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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 26, 2015	2015_369153_0001	T-026-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE SOUTHWESTERN ONTARIO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE BAYVIEW
550 CUMMER AVENUE NORTH YORK ON M2K 2M2

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

LYNN PARSONS (153), STELLA NG (507), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 8, 9, 12, 13, 14, 15, 16, 19, 20, 2015.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), assistant directors of care (ADOC), program manager (PM), dietary manager (DM), registered dietitian (RD), social worker (SW), environmental services manager (ESM), physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), activity aides, Residents' Council, Family Council, residents and substitute decision-makers (SDM).

The inspectors conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of clinical health records, complaint record log, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following critical incident report logs were inspected: T-379-14, T-1226-14, T-1241-14.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **10 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so their assessments are integrated with and complement each other.

A review of the current plan of care for resident #11 under the activities of daily living (ADL) personal hygiene section indicates staff are to insert upper and lower dentures in the morning and to remove, clean and place the dentures in a cup at bedtime.
A review of the current plan of care for resident #11 under the chewing difficulty section completed by dietary indicates the chewing difficulty is related to poor mastication due to the resident's upper denture missing.

Interviews with nursing staff and the SDM confirmed the resident received new upper and lower dentures on December 4, 2014.

Observations during this inspection confirmed resident #11 has both upper and lower dentures.
Interview with the registered staff confirmed there was a lack of collaboration with the dietary department in relation to the resident having dentures in place. [s. 6. (4) (a)]

2. The licensee failed to ensure that the provision of the care set out in the plan of care is documented.

Record review revealed that resident #01 is to receive an identified nutritional intervention. The physician's orders state all intake is to be recorded every shift. Record review revealed there were four days in December 2014, and two days in January 2015, when these intakes were not recorded on the evening shift. Interview with registered staff and the RD confirmed resident #01's should have been documented on those days.

Record review revealed that resident #18's plan of care states the resident should be repositioned every two hours and this should be documented on a sheet at the bedside. Record review and staff interviews confirmed resident #18's repositioning was not completely documented on 20 days during the period from September 1 to December 31, 2014.

Family interview revealed that resident #17's teeth are not always cleaned twice daily. Staff interview revealed that resident #17 has a history of having gingivitis and the resident's teeth are usually brushed by staff three times daily. Record review revealed that from the period from December 23, 2014, to January 14, 2015, oral/denture care was not documented as being provided on one day shift and two evening shifts.

Interview with the DOC confirmed that the provision of the care set out in the plan of care was not documented for residents #01, #17 and #18. [s. 6. (9) 1.]

3. The licensee failed to ensure that the effectiveness of the plan of care is documented.

Interview with an identified registered staff confirmed that behaviour monitoring can be initiated at 30 minute intervals at any time whenever staff have concerns of a resident's responsive behaviour which may pose risk to him/her or other residents/staff. The registered staff can discontinue the behaviour monitoring when the intervention is no longer necessary.

Record review revealed that resident #04 was placed on behaviour monitoring at a 30

minute interval on September 5, 2014, after exhibiting aggressive behaviour towards another resident. There were no incidents of aggressive behaviour since September 23, 2014.

Interview with an identified PSW confirmed that resident #04 had been placed on behaviour monitoring in September 2014, but was not on behaviour monitoring as of January 15, 2015.

Record review and interview with the identified registered staff confirmed that there was no documentation in relation to the discontinuation of the behaviour monitoring for resident #04. Interview with the DOC confirmed that it is the home's expectation of the registered staff to document the initiation and discontinuation of the behaviour monitoring in the progress notes. [s. 6. (9) 3.]

4. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A review of the the plan of care for resident #11 identified the following goals:
- will remain engaged in programs for full duration, resident leaves programs no more than one to two times per month
- will have increased involvement in recreational programs by the next quarter attending at least one to two programs per week.

A review of the plan of care for resident #11 identified the following strategies:
- provide resident with the opportunity to listen to the resident's favourite station on the radio
- provide group programs such as musical programs, active games that match the resident's abilities and level of cognition.

Observations conducted throughout the inspection indicated resident #11 does not attend programs in the home.
A review of the participation records indicates resident #11 did not attend any programs in November 2014, attended two programs in December 2014, and one program in January 2015, despite a goal that the resident would have increased involvement in recreational programs by the next quarter by attending at least one to two programs per week.

Interviews with the activity staff and the PM confirmed the plan of care for resident #11 had not been reassessed and revised to reflect current goals and interventions. [s. 6. (10) (b)]

5. A review of the plan of care for resident #15 under the ADL personal hygiene section indicated staff are to clean glasses before the resident puts them on.
Observations conducted throughout the inspection failed to reveal the resident wore glasses.
Interviews with PSWs and registered staff confirmed resident #15 has not worn glasses for over one year.
The RN confirmed resident #15's plan of care had not been reviewed or revised to indicate the resident no longer wears eyeglasses. [s. 6. (10) (b)]

6. A review of resident #15's plan of care under the activity section revealed the following goals:
- will have increased involvement in recreational programs, one to two times each month
- will participate in activities, especially music programs
- will have spiritual and cultural preferences maintained.

A review of resident #15's plan of care revealed the following interventions:
- maintain spiritual/cultural interests including attending services and special cultural celebrations in the home
- resident goes home with family on occasion for holidays and some weekends
- invite resident to attend one spiritual program one time per month, with encouragement
- encourage resident to attend on-unit programs one to two times weekly.

Observations throughout the inspection indicated resident #15 remains in his/her room all the time.
A review of the program participation records indicated resident #15 did not attend any programs for the months of November 2014, December 2014, and up to and including January 16, 2015.
Interviews with the activity staff and PM confirmed resident#15 does not attend recreational programs including spiritual and cultural activities.
Interviews with the activity staff and PM confirmed the plan of care for resident #15 had not been reassessed, reviewed and revised in relation to program needs. [s. 6. (10) (b)]

7. A review of resident #16's plan of care under the activity section revealed the following information:

- resident is in bed most mornings, only getting up in the afternoons and therefore the resident misses morning activities
- resident will have spiritual preferences met by attending one to two spiritual programs per month.

A review of the program participation report failed to indicate resident #16 attended any spiritual programs between November 1, 2014, and January 16, 2015, despite a goal to attend one to two spiritual programs per month.
A review of the participation reports indicated the resident attended programs but will not remain for the entire program on a consistent basis.

Interview with the activity staff indicated resident #16 attends programs but leaves the program early and no longer remains in bed in the morning.
Interview with PM confirmed resident #16's plan of care had not been reassessed and the plan of care reviewed and revised when the resident's programming needs changed. [s. 6. (10) (b)]

8. A review of the minimum data set (MDS) assessment for resident #16 dated October 23, 2014, indicated the resident uses incontinence pads and briefs.
A review of the resident's plan of care under the urinary section indicated the resident refuses to wear incontinent pads.
Interviews with nursing staff revealed resident #16 wears incontinent briefs at all times.
Interview with RN confirmed the plan of care had not been reviewed and revised in relation to the use of incontinent briefs. [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:
- staff and others involved in the different aspects of care collaborate with each other in the assessment so that the different aspects of care are integrated and are consistent with and complement each other
- the provision of the care set out in the plan of care and the effectiveness of the plan of care is documented
- the resident is reassessed and the plan of care reviewed and revised 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, the resident has been assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Record review of the home's policy #08-10-01 titled Bed Entrapment and Proper Use of Bed Rail Devices dated April 2011, states that registered staff are to conduct a needs assessment for bed rail devices with every resident.
On January 9 and 16, 2015, the inspector observed that side rails were used on resident #13's bed. On one side of the bed there was a full rail and on the other side there was a partial rail. Record review and staff interviews revealed that a needs assessment for bed rail devices for resident #13 had not been conducted. Interview with the DOC confirmed that their documentation has not captured this in the past but that a new policy regarding the use of bed rails is going to be implemented in the near future which will address this concern. [s. 15. (1) (a)]

2. On January 14, 2015, the inspector observed resident #02 using the bed rail on the right side of the bed while transferring from wheelchair to bed.

Record review revealed and interviews with an identified PSW and an identified registered staff confirmed that resident #02 uses bed rails for transfer and bed mobility. Record review and interviews with the identified registered staff and the PT confirmed that resident #02 has not been assessed for the use of bed rails. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident has been assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed and used by resident, staff and visitors at all times.

On January 8, 2015, the inspector observed the call bell by the toilet in the shower room in the north east unit could not be activated by pulling the call bell cord. Interview with an identified PSW confirmed the call bell could not be activated by pulling the call bell cord and maintenance would be notified.
On January 12, 2015, the inspector observed the call bell could be activated by pulling the call bell cord. [s. 17. (1) (a)]

2. On January 9, 2015, the call bell at the bedside in resident room #139A could not be activated. A PSW was notified and reported the issue to maintenance. This call bell station was observed to be functioning on January 13, 2015.

On January 12, 2015, the call bell in the washroom of room #264 was observed to be wrapped around the grab bar and unable to be activated. It was reported to the RPN who removed the call bell from the grab bar which allowed the call bell to be activated. The RPN confirmed the call bell should not have been wrapped around the grab bar. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the home is equipped with a resident-staff communication and response system that can be easily accessed and used by resident, staff and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are not neglected by the licensee or staff.

On March 2, 2014, at approximately 7:00 a.m., resident #31 was found in bed by the day PSW with an incontinent brief and bed sheet saturated with urine.
Review of the written plan of care for resident #31 indicated that the resident is frequently incontinent of urine especially at nights, and requires total hygiene care.

Interviews with the day PSW and registered staff confirmed resident #31 was found to be incontinent of urine at 7:00 a.m. on March 2, 2014.
Interview with the night PSW confirmed that the resident's brief was wet prior to the change of shift, and the resident was not changed because the PSW was not able to raise the bed to provide continence care.

Record review revealed and interview with the administrator confirmed that an internal investigation was conducted and an incident of neglect was identified. As a result of the home's investigation, the identified PSW received a letter of disciplinary action. [s. 19. (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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

On March 2, 2014, at approximately 7:00 a.m., resident #31 was found in bed by the day PSW with a incontinent brief and a bed sheet saturated with urine.
Review of the written plan of care for resident #31 indicated that the resident is frequently incontinent of urine especially at nights, and requires total hygiene care.
Interviews with the day PSW and registered staff confirmed resident #31 was found to be incontinent of urine at 7:00 a.m. on March 2, 2014.
Interview with the night PSW confirmed that the resident's brief was wet prior to the change of shift, and the resident was not changed because the PSW was not able to raise the bed to provide continence care.

Record review revealed that the allegation of neglect was not reported to the Director until noon, on March 3, 2014. Interview with the administrator confirmed that the allegation of neglect should have been reported to the Director immediately. [s. 24. (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 person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

On January 13, 2015, the inspector observed the toenails of resident #01 to be long and the right great toe to be discoloured. Interview with an identified PSW and registered staff revealed the family had at first been providing foot care but this had not been sustained. Interview with the registered staff confirmed that the toenails of this resident were long, showed signs of a potential infection and foot care should have been provided to this resident by the home. [s. 35. (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 ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving concerns from Residents' Council.
On September 18, 2014, the following concerns were raised during the Residents' Council meeting:
- requested more information related to juice crystals being substituted for real juice
- requested to be informed of the next education session pertaining to beverage distribution.
An email response was received from the DM on October 16, 2014, which was not within 10 days.
Interview with the PM confirmed a written response was not provided within 10 days. [s. 57. (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 a written response is provided within 10 days of receiving concerns from the Residents' Council, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle.

Interview with resident #05 revealed that he/she is unhappy with the food because the home does not serve Chinese food. Record review revealed that the resident is at high nutritional risk due to poor intake of meals and is on a nutritional supplement four times a day. Interview with the RD and DM confirmed that the home has offered resident #05 snacks to supplement the resident's intake but have not considered an individualized menu to accommodate his/her cultural preferences. [s. 71. (5)]

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 an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of resident is dealt with as follows: the

complaint shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint.

Interview with resident #13 revealed that he/she is unhappy with an identified PSW providing care to him/her and the resident's SDM submitted a complaint sometime in December 2014, (before Christmas). Interview with an identified registered staff confirmed knowledge of this complaint. Interview with the administrator revealed he did not receive the complaint but that the evening receptionist remembers receiving and putting it in the administrator's mailbox. Interview with the DOC and SDM revealed that the matter had been dealt with and resolved as of January 16, 2015, after it was brought to the home's attention by the inspector. Interview with the administrator confirmed that the home did not respond within 10 business days of receipt of the complaint and the home will review their process for receiving complaints. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record of every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is kept in the home that includes,
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; and
(e) every date on which any response was provided to the complainant and a description of the response;

Review of the home's 2014 complaints record revealed the following:
- one complaint did not contain the date it was received
- one complaint did not contain the type of action taken to resolve the complaint
- 11 complaints did not contain the date on which a response was provided to the complainant and a description of the response.

Interview with the administrator confirmed the 2014 complaint record did not include the above required information. [s. 101. (2)]

3. The licensee failed to ensure that the licensee's documented record of every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home,
(a) is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and

(c) a written record is kept of each review and of the improvements made in response.

Record review revealed and interview with the administrator confirmed that the home's record of complaints has not been reviewed and analyzed for trends at least quarterly as required. [s. 101. (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:
- every written or verbal complaint made to the licensee or a staff member concerning the care of resident is dealt with as follows: the complaint shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint
- a documented record of every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is kept in the home that includes,
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; and
(e) every date on which any response was provided to the complainant and a description of the response
- the licensee's documented record of every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home,
(a) is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

On January 9, 2015, inspector #507 observed a PSW, pick up a call bell from the floor in an identified resident room, and place it on the resident's bed without being disinfected. Interview with the identified PSW confirmed the call bell should have been disinfected before placing it on the bed. The PSW then used the hand sanitizer in the room to disinfect the call bell cord.
Interview with the identified PSW and the RN, confirmed the hand sanitizer is for completing hand hygiene, and the wipes on the wall in the hallway are for cleaning equipment. The RN confirmed the wipes should have been used to clean the call bell cord prior to placing it on the resident's bed.

In January 2015, inspector #507 observed a PSW in an identified resident room, collecting clothes in a hamper without wearing any personal protective equipment (PPE) despite signage on the door indicating contact precautions.
Interview with an identified registered staff, revealed that resident #32, was on contact precautions for an infectious disease. The resident had passed away. Family was contacted, but did not provide directions in handling the resident's belongings. The home's policy is to conduct two deep cleanings by the housekeeping staff for a resident on contact precautions after the belongings are removed. Deep cleaning for the bed and the room was not conducted as the home was waiting for direction from family in regards to the resident's belongings. Family was contacted again and directed staff to pack the belongings for family to pick up at a later date. The registered staff confirmed that the identified PSW should have worn appropriate PPE when packing the belongings. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

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

Record review of the Family Council meeting minutes of October 8, 2014, revealed that there is a concern regarding family members and private personal support workers helping themselves to the beverage carts in the dining room. Interview with the administrator revealed that the home is considering revamping their meal service which would incorporate finding a solution to this concern but confirmed that the home has not communicated this to the Family Council and has not responded in writing within 10 days to the Family Council. [s. 60. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council in carrying out the satisfaction survey.

Record review and interviews with the administrator and PM confirmed the licensee did not seek the advice of the Residents' Council in carrying out the satisfaction survey. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident`s SDM, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of neglect of the resident.

On March 2, 2014, at approximately 7:00 a.m., resident #31 was found in bed by the day PSW with the incontinent brief and bed sheet saturated with urine.
Review of the written plan of care for resident #31 indicated that the resident is frequently incontinent of urine especially at nights, and requires total hygiene care.
Interviews with the day PSW and registered staff confirmed resident #31 was found to be incontinent of urine at 7:00 a.m. on March 2, 2014.
Interview with the night PSW confirmed that the resident's brief was wet prior to the change of shift, and the resident was not changed because the PSW was not able to raise the bed to provide continence care.
Record review revealed and interview with the administrator confirmed that resident #31's SDM was not notified of the allegation of neglect. [s. 97. (1) (b)]

Issued on this 26th day of January, 2015

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

Original report signed by the inspector.