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 Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Aug 26, 2015	2015_200148_0023	O-002371-15	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

AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), LISA KLUKE (547)

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 10-14 and 17-19, 2015, on site.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Associate Director of Care, RAI Coordinator, Activity Director, Maintenance Supervisor, Office Manager, Personal Support Worker Support Manager, Nutritional Manager (NM), Registered Dietitian (RD), Physiotherapist (PT), Physiotherapy Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers, Residents and Family Members.

In addition the inspection team, reviewed resident health care records, food production documents including planned menus, resident council minutes, documents related to the home's investigations into alleged incidents of abuse/neglect and policies related to restraint use, falls prevention, medication management and prevention of abuse. The inspection team observed aspects of resident care and interactions with staff, along with medication administration and several meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
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
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.
12 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

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.

Resident #38's most recent physiotherapy assessment identifies that the resident receives physiotherapy treatment for range of motion exercises three times a week.

Inspector #573 reviewed Resident #38's written plan of care, there was no indication in the plan of care that the resident is to receive physiotherapy treatment.

Inspector spoke with PTA S#114 , who indicated that currently Resident #38 is not seen for any physiotherapy exercises and indicated that she does not have directions from the Physiotherapist to provide physiotherapy treatment for Resident #38.

On August 17, 2015 during an interview with Inspector #573 the home's Physiotherapist stated that Resident #38 is currently on physiotherapy treatment for range of motion exercises. The PT confirmed that the written plan of care for Resident #38 related to physiotherapy was not revised and the treatment program was not communicated to PTA S#114.

Resident #38's written plan of care for physiotherapy does not set out clear directions to the physiotherapy assistant regarding the physiotherapy treatments as indicated by the assessment of July 29, 2015. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision maker, if any, and any other persons designated by the resident or substitute decision-maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #36 was admitted to the home on a specified date with multiple diagnoses, including dementia and benign hypertension. The resident's health record indicates that Resident #36 has impairments in decision making and that the daughter is the substitute decision maker (SDM) for care.

During an interview with Resident #36's SDM, it was reported that the SDM was not informed by the Registered nursing staff when a new blood pressure medication was added for Resident #36's hypertension. Further, the SDM indicated worry, as it relates to Resident #36's physical status and the potential side effects of the new medication.

On August 14, 2015, the Inspector spoke with RPN S#112, who indicated that Resident #36's SDM is actively involved in the resident's personal care and frequently inquires about the resident's medications. RPN S#112 confirmed that Resident #36's SDM was not made aware of the addition of the new blood pressure medication at the time when the medication change was implemented.

During separate discussions with Inspector #148 and Inspector #573, the DOC reported that it is not the practice of the home to ensure that SDM's are notified of all medications changes including dose reductions, increases or medication additions. [s. 6. (5)]

3. 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.

Resident #2 is care planned to receive 125ml of nutritional supplement three times a day, if meal is refused. The supplement was initiated after a significant weight loss.

On August 13, 2015 the resident was observed at the lunch meal to have both meal and supplement provided. At the time, the resident had not yet attempted to consume the meal, 75% of the supplement had been consumed. A PSW staff member seated at the

table, providing assistance and encouragement to residents, indicated that Resident #2 always gets a supplement with each meal regardless of meal consumption. Upon discussion with the resident and staff member, it was determined that the supplement was served prior to the meal. Intake records for both meals and supplement, as maintained by PSW staff, support that the supplement is given at each meal regardless of meal consumption.

The plan of care for Resident #2 is not provided to the resident as set out in the plan, as it relates to the implementation of a nutritional supplement. [s. 6. (7)]

4. On a specified date, Resident #14 had a fall which resulted in injury.

On August 13, 2015, Inspector #547 reviewed Resident #14’s post fall assessment, that indicated Resident #14 was walking unattended by a staff member and fell. The resident’s plan of care in place at the time of the fall, indicated that staff are to walk Resident #14 to the bathroom and is not to be left unattended while being toileted.

On August 13, 2015 Inspector #547 interviewed the ADOC regarding Resident #14’s fall with injury, who indicated that a PSW toileted the resident and then left the resident unattended to assist another resident in another resident room. The PSW returned and found the resident on the floor. The ADOC indicated that Resident #14 should not have been left unattended on the toilet. [s. 6. (7)]

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, as it relates to Resident #14's toileting care, is provided to the resident as specified by the plan, 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 has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

During a tour of the home, Inspector #148 identified the lack of a resident-staff communication and response system in the television room known as the Gathering Place, the main lobby area and both seating areas located near both the nursing stations (one located between unit #1 and #2 and the second located near unit #3 and #4). Each of these areas were observed to be used as a place for residents to congregate and socialize.

Inspector #148 discussed the above observations with the home's Maintenance Supervisor, who agreed that the main lobby and areas near the two nursing stations were used by residents for gathering and were not equipped with a resident-staff communication system. Upon a tour of the room known as the Gathering Place, the Supervisor indicated that a console for the resident-staff communication system does exist but was rendered non-functioning and is located behind a wall hanging, and therefore not easily visible. The console did not have, in any way, a method to activate the call bell. The Supervisor indicated that he would attempt to activate the call bell by end of day.

On August 18, 2015, Inspector #148 confirmed that the console was functioning in the Gathering Place and accessible to staff, residents and visitors. In addition, the Maintenance Supervisor reported that the home had been in contact with a vendor to install communication systems in the common areas, as identified. [s. 17. (1) (e)]

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 resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.
[O-001676-15]

The home's policy to promote zero tolerance of abuse and neglect of residents was identified as the Prevention of Abuse and Neglect - Resident Abuse Policy ADM 4-20. Within the policy under Mandatory Reporting of Abuse or Neglect it states that any 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 their Supervisor, the DOC or the Administrator.

On a specified date, PSW S#125 witnessed PSW S#126 to yell at Resident #22, while being demanding and forceful as it related to the activity of dressing. PSW S#125 approached PSW S#126, indicating that the behaviour toward Resdient #22 was not appropriate. PSW S#125 reported the incident eight days after the incident occurred, to the PSW Support Manager, at which time the information was brought to the DOC's attention. An internal investigation was initiated that later concluded in a disciplinary letter to PSW S#126.

On August 19, 2015, in an interview with Inspector #573, PSW S#125 confirmed that she did not report the incident of suspected verbal abuse immediately to a supervisor. PSW S #125 further indicated that she had been provided with training on the home's policy of abuse and mandatory reporting, both at the time of hire and during mandatory training in 2014.

On August 19, 2015, the DOC indicated that the incident, as described above, should have been reported by PSW S#125 immediately to a supervisory staff member or member of the management team who was working at that time, as per the home's policy to promote zero tolerance of abuse and neglect. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: 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).

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 the planned menu items are offered and available at each meal and snack.

On August 10, 2015, Inspector #547 observed the lunch meal service in the unit three-four dining room. The planned menu for the puree texture modified menu was as follows: Boiled potato or whipped potato, squash, lemon asparagus chicken or a commercially prepared puree beef, banana/oranges mix.

Planned items that were offered and available for the residents who required a puree texture was as follows:
Whipped potato, regular texture squash, and a commercially prepared puree item, which was later identified by Cooks #S100 and #S101 as lasagna, and apple sauce.

The food items available and offered for residents requiring puree texture was not as per the planned menu and did not provide for choice of vegetable, entrée or dessert.

Dietary Aide S#102 indicated to Inspector #547 that the kitchen usually only sends one minced vegetable and one puree entrée item for residents in unit three-four dining room. In addition, Dietary Aide S#102 indicated for this meal, the regularly prepared squash was prepared for puree, at point of service, by mashing it with a fork and adding gravy, otherwise they take the minced vegetable, and mash it with a fork and add gravy to soften the texture and serve as puree. This method is not as per the home's recipe for pureed items posing a potential risk to residents with chewing/swallowing difficulty.

Inspector #547 also observed that there was not enough of the bananas and oranges dessert option, as twenty residents in the second half of the dining room were only offered the apple blossom desert pastry or apple sauce as choice for dessert. Resident who required minced or pureed texture meals were only offered the apple sauce dessert with no alternative choice.

On August 12, 2015 Inspector #547 observed the lunch meal in unit three-four dining room.
The planned menu for the puree texture modified menu was as follows:
Red mashed potato or whipped potato, broccoli or cocktail vegetable medley, a commercially prepared puree beef or creamy salmon and pears for dessert.

Planned items that were offered and available for the residents who required a puree texture was as follows:
Whipped potato, minced broccoli mashed with a fork with gravy, a commercially prepared puree beef, and puree pear.

The food items available and offered for residents requiring puree texture was not as per the planned menu and did not provide for choice of vegetable, entrée or dessert.

On August 17, 2015 Inspector #547 observed the lunch meal in the Cozy Corner and Rural Retreats dining rooms.
The planned menu for the puree texture modified menu was as follows:
Whipped potato or scalloped potato, brussel sprouts or carrots, Pollock in creamy mushroom sauce or Hawaiian ham, and apple blackberry crumble or applesauce.

Planned items that were offered and available for the residents who required a puree texture was as follows:
Whipped potato, minced brussel sprouts mashed with a fork with gravy or pureed carrots,

a commercially prepared puree chicken or beef, and apple sauce.
The food items available and offered for residents requiring puree texture was not as per the planned menu and did not provide for choice of entrée or dessert.

Inspector #547 interviewed the home's Nutritional Manager who indicated residents are to be provided three different textures, regular, minced and pureed at every meal for the main meal and alternates as per the planned menu in the home. The planned menu entrees in both regular, minced and puree textures should be available in every dining room with the commercially prepared entrée options for the pureed textures as identified on the planned menu to try to match the meals of the other residents as much as possible.

The licensee has failed to ensure that the planned home's menu cycle includes alternative choices of entrees, vegetables and desserts at lunch and dinner.

Upon review of the home's planned menu for August 10 and 12, 2015, it was noted that the planned menu does not include for choice of dessert for the puree texture modified menu. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items for regular, therapeutic and texture modified diets are offered and available at each meal and snack, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply in that all areas where drugs are stored is to be kept locked at all times, when not in use.

On August 10, 2015, Inspector #547 observed Resident #27 had a tube of prescribed cream inside the resident's unlocked basket in the shared bathroom of four residents.

On August 13, 2015, at approximately 12:00pm, Inspector #547 observed that the prescription treatment cart was unlocked inside the unit three and four tub room across from the drug room. The tub rooms in the home are not kept locked, and the doors are kept open when residents are not bathing. PSW S#119 indicated that she does not have a key to the treatment cart as it is kept with the Registered Nursing staff. Day shift RPN S#105 and RPN S#120 indicated to Inspector #547 that they have keys to the treatment cart, however, they had not yet opened the treatment cart this shift, indicating that the treatment cart had not been locked since at least the night shift or when the last skin treatment was provided. RPN S#105 indicated that the treatment carts are to be kept locked when unattended as they have all the prescribed ointments and creams for residents on units three and four.

On August 13, 2015, Inspector #547 observed the medication cart for units three and

four, located in front of the drug room, to be unlocked and unattended by any registered nursing staff from 12:02-12:09pm. During this period of time, Resident #36, diagnosed with Alzheimer's disease was wandering in front of this unlocked medication cart.

Inspector #547 interviewed RPN S#105 on the home's expectation of the locking of the medication carts while unattended by Registered Nursing staff. RPN S#105 indicated that she noticed she had forgotten to lock her medication cart before entering the dining room, out of sight of her medication cart, and that the medication cart should always to be locked when they step away from the cart for resident safety. [s. 130. 1.]

2. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply regarding access to these areas is restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator.

On August 11, 2015, Inspector #547 observed the Maintenance Supervisor request RN S #111 to provide him with the keys to the drug room located on Unit three next to the nursing station desk. The Maintenance Supervisor proceeded to unlock and enter the drug room, unattended by any registered nursing staff. The drug room contains government stock medication, resident medications and supplies in unlocked cupboards. This drug room is not within view from the nursing station desk where RN S#111 was reviewing resident health records. The Maintenance Supervisor was inside the drug room for four minutes removing the slurry pails from under the counter. The Maintenance Supervisor then closed the drug room, and brought the slurry pails to the basement storage area. The Maintenance Supervisor then returned and indicated to RPN S#112 that he forgot RN S#111's keys inside the drug room. RPN S#112 proceeded to give him her keys to unlock the drug room. The Maintenance Supervisor then unlocked the drug room, and entered this room for an eight minute period unattended by any registered nursing staff to mop and clean this room.

On August 13, 2015, Inspector #547 interviewed the Maintenance Supervisor who indicated that he does enter the nursing drug rooms in the home and was not aware that he should not be in these spaces unattended by the registered nursing staff. The Maintenance Supervisor showed Inspector #547 that he stored the slurry pails for medication destruction inside the maintenance storage room in the basement of the home. The Maintenance Supervisor indicated that maintenance staff have the key to unlock this storage room, and it was noted that often the medication is sitting in whole form inside packages and medication containers at the top of the slurry pails that have not been denatured. These medications inside these slurry pails have not been

denatured and therefore the security of the drug supply regarding access to these areas has not been restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored shall be kept locked at all times when not in use and restrict access to these areas by anyone who cannot dispense, prescribe or administer drugs in the home, to be implemented voluntarily.

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 has failed to ensure that the home's policy and procedure titled "Disposal and Denaturing of Unused Medications NURS 6-210" was complied with as per O.Reg 136.(2) whereby the drug destruction and disposal policy must provide that drugs that are to be destroyed and disposed of shall be stored safely and securely within the home.

On August 11, 2015, Inspector #547 noted the Maintenance Supervisor remove three slurry pails from the drug rooms, located near the nursing stations in the home to bring them to the basement. Upon observation of these slurry pails with the Maintenance Supervisor, it was noted through the opening of the slurry pails, that there were medications in whole form inside plastic dispill packages at the top of the pail.

The Maintenance Supervisor indicated to Inspector #547 that he was concerned that these medications will never touch the slurry solution that is prepared in the pail and that remain sealed in the dispill packages and not destroyed.

The home's policy and procedure for disposal and denaturing of unused medications indicates:
B. Non-Controlled Medications- All non-controlled medications that are to be disposed of and denatured will follow this protocol.
5. Dispose of the unused medications in the slurry bucket containing water and dish soap.

On August 18, 2015, Inspector #547 interviewed RN S#113, RPN's S#104 and S#105, regarding the process for disposal and denaturing of unused medications. RPN S#105 indicated that steriCycle have indicated to staff that they can dispose of dispill packages and plastic containers in whole form inside these buckets on top of the slurry. Upon review of the process, the above Registered Nursing staff realized that by placing these packages with medication inside them into the slurry bucket, that the medication could not be denatured in the slurry solution as per the home's process. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On August 10, 2015, Inspector #547 observed that the storage room on Unit three, located next to the ADOC's office, was equipped with a lock, closed but not locked, while unsupervised by staff.

On August 11, 2015, Inspector #547 observed the same storage room door was not closed or locked from 12:30 to 12:45pm while unsupervised by staff.

On August 11, 2015, Inspector #547 interviewed the ADOC in the home who indicated that this storage room is a non-residential area, and that the door should be kept closed and locked when staff leave the room. [s. 9. (1) 2.]

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 ensure that the licensee responds in writing within 10 days of receiving a concern or recommendation to the Resident's Council.

On August 12, 2015, a member of the Resident's Council leadership team, reported to the Inspector that the resident was not sure if the licensee responds in writing within 10 days of receiving any concern or recommendation from the Residents’ Council. The resident further indicated that sometimes the concerns or recommendations were discussed at the next council meeting.

Inspector #573 reviewed the minutes of the Residents' Council Meetings from March to August 2015. It was observed by Inspector #573 that:
- For March 4, 2015, the council meeting minutes identifies dietary concerns, including canned vegetables that were very salty and variety for evening. There is no documentation regarding a written response that was provided to the councils concerns.

- For May 13, 2015, the council meeting minutes identifies nursing operation concerns including the PSW’s staff members helping clean up in the dining rooms. A written response document dated May 15, 2015, regarding Resident’s Council concerns was attached in the meeting minutes binder. Upon further reviewing of the meeting minutes for June, the Activity Director read the response to concerns.

On August 12, 2015, the Activity Director who is the Secretary for the Resident’s Council indicated to the inspector that for any concerns or recommendations from the Resident’s Council a verbal response is given within 10 days to the concerned Resident who arise the issue in the meeting and its documented in the council meeting minutes binder. Further the Activity director indicated that the written response is not communicated to the Resident's Council until the next scheduled Resident’s Council meeting. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record, with respect to each resident, weight on admission and monthly thereafter.

During health care record reviews conducted on August 10-12, 2015, it was identified by the inspection team that monthly weights were not available for each month, for each resident in the electronic record.

Inspector #148, reviewed the weight entry report within the electronic record and identified 33 out of 95 residents to have one or more missing monthly weights between February and July 2015, with 9 of the 33 residents, missing two or more weights during the same time frame. The lack of monthly weights for all residents was discussed with the home's Registered Dietitian, Registered Nursing staff and Administrator. It was determined that no history of hard copy weights could be obtained. Discussion with staff lead to the identification of two residents within the sample who were identified as known to refuse bathing care, which may have contributed to missing weights, as body weights are measured during bathing care. Explanations could not be identified for the other 31 residents.

It was further noted in review of resident body weights that several resident weights, including Resident #2, #24 and #41 appear inaccurate. In discussion with the home's RD, the weight measures are not always reliable. Both the RD and Administrator indicated that they are aware that the weight monitoring system requires follow up to ensure monthly weights are completed and accurate. [s. 68. (2) (e)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with weight changes, as described under this section, are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated.

Resident #2, was identified by the RD on in June 2015, to have a significant and unplanned weight loss of more than 5% over 1 month. The nutritional assessment, at that time, concluded that the resident required a nutritional supplement to be provided if meal was refused. The resident plan of care was updated and the supplement implemented. Upon follow up, Inspector #148 observed that the resident was provided the nutritional supplement regardless of the resident’s intake and that the body weight measure for July was erroneous, with no August weight yet available.

A review of the health care record and interview with the home’s RD, on August 18, 2015, indicated that the outcomes, related to the actions taken in response to the weight loss of June 2015, had not been evaluated.

Resident #24 was identified by the Inspector as having a weight loss of more than 7.5% over 3 months in June 2015. The resident was assessed by the RD in May 2015 as part of the home's quarterly Minimum Data Set (MDS) Assessment, whereby weight was assessed noting a decrease in weight and need to monitor. A review of the health care record and interview with the home's RD, indicates that the weight loss of June 2015 was not identified or assessed nor actions taken. The home's RD reported an intention to review the resident's weight in August 2015, as the weight exceptions report produced by the electronic record indicates a weight loss of over 5% in 1 month and more than 10% over 6 months.

Resident #41 was identified by the Inspector as having a weight loss of more than 5% over 1 month in June 2015 and a loss of more than 7.5% over 3 months in July 2015. A review of the health care record and interview with the home's RD, indicates that the weight loss of June and July 2015 were not assessed.

The weight monitoring system does not ensure that for all residents, weight loss defined by O.Reg 79/10, is assessed and that actions are taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the communication of the seven-day and daily menus to residents.

As indicated in O.Reg 71.(1) the licensee shall ensure that the home's menu cycle is to include menus for regular, therapeutic and texture modified diets for both meals and snacks.
Inspector #547 noted that the daily menus and the seven day menus communicated to residents did not include the puree texture modified menu.

On August 18, 2015, Inspector #547 interviewed the Nutritional manager who indicated that the puree textured entrees are commercially prepared and therefore do not always match the menu that is communicated to residents. Menus in the home are communicated to residents by postings outside of the dining rooms. The Nutritional Manager confirmed that the daily and weekly puree texture modified menu is not communicated to residents. [s. 73. (1) 1.]

2. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On August 10, 2015, Inspector #547 observed the lunch meal in unit three and four

dining room, and noted that Resident's #25 and #39 were offered their dessert choice while they had their main meal in front of them. Both Resident #25 and #39 do not have any specifications in their plan of care to indicate that they should not receive their meals course by course. Resident #39 indicated to Inspector #547 to feel a bit rushed at times, but knows that residents can take the time they need.

On August 18, 2015, Inspector #547 observed all the residents in the Cozy Corner dining room, off unit one and two, to be eating their main meal and have their desserts already served. Resident's #44 and #45 had their dessert and main meal together and eating from both dishes at the same time.

Inspector #547 interviewed PSW's S#121, S#122 and S#123, who were assisting residents in the Cozy Corner, each indicated the kitchen staff bring the desserts to the dining room and serve them to the residents once all the main meals have been served to residents. The residents may not be completed with their main meal. They indicated that the residents are always served their meals this way, and that no residents in this dining room had any need or request to have their meal courses at the same time, but rather it is simply the kitchen staffs' process for providing the meal service.

Inspector #547 interviewed the Nutritional Manager who indicated that the residents should be offered their meals course by course in order for the residents to not feel rushed, and to finish encourage the consumption of the main meals before the second course (dessert) is served. [s. 73. (1) 8.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee informed the Director no later than one business day after the occurrence of an incident with Resident #14 that caused an injury which resulted in a significant change in the Resident's health condition and for which the resident was taken to a hospital.

On a specified date, Resident #14 fell and was sent to hospital further assessment of injury. Inspector #547 reviewed the resident's health records which indicated that the Resident returned from hospital and due to the injury sustained from the fall, changes were made to the resident's plan of care related to mobility, transfers, positioning, medications and pain management.

On August 13, 2015, Inspector #547 interviewed the DOC and ADOC regarding the critical incident for Resident #14 and indicated that they did not report the incident to the Director. [s. 107. (3) 4.]

Issued on this 26th day of August, 2015

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

Original report signed by the inspector.