.

Interviews with identified staff members confirmed the windows were opened greater than 15 centimeters wide. The concern was brought to the Administrator and the DOC. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with a range of continence care products that promote resident comfort, ease of use, dignity and good skin integrity.

Review of the home's list of incontinent residents revealed that residents #030, #031, #032, #033 and #034 wore a specified incontinence product.

Interview with resident #030's SDM confirmed the resident wears the specified incontinence product and the family has been purchasing the product since the resident was admitted in the home. Further, the SDM stated the resident had never been offered the above mentioned product and using this product was an issue of dignity for the resident as the resident was not fully incontinent and only requires it related to unexpected but occasional incontinence episodes.

Observations of the home's incontinence product stockroom revealed a box of the above mentioned incontinence product.

Interview with an identified ADOC revealed it had not been part of the home's practice to offer residents that specified product. Also, the ADOC stated they hadn't done so for budgetary reasons as the home's incontinence product representative had stated that the home was over budget on their incontinence program.

Interview with the DOC confirmed residents were not provided with a range of continence care products [s. 51. (2) (h) (iii)]

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 ensure that residents are provided with a range of continence care products that promote resident comfort, ease of use, dignity and good skin integrity, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in skin and wound care at times or at intervals provided for in the regulations.

A review of the home's Skin and Wound program training records revealed and interview with an identified ADOC confirmed 17 per cent of the direct care staff did not received training on the above identified area in 2014. [s. 221. (1)]

2. The licensee has failed to ensure that all staff who provide direct care to residents are provided training related to continence care and bowel management on an annual basis.

Review of the home's Continence Care training records revealed and interview with an identified ADOC confirmed 16.67 per cent of direct care staff did not receive training in continence care in 2014. [s. 221. (1) 3.]

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:
- who provide direct care to residents receive, as a condition of continuing to have contact with residents, are provided training in skin and wound care at times or at intervals provided for in the regulations, and
- who provide direct care to residents are provided training related to continence care and bowel management on an annual basis, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has failed to ensure that the following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from the Minister under section 90 of the Act.

Review of the home's incontinence product inventory list revealed residents #005, #030, #031, #032, #033 and #034 have been assessed as requiring a specified incontinence product.

Interview with resident #030's SDM confirmed the resident wears the specified incontinence product and the family has been purchasing the product since the resident was admitted in the home. Further, the SDM stated the resident had never been offered the above mentioned product.

Review of correspondence between the home and the incontinence products representative revealed the home was over budget on their incontinence program.

Interview with an identified ADOC confirmed it had not been part of the home's practice to offer residents pull ups for budgetary reasons. Interview with the DOC confirmed that residents were not provided a range of continence care products to meet their assessed needs. [s. 245. 1. ii.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from the Minister under section 90 of the Act, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents to be afforded privacy in treatment and in caring for his or her personal needs are fully respected and promoted.

On a specified date on time, the inspector observed through an open shower room door on an identified floor, resident #035 seated in his/her shower chair, unclothed while an identified staff member was combing the resident's hair.

Interview with the identified staff member revealed he/she had left the shower room door open because the shower room gets very hot. When asked by the inspector if the resident was OK with the door being open, the identified staff responded no. The identified staff then proceeded to put a garbage can in between the door and the door frame and as a result, the door was still left open and the resident was still visible to the

inspector. The inspector informed the identified staff the resident could still be seen from outside the bathroom and then proceeded to close the door completely.

Interview with an identified nursing staff revealed it gets hot in the shower room as there was no ventilation in there. The staff further stated he/she had not personally seen or heard that the door was routinely kept open after showers such that privacy was not provided to the residents.

Interview with another nursing staff and the DOC confirmed that the door should have been closed for the resident's privacy. [s. 3. (1) 8.]

2. The licensee has failed to ensure that the rights of residents to 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 are fully respected and promoted.

On an identified date and time, the inspector observed an unattended medication cart to be stored outside of the dining room during breakfast on the first floor. The Electronic Medication Administration Record (E-MAR) screen was left open to resident #020's personal medication administration record, which was visible to the public.

Interview with an identified nursing staff confirmed the medication screen was unlocked and was visible to anyone passing by and did not protect the resident's personal health information.

Interview with the DOC confirmed that the medication cart and E-MAR screen was to be kept locked at all times when the cart was left unattended. [s. 3. (1) 11. iv.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On August 10, 2015, during lunch meal service, the inspector observed the refrigerator in the servery located on third floor was dirty and soiled with dried stains.

Review of two weeks cleaning schedule revealed the refrigerator in the servery was to be cleaned by the dietary aide weekly after meal service. There was no indication on the schedule the refrigerator was cleaned.

Interviews with dietary staff and the Dietary Manager (DM) confirmed the above identified refrigerator was not clean. Interview with the DM confirmed a schedule to clean the refrigerator was available and staff should clean according to schedule. [s. 15. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

On specified date and time, the inspector observed red marks on resident #007's identified body part.

Interview with an identified nursing staff revealed resident #007 had an identified medical condition and was receiving specified treatment for the above identified condition.

A review the resident's specific assessment record, progress notes and plan of care did not revealed any record of the above mentioned medical condition.

An interview with identified nursing staff and ADOC confirmed the altered skin integrity should have been captured in a head to toe assessment as well as documented in the plan of care. [s. 30. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed by the method of his or her choice, including tub baths, showers, and full body sponge baths unless contraindicated by a medical condition.

Interview with resident #009 revealed his/her preference was to receive one shower and one bed bath per week. The resident further stated staff are aware of his/her preference and some staff are refusing to honour the request.

Record review of the resident most recent plan of care indicated the resident received two showers per week as per preference.

Interview with the DOC confirmed the resident's plan of care did not include the resident's preference method for bathing. [s. 33. (1)]

WN #11: 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 has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the Residents' Council meeting minutes dated July 7, 2015, revealed a concern related thickened fluid consistency was raised to the food committee.

An interview with the DM confirmed a concern related to thickened fluid consistency was brought to his/her attention during the meeting. The DM indicated that he/she followed up after the meeting, but did not respond to the Resident's Council in writing. Interview with the Administrator confirmed a response was not provided in writing to Residents' Council. [s. 57. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

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

Record review of the family council's meeting minutes dated February 26, 2015, revealed a concern was brought forward related to the home being short staff.

An interview with the Family council president and the administrator confirmed a response was not provided in writing to Family Council. [s. 60. (2)]

WN #13: 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 failed to ensure that planned menu items are offered and available at each meal.

Observation on August 10, 2015, during lunch meal service revealed Tuscan bean and vegetable soup, Mediterranean vegetable sandwich on whole wheat bread, and red pepper were not available and not offered to the residents.

Review of week-3 of the Spring/Summer menu revealed the residents on regular vegetarian diet and regular renal diet should receive the above identified menu items as alternate choice during lunch service.

Interviews with identified staff members and the DM confirmed the above identified items were not prepared or offered to the residents. [s. 71. (4)]

WN #14: 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 home's policy to promote zero tolerance of abuse and neglect of residents,
- The duty to make mandatory reports under section 24, and
- The whistle-blowing protections

Review of the home's Abuse policy revealed the above mentioned areas are components of the home's abuse policy and in-service as one policy. Review of the hone's abuse policy training records revealed and interview with the DOC confirmed that 18 per cent of the staff did not receive training on the above mentioned policy in 2014. [s. 76. (4)]

WN #15: 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,
i. that is used exclusively for drugs and drug-related supplies,
iv. that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting)

On August 18, 2015, the inspector observed the following inside the medication cart on the third floor:
- an identified medical supply for resident #038,
- an identified medication with no opened date, as per manufactures directions, date opened was to be labeled on the package,
- an identified medication with expiration date of June 2015,
- an identified medication opened on April 15, 2015, did not have discontinued or discarded date. As per manufactures directions once opened it is to be discarded 30 days after opening.

Interview with identified nursing staff and ADOC confirmed the medication cart consisted of the above findings. The ADOC immediately took out the above identified medications and one non-medication items out of the medication cart. [s. 129. (1) (a)]

Issued on this 29th day of October, 2015

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

Original report signed by the inspector.