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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Nov 7, 2014	2014_225126_0028	O-000183-14	Resident Quality Inspection

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

LINDA HARKINS (126), AMANDA NIXON (148), LISA KLUKE (547), MELANIE SARRAZIN (592), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 20-24 and October 27-31, 2014

The RQI included to following Logs #O-000690-14,O-000618-14, O-000615-14, O-000546-14, O-000543-14, O-000331-14 and O-000972-14.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, RN Team Leader, Registered Practical Nurse-Resident Assessment Instrument(RPN-RAI) Coordinator, the Activity Director, the Nutritional Manager, the Building Maintenance Manager, the Maintenance Supervisor, the Office Manager, the Personal Support Worker (PSW) Manager, the home's Physiotherapist, the Registered Dietitian, Cooks, several Registered Nursing staff, several non-Registered Nursing staff, a maintenance staff , a housekeeping aide, the President of Resident Council, several Residents and their families.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident care being provided, observed resident meal services, observed medication administration, reviewed several of the home's policies and procedures, reviewed several resident health care records, review of the preventative maintenance schedules, reviewed the home's current menus, menus approval and related food production data, resident council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
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
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. 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's equipment is kept clean and

sanitary.

During a discussion with the Director of Care on October 25, 2014 it was indicated to Inspector #549 that the wheelchairs, including the lap belt and the cushions are cleaned by the night Personal Support Worker (PSW)'s on the night shift before the resident's scheduled bath day. The night PSW is to sign off that the cleaning of the resident's equipment was completed on the Point Of Care (POC)documentation system. The Director of Care also indicated to Inspector #549 that it is the expectation of the home that the PSW's on all shifts do daily wiping of any debris or dirt that is left on the resident's equipment on a daily basis including seat cushions and lap belts.

The Director of Care also indicated to Inspector #549 that the PSW Manager is responsible for ensuring the cleaning of resident's equipment is assigned in the POC for the PSW's as a night task.

On October 21, 2014 Inspector #549 observed Resident #16's wheelchair to have dried caked on debris on the left and right side of the seat cushion, the lap belt and along the frame of the wheelchair. The front wheels and the brakes of the wheelchair had a large amount of dried caked on debris in the spokes.

On October 24, 2014 Inspector #549 observed Resident #16's wheelchair again, it still had dried caked on debris in the same areas as observed on October 21, 2014.

On October 27, 2014 at 9:26 Inspector #549 and the RN Team Lead observed Resident #16's wheelchair to have dried debris on the left and right side of the seat cushion, under the seat cushion, the lap belt and along the frame of the wheelchair. Inspector #549 with the RN Team Lead reviewed the POC documentation which indicated that the Resident # 16's wheelchair was signed off by the night PSW as being cleaned on October 25, 2014 at 05:46.

On October 23, 2014 Inspector # 126 observed the front of Resident #15's lap belt to be covered with dried debris. On October 25th and 27th, 2014 Inspector #549 observed the front of Resident #15's lap belt to be covered with caked on dried debris.

Inspector #549 reviewed the POC documentation which indicated that the Resident #15's wheelchair which includes the lap belt was signed off by the night PSW as being cleaned on October 27, 2014 at 00:10.

On October 27, 2014 Inspector #549 and the Activity Director noted that the front of Resident # 3's lap belt; the sides of the seat cushion and wheelchair frame had caked on dried debris.

Review of the POC documentation indicated that the Resident # 3's wheelchair which includes the lap belt and seat cushion was signed off by the night PSW as being cleaned on October 25 at 04:25.

On October 28, 2014 the RN Team Leader indicated to Inspector #549 the process for cleaning of the resident's equipment is as follows: the night PSW will check the bath list for the next day and clean the residents' equipment that is on the bath list for that day, once the equipment is cleaned the night PSW will sign off that the specific equipment was cleaned in the POC.

During a discussion on October 28, 2014 the PSW Manager indicated to Inspector #549 that audits are not completed to ensure the cleaning of the residents equipment is completed as assigned. [s. 15. (2) (a)]

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

The source of heat for each of the resident rooms is a single eight foot light brown electric baseboard heater which is located under the window in the resident room.

On October 22, 2014 while completing the environmental observation for Resident #6 as part of the Resident Quality Inspection, Inspector #549 observed that the electric baseboard heater in the resident's room (#24) was covered from one end to the other with scrapes, chipped paint enamel and rusted.

On October 24, 2014 room # 7, 8, 9, 10, 11, 12, 14, 27, 28, 30, 105, 109 and 125 were inspected and observed by Inspector #549 to have the electric baseboard heater in the same state of disrepair as room #24.

The Maintenance Supervisor indicated to Inspector #549 on October 24, 2014 that resident rooms will be painted including the baseboard heaters when a room is empty which usually happens when a resident moves out of the room.

During the same discussion with the Maintenance Supervisor on October 24, 2014 it was indicated to Inspector # 549 that the home does not have a plan to address the scrapes, chipped paint enamel and rust on the electric baseboard heaters in the resident rooms.

The Building Maintenance Manager confirmed with Inspector #549 on October 24, 2014 that the home does not have a plan to address the scrapes, chipped pain enamel and rust on the electric baseboard heaters in the resident rooms. [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's equipment is kept clean, sanitary and furnishing and equipment are maintained in a safe condition and in good state of repair., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.31(2) whereby the restraining of a resident by a physical device may be included in a resident's plan of care only if the requirements of section 31(2) have been satisfied.

During Stage 1 activities, Inspector #148 observed Resident #1 seated in a wheelchair with a Velcro alarm seat belt applied. The resident was approached twice by the Inspector on two separate days, at both times the resident was not able to follow instructions to remove the seat belt. Inspector #148 reviewed the plan of care which indicated the use of a Velcro seat belt due to a risk of falls. Further review of the health care record demonstrated no physician order or assessment for the application of the restraint including alternatives to the restraint and the reasonable use of the restraint. A general consent to the use of all types of restraints and PASD's was obtained from the resident substitute decision maker, however was not specific to implementation of the Velcro seat belt as a restraint for Resident #1.

Inspector #148 spoke to both the home's Physiotherapist and Director of Care, related

to the use of the seat belt for Resident #1. Both indicated that the seat belt was implemented at a time when the resident was able to remove the seat belt. On the same day, an assessment was completed by the DOC, it was determined that the resident could no longer remove the belt and that the resident no longer required the seat belt for safety. The seat belt was removed and replaced with a therapeutic seat cushion.

Resident #1 was being restrained by a physical device during observations on October 21-24, 2014. The resident was being restrained without having satisfied the significant risk to the resident or others, that alternatives were considered, the method of restraining reasonable, a physician order or onsent.[s. 31. (2)]

2. The licensee failed to comply with LTCHA 2007, c.8, s.31(2) whereby the restraining of a resident by a physical device may be included in a resident's plan of care only if the requirements of section 31(2) have been satisfied.

During Stage 2 activities, Inspector #126 observed Resident #4 seated in a wheelchair with a Velcro alarm seat belt applied. The Resident was approached by the Inspector and was not able to follow instructions to remove the seat belt. Also, on two occasions, Resident #4 was observed sleeping in bed with two full bed rails up. Inspector #126 reviewed the plan of care which indicated the use of a Velcro seat belt and two bed rails due to a risk of falls. Further review of the health care record demonstrated no physician order or assessment for the application of the restraint. A general consent related to application of restraints (belt, bedrail and chemical) was signed May 13, 2014.

Inspector #126 spoke with the Staff member S #104, related to the use of the seat belt and full bed rails for Resident #4. S #104 indicated that the seat belt was implemented at a time when the Resident was able to remove the seat belt.

Resident #4 continues being restrained by a physical devices (velcro belt and full bed rails) during observations on October 24,25, 27 and 29, 2014, without having satisfied the significant risk to the resident or others, that alternatives were considered or the method of restraining reasonable and a physician order . [s. 31. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure when restraining of a resident by a physical device may be included in a resident's plan of care only if the requirements of section 31(2) have been satisfied., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

The licensee failed to comply with O.Reg 74(2), whereby the licensee did not ensure that a registered dietitian, who is a member of the staff of the home is on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Dundas Manor has 98 licensed beds. Inspector #148 confirmed with the Office Manager that the home usually maintains an average of 98% occupancy for the year. At 98 beds, the home is required to ensure there is a Registered Dietitian on-site at the home for 49 hours each month.

On October 29, 2014, Inspector #148 spoke with the home's RD who reported that she provides approximately 11.5 hours per week, submitting invoices for 23 hours every two weeks, equally approximately 46 hours per month. She further indicated that the hours provided to the home are both on and off site. A review of October 2014 invoices to date, indicate 12 off-site hours, 8.5 off-site hours in September 2014 and 17.5 off-site hours in August 2014.

Information obtained indicates that the home is not providing for a registered dietitian on-site, 30 minutes per resident per month.

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 a registered dietitian is on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties, to be implemented voluntarily.

WN #4: 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 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 October 28, 2014 Inspector #547 noted during the medication observation of the medication room drug cart for units 3-4 with Staff #111 and Staff #114, that benzodiazepine medications were not stored in a separate locked area on the medication carts in the home.

Inspector #547 interviewed Staff #114 who indicated that all benzodiazepines, such as Lorazepam, Oxazepam, Rispiridone, were located in thirty five day medication cards , for PRN medication for residents are kept in the middle drawer of the medication carts, which is not a separate locked area on these medication carts. Staff #111 further indicated that if a resident is ordered a benzodiazepine medication on a regular basis that the pharmacy would add this medication to the resident's dispill packages provided by the pharmacy. These resident dispill packages are stored for the current day in the medication trays provided from the pharmacy in the top drawer which is also not kept as a separate locked area of the medication cart. The rest of the dispill medication cards are kept on metal racks in an unlocked lower cupboard of the medication room in the home.

Inspector #547 interviewed the Director of Care who indicated that benzodiazepine medications were not stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart in the home, as she was not aware that benzodiazepine medications were considered to be a controlled substance. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that all controlled medications are to be safely stored in a separate, double-locked stationary cupboard in the medication room and stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
4. That drugs that are to be destroyed are destroyed in accordance with subsection (3). O. Reg. 79/10, s. 136 (2).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the drug destruction and disposal policy must provide for the following:

That drugs that are to be destroyed are destroyed in accordance with subsection (3)O. Reg.79/10, s.136 (2). [s. 136. (2) 4.]

The licensee has failed to ensure that when a drug is to be destroyed is a controlled substance, it will be done by a team acting together and composed of one member of

the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist.

On October 28, 2014 Inspector #547 conducted the home's mandatory medication observation of the controlled substance storage box with S #111 who indicated that benzodiazepine medications are not kept locked in the home. S #111 further indicated that benzodiazepine medications are disposed and denatured with all other non-controlled medications by placing the medication inside a green plastic container in the top drawer of the medication cart during a medication pass, and once the cart is returned to the medication rooms, these green containers are then emptied into the slurry pails inside the lower cupboard under the sink labelled with stericycle. Staff #111 indicated that the disposal and denaturing of non-controlled medications are not required to be done as a team in the home.

On October 28, 2014 Inspector #547 interviewed the Director of Care, who indicated that she was not aware that benzodiazepine medications were considered to be a controlled substance and that they would currently be disposed and denatured with the slurry pails in the medication rooms on both units which is not done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist. [s. 136. (3) (a)]

3. The licensee has failed to ensure that, as part of the medication management system, that their written policy should identify that non-controlled medications must be destroyed by a team acting together as stipulated in O.Reg.79/10, s.136 (3)(b).

On October 28, 2014 S #111 and S #112 both indicated that non-controlled medications, that are to be destroyed into the slurry pails in the medication rooms, do not require this action to be done by any team acting together and that the registered staff place the non-controlled medication into this pail alone.

On October 28, 2014 the Director of Care provided Inspector #547 a copy of the home's Disposal and Denaturing of Unused Medications Policy and Procedure for (Controlled and non-Controlled Medications), Section: NURS 6-210 of the Nursing Manual. Upon review of this policy, it was noted that no specifications are identified regarding non-controlled drugs must be destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of

Nursing and Personal Care. [s. 136. (3) (b)]

4. The licensee has failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

On October 28, 2014 Inspector #547 interviewed the Team Leader RN that Inspector #547 was able to remove the cap for the slurry pail for Medication room #2, for unit 3-4 when looking at the location of where the benzodiazepine medications are disposed for destruction. Team Leader RN along with Inspector #547 observed that the lid for this same pail was not installed to the pail to ensure that no person could access the contents of this pail. It was further noted that the contents of this pail, had several medications tablets sitting on top of a thickened layer of the medication slurry, in its whole form, dry that had not been altered or denatured to such an extent that its consumption is rendered impossible or improbable. [s. 136. (6)]

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 when Benzodiazepine medications are to be destroyed, which are controlled substances, that it will be done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist, to be implemented voluntarily.

WN #6: 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. (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).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(2), whereby the licensee did not 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 the resident.

The plan of care for Resident #2 indicated that the resident has a chewing impairment with choking risk, pocketing of food and significant weight loss. The plan of care further described that the resident needs extensive feeding assistance, with soft diet and moist food options and that swallow should be monitored. The diet list, used at point of service to guide the provision of care, indicates the resident requires liberal minced texture, lipped plate, small portions and extra gravy.

The most recent assessment from the Speech Language Pathologist indicated the resident pockets meats and requires minced meats with gravy, no crusts on bread and to avoid hard to chew and crumbly foods and to use the soft food diet recommendations, as provided to the home.

On a specified date, Resident #2 was observed to have his/her breakfast in the resident's bedroom, unsupervised at the time of the observation. The breakfast tray included two slices of white toast with crusts, cream of wheat, tea/coffee and two nosey cups with water and milk. The Resident reported to the Inspector that he/she does not require the nosey cups. The Resident noted that when he/she was previously unable to feed self that the nosey cups were used by staff members. The Resident noted that there is no need for them now and he/she can feed self.

On October 24, 2014, Resident #2 was provided toast with crust and fluids in nosey cups, the care is not based on the most recent assessment of the resident or the preferences of the resident.

WN #7: 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 has a screen and cannot be opened more than 15 centimeters.

The windows in the resident rooms have either two or three separate sections in them depending on the room. These sections in the windows are capable of being cranked opened outwards. Each section that is capable of being opened is three feet high and nineteen inches wide.

Inspector # 148 examined the windows in resident rooms # 23, 101 and 123. Inspector #549 examined the windows in resident rooms # 24, 26 and 31 all of these windows opened outwards to 60 centimeters.

On October 24, 2014 during a discussion with Inspector #549 the Maintenance Supervisor indicated that the home has established a procedure that will stop the windows from opening more than 15cm. However there is no plan in place with a timeframe for completing the required work to prevent the windows from opening more than 15cm.

The Maintenance Supervisor indicated to Inspector #549 on October 24, 2014 that only two windows in the home have been altered so that the opening is no greater than 15 cm.

On October 24, 2014 the Administrator confirmed with Inspector #549 that there is no plan in place to complete the required work to prevent the windows from opening greater than 15cm.

On October 27, 2014 the Building Maintenance Manager indicated to Inspector #549 that the home was aware of the windows opening more than 15cm since the spring of 2014.

On October 30, 2014 the Maintenance Supervisor informed Inspector #549 that all of the windows in the home that opens to the outdoors and is accessible to residents were outfitted with a chain which does not allow the windows to be opened more than 15 centimetres. [s. 16.]

WN #8: 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 available to each bed, toilet, bath and shower location used by residents.

On October 21 and 22, 2014 Inspector # 592 found that the system activation button was missing from the resident bed side system access cord in room two specific rooms.

On October 23, 2014 Inspector #549 found that the system activation button was missing from the resident bed side system access cord in another specific room.

The missing activation button rendered the bed side system unavailable to these residents.

On October 24, 2014 in discussion with the Maintenance Supervisor it was indicated that the home is unaware if there are more system access cord activation buttons missing rendering the bed side system unavailable to resident.

The Maintenance Supervisor indicated that checks are not being done to ensure the resident-communication and response system is available to each bed, toilet, bath and shower location used by residents. The Maintenance Supervisor indicated to Inspector # 549 that there would be the addition of checking the resident-communication and response bed side system access cord activation button to the daily maintenance checklist.

On October 27, 2014 the Building Maintenance Manager confirmed with Inspector #549 that the resident-communication and response bed side system access cord activation button has been added to the Maintenance Supervisor's daily maintenance checklist. [s. 17. (1) (d)]

WN #9: 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 :

The licensee did not ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

PSW Manager Staff member #S101, reported to Inspector #148, that on an unknown date, she recalls having a discussion with the family member of Resident #2 over the phone, at which time the family member described concerns related to comments made by PSW Staff member #108 during care. The PSW Manager encouraged the family member to formalize her concerns in writing and provide to the DOC, as she felt the matter needed to be investigated.

On the afternoon of a specified date, the family member sent an email to the home's DOC that described a concern with the attitude of PSW #S108, specifically indicating that Resident #2 had indicated PSW #108 had been rough and said identified inappropriate comments to Resident #2.

The home's DOC was not on-site at the time, when the PSW Manager spoke with the family member or when the email from the family member was sent. In the DOC's absence, the home's Clinical Team Leader followed up with the family member's email and immediately began an investigation into the suspected verbal abuse, at the request of the DOC.

On a specified date, upon the DOC's returned to the home, the DOC continued with the home's investigation, with the assistance of the Clinical Team Leader. In addition, on the same date the DOC notified the Director through the Critical Incident Report System. Interview with the DOC and a review of the home's investigation data indicated that verbal abuse was confirmed and PSW #S108 was disciplined.

It was confirmed that at no point did the PSW Manager or Clinical Team Leader report the suspected abuse to the Director. It was not until 5-7 days after initial information was provided to the PSW Manager that the home's DOC informed the Director of the suspected abuse.
[s. 24. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

The licensee failed to comply with O.Reg 79/10, s. 34 (2), whereby the licensee did not ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care.

The health care record for Resident #2 indicated that the resident has a chewing impairment with choking risk and pocketing of food. In addition the resident has had a significant weight loss over the last 6 months.

On October 24, 2014, Resident #2 was observed to have his/her breakfast in the resident's bedroom, unsupervised at the time of the observation. Inspector #148 spoke with the resident and discovered the resident did not have his/her dentures in place. When asked by the Inspector, the resident reported that he/she needed upper and lower dentures in order to eat the toast provided. The Inspector noted the dentures were on the bedside table out of reach of the resident. The Resident reported that he/she needed assistance with applying the adhesive and inserting the dentures. The Inspector informed Staff member S#102 and the dentures were provided and the resident was able to then complete his/her meal.
Resident #2 did not receive assistance to insert dentures prior to the breakfast meal on October 24, 2014.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to comply with O.Reg 79/10, s.37(1)(a), whereby the licensee did not ensure that each resident of the home has his or her personal items, including personal aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During stage 1 activities the following was observed in resident bedrooms:
Identified shared bedroom – two toothbrushes on the back of the sink with no label;
Identified shared bedroom - two toothbrushes on the back of the sink with no label;
Identified shared bedroom – both resident's in this room use a catheter, there were two 2000ml catheter bags hanging on the wall with no label (resident name labels placed on wall above the wall hook), two toothbrushes with no label;
Identified shared bedroom – hairbrush lying on the back of the toilet with no label, two toothbrushes with no label;
Identified private bedroom – two toothbrushes on the back of the sink with no label, hairbrush, comb, electric razor and deodorant with no label;
Identified private bedroom – two toothbrushes in a bedpan behind the toilet with no label, hair brush with no label.

Spoke with the home's PSW Manager #S101 who indicated that the labelling of resident personal items is the responsibility of the PSWs and herself, including the labelling of dentures and glasses. She was unsure how it would be that resident personal items were observed by Inspectors to be without a label.
[s. 37. (1) (a)]

WN #12: 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,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

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 :

The licensee failed to comply with O.Reg 79/10, s.71(1)(e), whereby the licensee did not ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home.

In accordance with O.Reg 71(1), the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks.

On October 27, 2014, the home began the implementation of the Fall/Winter 2014/15 menu cycle. Inspector #148 was provided with the therapeutic menus for Day 1-3, Monday through Wednesday, respectively. As indicated in the finding related to s. 71. (4), concerns arose related to the implementation of the planned menu.

On the morning of October 29, 2014, Inspector #148 approached the home's RD, who confirmed that the menu approval and review was completed on October 20, 2014. Upon further discussion, it was determined that the menu approval was based on the Regular diet/Regular texture menu. The home's diet list indicates the home offers a regular diet, minced and puree texture modifications, diabetic and weight reducing diets. The home's RD confirmed that she has access to the therapeutic and texture modified menus, however, the approval was based on the regular menu only.

It is acknowledged that after speaking with the home's RD regarding the menu approval, that a menu analysis was created for all planned therapeutics and texture modifications used in the home, which was reviewed by the home's RD. It was also confirmed, however, that the planned puree menu, in which the analysis was pulled, was not the puree menu provided to residents as observed during the inspection. The home's menu cycle, including therapeutic and texture modified diets for both meal and snacks, was not approved by the home's RD prior to the implementation of the menu on October 27, 2014.

The licensee failed to comply with O.Reg 79/10, s.71(4), whereby the licensee did not ensure that the planned menu items are offered and available at each mal and snack.

On October 27, 2014, Inspector #148 observed the lunch meal service in the Rural Retreats dining room. The planned menu for all texture modifications was as follows:
Chicken leg, parisienne potatoes and montego vegetables or
Fish, whipped potatoes and creamed corn
With a choice of chocolate cake or hot fruit compote for dessert.

Planned items were offered and available for the regular and minced texture modifications. Puree items included: puree chicken, whipped potatoes and puree montego vegetables or rice, bean and vegetable tray puree. When asked neither cooks on duty, Staff members #105 and #106, were unable to identify the tray puree vegetable. Puree parisienne potatoes, fish and cream corn were not available as indicated by the planned menu.

It was also observed that the hot fruit compote was not offered or available for dessert rather the alternative choice prepared was mandarin oranges and ambrosia, which was identified by Staff member #106 as left over from a previous meal.

On October 27, 2014 the planned menu for the puree texture modification and planned dessert for all therapeutics was not offered or available.
On October 28, 2014, Inspector #148 observed the lunch meal service in the Rural Retreats dining room.
The planned menu for all texture modifications was as follows:

Stew, tea biscuit and brussel sprouts or
Pork chops, garlic mashed potatoes and diced squash
With a choice of lemon bar or fruit cocktail

Planned items were offered and available for the regular and minced texture modifications. Puree items included: puree stew, mashed potatoes, puree brussel sprouts or beef, broccoli and potato tray puree with choice of pineapple sauce or butterscotch pudding for dessert. Puree pork, squash, fruit cocktail and lemon bar were not available as indicated by the planned menu.
On October 28, 2014 the planned menu for the puree texture modification was not offered or available.

Issued on this 26th day of November, 2014

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