Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 22, 2013	2013_103193_0001	T-35-13	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

MONICA NOURI (193), DIANE BROWN (110), NICOLE RANGER (189)

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 29, 30, 31, February 1, 4, 5, 6, 7, 11, 12, 13, 14, and 15, 2013

the following complaint log #1460-12 and critical incident log #1595-12 were inspected during this Resident Quality Inspection

During the course of the inspection, the inspector(s) spoke with residents, families, personal support workers (PSW), registered practical nurses(RPN), registered nurses(RN), acting Environmental manager(EM), housekeeping staff, Recreation and social activity manager and staff, physiotherapy (PT) assistant, food service staff, Dietary manager, social worker(SW), registered dietitian(RD), RAI MDS coordinator, Director of care(DOC), Assistant director of care, acting Administrator, Education coordinator, Residents' Council president and Family Council president

During the course of the inspection, the inspector(s) completed the initial tour of the home, reviewed residents health care records, review licensee's policies and procedures, training records, staff immunization, observed provision of care and staff to residents interactions, meal service and food production

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

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

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the Infection prevention and control program in following occasions;

- On February 5/2013 at approximately 15:00h on West unit an identified Registered Practical Nurse(RPN) after assisting a resident who was on contact precautions isolation came out of the room and proceeded to use the phone at the nursing station. The staff did not participate in hand hygiene after assisting the resident. [s. 229. (4)]

2. - On February 6/2013 at 17:00h, on South West unit, an identified Personal Support Worker (PSW) was observed responding to a call bell for a resident on contact precaution isolation with no Personal Protective Equipment (PPE) in vicinity. PSW did not practice hand hygiene before entering the room, did not wear the required PPE and proceeded to empty the resident's urinal and to arrange the resident's table.

- On February 7/2013 at approximately 9:00h on West unit, an identified housekeeping staff A was observed to remove isolation signs while residents were still on isolation with no directions to do so from registered staff.
The same housekeeping staff member was observed not to be wearing PPE while cleaning isolation rooms.
Housekeeping staff B was observed entering an isolation room without wearing PPE and providing cleaning services.
The inspector observed an identified physiotherapy (PT) assistant entering the room of an identified resident on contact precautions isolation without wearing PPE as required by the type of isolation precautions in place.
Staff interview with RPN on duty revealed RPN was providing inaccurate information to staff and visitors related to residents on contact precaution isolation. RPN indicated to use the "Daily tray request form" (the document used to request meal tray for a resident who is having his/her meal(s) in the room) to identify residents on isolation, and not the 24 hour surveillance form or the Enteric outbreak line listing form (documents used to record residents on isolation precaution).
There were five residents listed on the "Daily tray request form", while the Enteric outbreak line listing indicated seventeen residents on the list.

- On February 7/2013 at approximately 14:00h inspector observed no PPE available on West Central and North West units, despite the fact that every room on isolation should have its own isolation cart with necessary PPE as per home's Infection Prevention and Control policy. Staff interview with Infection control lead confirmed the

absence of PPE on above mentioned units.

- On February 7/2013 on East Unit, an identified RPN was not wearing PPE of resident #00004 being on isolation while assisting the resident in resident's room. [s. 229. (4)]

3. - On February 7/2013 at 10:24h, on North West unit, an identified PSW was observed providing care in the washroom for resident #00005, on contact precaution isolation, not wearing a gown as required by the type of isolation precautions in place. [s. 229. (4)]

4. - On February 5/2013 on South West unit, an identified PSW was observed not wearing PPE or practicing hand hygiene and going in and out of residents rooms who are on contact precaution isolation and residents rooms who are not on isolation.

- On February 5/2013 during the administration medication pass at 10:30h an RPN was observed not to practice hand hygiene or to wear PPE when administering medication to a resident who was on contact precaution isolation.

- On February 4/2013 an identified staff was observed not to practice hand hygiene or wear PPE when assisting resident #785 on contact precautions. [s. 229. (4)]

5. The licensee failed to ensure that resident #880 and resident #885 were screened for tuberculosis within 14 days of admission. Record review and staff interview indicated residents were not screened as required. [s. 229. (10) 1.]

6. The licensee failed to ensure that resident #911 and resident #885 were offered immunizations against pneumoccocus, tetanus and diphteria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

7. The licensee failed to ensure that any pet visiting the home as part of a pet visitation program has up-to-date immunization.
Two visiting dogs, Finegan and Dakota, did not have up to date immunizations. [s. 229. (12)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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
** each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of the screening are available to the licensee, and*
** residents are being offered immunization against pneumoccocus, tetanus and diphteria in accordance with the publicly funded immunization schedule posted on the ministry website, to be implemented voluntarily.*

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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

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

Findings/Faits saillants :

1. The Licensee failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

a) Interviews with resident #908 and resident #852 revealed that while assisting with evening care(toileting), an identified PSW was found on numerous occasions to be standing in the resident's room or sitting in the residents' chair watching their television while residents are in the washroom.
Residents also indicate that the PSW spoke to them in a disrespectful manner on different occasions.
Staff interview with PSW confirmed the received information. [s. 3. (1) 1.]

2. b) Interview with resident #880 revealed the licensee did not give notice before a change in roommate. Resident indicated that the staff did not introduce the resident to any of his/her roommates in the last year and feels there is a lack of courtesy by the staff.
Record review and staff interviews indicate that resident had numerous room mate within the last year. [s. 3. (1) 1.]

3. c) On February 11/2013 at approximately 10:00hr resident #00006 was observed on South West unit hallway in wheelchair asking an approaching PSW for a cup of coffee. The PSW did not acknowledge the resident's request.
When interviewed, PSW stated to the inspector: "This resident is doing this all the time. The resident is leaving the breakfast early, comes in the unit and asks for a cup of coffee. The nourishment will be here soon."
PSW did not return to the resident.
The inspector informed the Administrator and the licensee conducted an investigation of the incident. Measures were put in place to prevent re-occurrence. [s. 3. (1) 1.]

4. d) On July 15/2012 an identified Recreation and activation staff made an inappropriate comment related to the resident #00003 vision when the resident attempted to join an exercise class, denying resident's access to the class.
The licensee conducted an investigation of the incident and measures were put in place to prevent re-occurrence. [s. 3. (1) 1.]

5. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Interview with resident #880 revealed that on an identified date the resident was on the toilet with the door open, due to the wheelchair not fitting in the washroom, when resident heard a knock on the room door. Resident states that requested the staff to wait, however the staff member entered the room and proceeded to check the room. Resident indicated feeling disrespected by the staff. [s. 3. (1) 8.]

6. The licensee failed to ensure that every resident has the right to have his/her personal health information kept confidential in accordance with the Personal Health Information Act, 2004.

During tour observation on January 29/2013, the inspector observed on Est unit an unattended medication cart with residents' information displayed on the monitor screen. The inspector, residents, family members and visitors in the vicinity and passing by were able to view personal information pertaining these residents. [s. 3. (1) 11. iv.]

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 resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, and***
**** every resident is afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.***

WN #3: 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).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure 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.

Resident's #823 plan of care goal was to gradually lose weight to achieve a specific Goal Weight Range (GWR) in one year. Resident experienced significant weight loss and resident's family requested nutritional supplements, while on the program to loose weight which were subsequently ordered and received.
Resident's preference for further weight loss was not assessed or considered in the resident's plan of care. A revised GWR was documented on January 13/2013 without resident's inclusion in assessment. Interview with registered dietitian(RD)confirmed that the resident was not involved in this decision. [s. 6. (2)]

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

The current plan of care for resident #862 indicated for registered staff to monitor for effectiveness and side effects psychotropic medications such as dizziness, drowsiness, fatigue, increased agitation/sadness.
Record review and staff interviews indicated that there was no monitoring for effectiveness and side effects for psychotropic medication administered from February 1 to February 14/2013 for the resident. [s. 6. (7)]

3. The licensee failed to ensure that 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.

Resident #00001 had a fall on an identified date. The resident was admitted to the hospital for a fracture six days later. The plan of care was not reviewed and revised until resident's return from the hospital and new interventions were added in relation to pain management and fall prevention. [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
**** the care set out in the plan of care is provided to residents as specified in the plan, and***
**** residents are reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.***

WN #4: 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 :

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1. The licensee failed to ensure that staff complied with the home's policy IPC Contact precautions, Infection surveillance and control #03-01-09, from January 2013.
The policy requires isolation signage placed on the resident's door to indicate the PPE required to be worn by staff providing care, and for a mobile cart placed outside the door to the resident's room or at the door entrance with all the required PPE supplies.

From January 31/2013 to February 7/2013 at 14:00hr there were no isolation signs in the home to indicate the PPE required to be worn by staff providing care, and mobile carts were not placed outside the doors of the residents rooms or at the door entrance with all the required PPE supplies throughout the home for 23 identified rooms. [s. 8. (1)]

2. The licensee failed to ensure that staff complied with the home's policy Routine/standard precaution practices # INFE-02-01-01, from January 2013.
The policy indicates that "all items, including masks are single use disposable items worn where is a risk of the staff member's mucous membranes, eyes, nose and mouth being contaminated with resident's bodily fluids".

On February 7/2013 the following were observed:
- an identified housekeeping staff was observed in the main dining room, after breakfast was served, to clean the floor wearing a mask. No residents were in the room. Staff stated that the mask was worn "for my own protection, to don't get something with so many sick people here".
- an identified housekeeping staff was observed to wear the same mask when cleaning between isolated and non isolated rooms
- an identified RPN on West unit was observed to wear a mask under chin while assisting with breakfast in the main dinning room; RPN indicated that the mask is worn when on the unit and is aware that the mask is for single use
- an identified RPN on East unit was observed to wear a mask under chin while administering medication on the unit. [s. 8. (1)]

3. The licensee failed to ensure that staff complied with home's policy Pain Reassessment RESI-05-08-01.
The policy states pain flow records are used to assess pre and post analgesia pain scores as well as track use of prn pain.

The pain flow records were not completed for resident #885 on 3 identified dates, and

for resident #880 on 6 identified dates. [s. 8. (1)]

4. The licensee failed to ensure that staff complied with home's Falls policy # RESI-09 -02-01, from November/2011.
The policy holds registered staff responsible for ongoing assessment of a resident for 24 hrs after a fall if the resident remains in the home. Every shift the resident is to be assessed for pain, bruising, changes in functional status, cognitive status and range of motion status, and this is to to be documented in the progress notes.

Resident #00001 fell and remained in the home. The resident was not assessed for bruising, changes in functional and range of motion status for day shift on one occasion ,and for pain, bruising, changes in functional, cognitive and range of motion status for evening shift of the same day, as required by the home's policy. Record review and staff interview confirmed it. [s. 8. (1)]

5. The licensee failed to ensure that staff comply with home's policy Disposal of Surplus Prescription Medication # 4.13, from September 1/2011.
The policy states each time a medication is wasted or discontinued, the medication must be removed from the medication supply in current use and entered on the surplus/discontinued drugs form.

On January 31/2013, inspector observed discontinued Peridex medication for resident #0016 in the East 2 medication cart. The Peridex medication was discontinued on October 24/2012. Staff interview confirmed that medication was discontinued. [s. 8. (1)]

6. The licensee failed to comply with home's policy Expiry and Dating of Medication #5.1, from February/2012.
The policy requires staff to examine the expiry date of all medications on a regular basis and remove any expired medication from stock.

a) On January 31/2013 at 14:30h on South East unit, the medication room was observed and the following expired medications were identified:
- one Glycerin suppository with expiry date of 04/2012, and one Glycerin suppository with expiry date 2011,
- multiple Dymenhydrinate tablets with expiry date of 06/2012
- no expiry dates on 2 bottles of Fludrocortisone Acetate

b) On January 31/2013 at 11:14h the medication cart on South West unit was observed and the following was identified:
- Codeine phosphate syrup 5mg/ml with no expiry date.

c) Medication fridge on South West was observed and the following were identified:
- one Pneumovax vaccine with expiry date of August 5/2012,
- eight Glycerin suppositories with expiry date of 04/2012,
- medication without expiry dates: Zopiclone 7.5 mg ordered November 30/2012 for resident #00008, Dextrometrophan ordered November 30/2012 for resident #00007, and all topicals in the medication cart

d) On February 11/2013, the emergency drug box on the South unit was observed and the following were identified:
- one vial of Xylocain 1% with expiry date of 11/2012
- two vials of Epinepherine injections 1mg/ml with expiry date of January 2013
- four Gen glucose tablets with no expiry date [s. 8. (1)]

7. The licensee failed to comply with home's policy Drug destruction and disposal #5-4, from February/2012.
The policy requires for drug destruction and disposal medication record to include documentation of reason for destruction and manner of destruction of the drug.

Review of documentation on the drug destruction and disposal and staff interview with the DOC indicated the record does not include:
- the reason for destruction
- the manner of destruction of the drug. [s. 8. (1)]

8. The licensee failed to comply with home's policy Drug destruction and disposal #5-4, from February/2012.
The policy requires for discontinued narcotics/controlled substances to be disposed in separate double locked area from drugs to be administered.

On January 31/2013 interview with registered staff revealed that for nights and weekends the discontinued controlled substances will be kept in the narcotic bin, in the same place with controlled substances to be administered, until they can be given to the DOC for disposal.

The DOC confirmed the practice of keeping the discontinued/expired narcotics/controlled substances in the narcotic bin in the medication cart for nights and weekends. [s. 8. (1)]

9. The licensee failed to comply with policy Changes in resident weight, # RESI-05-02-07, from December 2002.
The policy requires all residents to be weighted at least once a month as an ongoing assessment of nutritional status.

Resident #00001 was not weighted monthly as required, specifically in January/2013. Last recorded weight is from December 10/2012. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system is in compliance with and implemented in accordance with all applicable requirements under the Act and, is complied with, to be implemented voluntarily.

WN #5: 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, furnishing and equipment are kept clean and sanitary.

On February 4/2013 at 11:00h soiled chairs were observed in the Phylis dining room. [s. 15. (2) (a)]

2. On February 11/2013 the following were observed;
- the West lounge had a build up of dirt and grease in all floor joints
- soiled baseboards with spill like markings over a period of several days during the inspection

An interview with the Acting Environmental Manager(AEM) confirmed that these soiled areas are not currently assigned to be cleaned in the housekeeping aides or janitor's routines.
- the floor areas around the sink in East and West lounges were cracked, peeling, with exposed rotting wood.

AEM acknowledged that these areas were in poor condition and that replacement requests have been longstanding. [s. 15. (2) (a)]

3. On January 29/2013 at approximately 9:30h, when conducting the initial tour of the home on West unit, the following were observed;
- black marks on lower side of the housekeeping door
- heavily soiled chair in the lounge area
- black marks on lower wall near the entrance of North West unit [s. 15. (2) (a)]

4. The licensee has failed to ensure that the floors in the home are maintained in a safe condition and in a good state of repair.

On February 11/2013 the following floor areas were identified to be cracked, buckling with a concave surface potentially causing a tripping hazard for residents.
- West unit flooring running across corridor between room 146 and shower room; all eight tiles were cracked and 4 centre tiles had buckled with a concave surface
- South West unit flooring running across corridor between rooms 121 and 120; six out of 8 tiles were cracked and 5 centre tiles had buckled with at least one inch concave surface. [s. 15. (2) (c)]

5. On January 29/2013 at around 9:30h, when conducting the initial tour of the home on West unit, the inspector observed the supply room, next to the shower room, open

and 2 square holes around the tap fixtures and broken tales.
Concerns were shared with AEM. [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, furnishing and equipment are kept
**** clean and sanitary, and***
**** are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care is based on, at minimum, interdisciplinary assessment of the cultural, spiritual and religious preferences and age -related needs and preferences.

Resident's #887 plan of care is not based on resident's cultural age-related needs and preferences.
Interview with the resident revealed that the resident does not attend most programs and activities related to a language barrier. Resident also expressed loneliness for conversation.
A review of Activity programs reveals that no cultural based program in resident's language have been available since November 5/2012.
On December 11/2012 resident was referred to Resident program manager by social worker(SW) to provide for a volunteer who speaks the same language as the resident speaks, who could be company for the resident. A volunteer is currently not available. Staff interview confirmed that no further interventions are in place currently to address this resident's recreation and social needs. [s. 26. (3) 22.]

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 by ensuring that for every resident in the home the plan of care is based on, at minimum, interdisciplinary assessment of the cultural, spiritual and religious preferences and age-related needs and preferences, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee did not ensure that there are standardized recipes for all menus.

Standardized recipes were not available for all lunch menu items on February 12/2013. The Dietary Manager confirmed through interview that recipes are being developed, but not all available at this time. [s. 72. (2) (c)]

2. The licensee did not ensure that the organized food production system must, at minimum, provide for preparation of all menu items according to the planned menu.

Standardized recipes were not followed altering the flavour, nutrient value and appearance of the planned menu items.

Interview with the Dietary Manager revealed that staff expectation is to follow the approved menu and standardized recipes. Any changes made to the menu are to be approved by the management.

The preparation of the lunch meal was observed from start to finish on February 12/2013. The following was noted:
- The menu called for vegetarian chili- a turkey chili recipe was prepared and served
- Staff added onions and parsnips to a ready-to–serve vegetarian chili to "thicken" it for plating as the kitchen did not have enough bowls for soup and chili.
- The pureed bread recipe includes vanilla, sugar and skim milk powder. These items were omitted, only bread and fluid milk were used.
- A commercially prepared quiche was texture modified for the pureed menu, while a from scratch quiche was prepared and required to be served on all menus. The commercially prepared quiche was different from scratch recipe.
- Cucumber and onion salad recipe calls for home made dressing; a prepared creamy cucumber dressing was used instead.
- Cornbread recipe is from scratch but a prepared product was used.
- Caesar salad recipe calls for parmesan cheese but a blend of parmesan and romano cheese was used.
- the home's French onion soup recipe is a recipe from scratch. A prepared product was served.
- Strawberries were not defrosted in advance and served partially frozen at breakfast on February 12/2013. This issue has been raised at Food Committee Meetings February 9/2012 and September 27/2012. [s. 72. (2) (d)]

3. The menu and standardized recipes were not followed impacting the quality of meat served.
- Veal Scallopini was substituted for a veal cutlet on Sunday February 10/2013.
- Roast turkey served on Sunday, February 10/2013 at dinner was a precooked deli turkey meat; recipe called for a raw roast turkey breast roll to be roasted in house;
- Roast beef recipe calls for a raw inside round to be roasted; staff interviews revealed that a precooked deli roast beef has been used over the past 3 months.

Resident interviews reveal that many of the residents do not like the taste and the appearance of the food.
Food Service Worker interviews revealed that changes to the menus have been made related to the budget.
Interview with the administrator revealed that the homes most recent satisfaction survey of July 2012 included a 61.8% satisfaction rating for "taste of food". Resident interviews confirmed dissatisfaction with food. [s. 72. (2) (d)]

4. The licensee failed to ensure that all menu substitutions are documented on the production sheet.

A menu change was made Sunday, February 10/2013 at dinner according to staff interviews, but no record of the change was documented. The planned menu item was not available. Interviews with cooking staff reveal they routinely do not document menu substitutions on the production sheets. [s. 72. (2) (g)]

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 food production system is providing for, at minimum, standardized recipes and production sheets for all menus***
**** preparation of all menu items according to the planned menu, and***
**** documentation on the production sheet of any menu substitution, to be implemented voluntarily.***

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that no staff of the home perform their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The Food services supervisor, and a Dietary aide, did not receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. [s. 76. (2) 3.]

2. The licensee failed to ensure that staff received training in the area of duty under section 24 to make mandatory reports, prior to performing their responsibilities.

The Food services supervisor, a Dietary aide,and a PSW,did not receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities. [s. 76. (2) 4.]

3. The licensee failed to ensure that no staff of the home perform their responsibilities before receiving training in the area of protections afforded by section 26 of the Act.

The Food services supervisor, a Dietary aide, and a PSW, did not receive training in the area of whistle-blowing protections afforded under section 26, prior to performing their responsibilities.

This information was confirmed by the Education Coordinator. Also, the Education Coordinator indicated that all staff who received mandatory training before March/2012 did not receive training in the area of mandatory reporting under section 24 of the Act and whistle-blowing protections afforded under section 26, prior to performing their responsibilities. [s. 76. (2) 5.]

4. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas mentioned below at annual intervals as provided for in the regulations.

Through record review, interviews with front line staff and the Education Coordinator it was determined that not all staff who provide direct care to residents received the training in areas mentioned below:
a) mental health issues, including caring for persons with dementia

- no training was provided in 2011
- only 79.6% of all direct care staff received the training in 2012 [s. 76. (7) 2.]

5. b)behavior management
- no training was provided in 2011
- only 79.6% of all direct care staff received the training [s. 76. (7) 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 by ensuring that
**** no staff perform their responsibilities before receiving training in areas of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, duty under section 24 to make mandatory reports, protections afforded by section 26 of the Act, and***
**** all staff who provide direct care to residents receive annual training in mental health issues, including caring for persons with dementia and bahaviour management, unless the licensee assesses the individual training needs of staff, to be implemented voluntarily.***

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

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1. The licensee failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropics drugs, there is monitoring and documentation of the residents response and the effectiveness of the drug appropriate to the risk level of the drug.

- Resident #862 is receiving a combination of psychotropic drugs at bedtime. Documentation was reviewed from February 1 to 14/2013. Staff interviews confirmed that there was no monitoring and documentation of the resident's response and the effectiveness of the drugs. [s. 134. (a)]

2. - Resident #00001 received on an identified occasion Seroquel 25mg. Through review of documentation and staff interviews it was confirmed that there was no monitoring and documentation of the resident's response and the effectiveness of the drug. [s. 134. (a)]

3. - Resident #885 is receiving an identified psychotropic drug at bedtime. Documentation was reviewed for February 1 to 14/2013. Staff interview confirmed that there was no monitoring and documentation of the residents response and the effectiveness of the drug. [s. 134. (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 when a resident is taking any drug or combination of drugs, including psychotropics drugs, there is monitoring and documentation of the residents response and the effectiveness of the drug appropriate to the risk level of the drug, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to provide training to all staff who provide direct care to residents in falls prevention and management.

Through interviews with front line staff and the Education Coordinator it was determined that only 51% of all staff who provide direct care to residents received the training for falls prevention and management in 2012. [s. 221. (1) 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 training in falls prevention and management is provided to all direct care staff annually, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On January 29/2013 at approximately 9:30h, when conducting the initial tour of the home on West unit the inspector observed the door of the room to the electric panel and the door of the electric panel to be open. There are wandering residents in the unit. [s. 5.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of the verbal abuse investigation related to resident #00003. [s. 23. (2)]

WN #13: 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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. An identified RPN and the DOC failed to immediately report the suspicion and the information about a verbal abuse incident of the resident #00003 when became aware of it. The incident was reported to the Director nine days later. [s. 24. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Fall prevention program includes a written description of the program's goals and objectives. [s. 30. (1) 1.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home receive individualized personal care, including hygiene care and grooming on a daily basis.

On February 6/2013 at 11:40h inspector observed resident #00018 not dressed appropriately and wearing a night gown. The resident's room was untidy and the bed not made.
Family member reported to the inspector that resident did not receive morning assistance. The family member found the resident without dentures, incontinent and wearing a nightgown when he/she arrived at 11:30h. [s. 32.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies are developed and implemented to meet the needs of residents who can not communicate in the language used in the home.

Resident #887 indicates that staff did not involve the resident in decision making about personal care because of the inability to communicate in the language used in the home, despite the fact that the resident is able to understand and make self understood when a translator is available. [s. 43.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record related to annual evaluation of the Responsive behaviours program for 2012 includes dates when changes made to the program were implemented.

Record review and the DOC statement confirmed the above information. [s. 53. (3) (c)]

WN #18: 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 if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee responds to the Residents' Council in writing within 10 days of receiving the advice.

Residents' Council meeting minutes were reviewed from February 15/2012 until December 19/2012.
On July 18/2012 and September 11/2012 meeting minutes concerns related to delays in meal service were identified and confirmed through resident interviews to be an unresolved concern.
Inspector observations confirmed that residents experienced long delays between courses.
An interview with the President of Residents' Council and Acting Administrator confirmed that no written response had been provided to the Residents' Council.

The following were noted in Residents' Council meeting minutes on September 11/2012 and October 17/2012;
- "Food waste is high. Is it due to food quality or have people lost their appetites and they don't eat as well?"
- "Can meal service routines be reviewed and reworked to see if the serving time can be lessened?"
An interview with the President of Residents' Council and the Acting Administrator confirmed that no written response had been provided as required. [s. 57. (2)]

2. The home's Food Council meetings minutes were reviewed from February 9/2012 until the last meeting of November 15/2012. The following concerns and recommendations were raised;
On February 9/2012 minutes were noted;
- cream for coffee was requested in the dining room; cream was not observed to be served during this Resident Quality Inspection and staff stated that it has been at least 2 years since cream has been available last time
- complaints made about berries served frozen
On May 31/2012 minutes were noted;
- residents requested a deep fryer for French fries
- complaints made about roast beef served too dry and being too hard to chew
On September 27/2012 minutes were noted;
- brown rice and a more variety of breads were requested

- complaints about berries served frozen
On November 15/2012 minutes were noted;
- more beans on the menu were requested
The Dietary manager confirmed through interview that all concerns raised were not investigated and resolved, and no written response was sent to the Residents' Council within 10 days of receiving the concerns. [s. 57. (2)]

WN #19: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that Residents' Council review the meal and snack times.

Interview with the Program manager and president of the Residents' Council confirmed that a review of meal and snack times by Residents' Council has not been completed. [s. 73. (1) 2.]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to ensure that the package of information for residents include an explanation of the duty under section 24 to make mandatory reports.

Record review and staff interview indicates there is no explanation of the duty under section 24 to make mandatory reports in the admission package. [s. 78. (2) (d)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that on February 10/2013 at 10:00hr the following information was posted in the home, in a conspicuous manner and easily accessible location that complies with the requirements;
- licensee name and telephone number [s. 79. (3) (h)]

2. - the latest Family Council minutes [s. 79. (3) (o)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On January 29/2013 at approximately 9:30h, while conducting the initial tour of the home, the inspector observed on West unit a storage room on the right side of the shower room with the door open despite the sign on the door to keep it close at all times. The following hazardous substances were accessible to residents;:
- five 9.46L containers with cleaning solutions connected to a tap system, and
- six 1L bottles of desinfectant [s. 91.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the AEM had knowledge of evidence-based practices or prevailing practices related to housekeeping, laundry and maintenance.

The AEM, with no previous work experience in environmental services, does not have knowledge of evidence-based practices or prevailing practices relating to housekeeping, laundry and maintenance. An interview with the EMS revealed that her knowledge included reference to the homes Environmental Services policy and procedure manual and an on-line infection control program. [s. 92. (2) (b)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that the written record of the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents included the date that the changes and improvements were implemented. [s. 99. (e)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director, C2460-000034-12,included;
the names of any staff members or other persons who were present at or discovered the incident [s. 104. (1) 2.]

2. the outcome or current status of the individual who was involved in the incident [s. 104. (1) 3.]

3. whether an inspector was contacted and if so, the date of the contact and the name of the inspector [s. 104. (1) 5.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy until administered to a resident or destroyed.

On January 31/2013 observation of the East 1 medication cart identified an unlabelled Spiriva medication (inhalation medication) and a box with multiple unlabelled medications. [s. 126.]

WN #27: 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 failed to ensure that drugs are stored in a medication area that is used exclusively for drugs and drug related supplies.

Medication areas in the home were observed and following were noted.
The medication fridge in the medication room on South West unit contained two 1.96 L apple juice boxes, one Resource 2.0 946 ml, two Ensure 235 ml, two Diabetic Resource 250 ml, five orange juice 114 ml sealed containers, four popsicles, one water bottle 500 m and two batteries.
The medication fridge on South East unit contained six sealed orange juice containers and two packs of batteries.
The narcotic bin in the medication cart on South East unit contained money. [s. 129. (1) (a)]

2. On January 31/2013 the medication fridge on East unit contained chocolate and one sealed yogurt container. [s. 129. (1) (a)]

3. The licensee failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

During tour observation on January 29/2013, on East unit, the inspector observed an unlocked and unattended medication cart. [s. 129. (1) (a)]

WN #28: 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 failed to ensure that access to all areas where drugs are stored is restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator.

On February 13/2013 on West unit, an identified maintenance staff was observed in the medication room unsupervised by registered staff. Inspector was at the nursing station desk for 15 minutes while the maintenance staff was in the medication room unsupervised. [s. 130. 2.]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On February 5/2013, on East unit, RPN administered Metformin 1000mg to resident #00019 at 10:30h. Physician's order indicated for medication to be administered at 8:00h. [s. 131. (2)]

WN #30: 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. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective.

Interview with DOC on February 16/2013 confirmed that the drug destruction and disposal system is not being audited. [s. 136. (5)]

Issued on this 28th day of March, 2013

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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONICA NOURI (193), DIANE BROWN (110), NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2013_103193_0001
Log No. / Registre no:	T-35-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 22, 2013
Licensee / Titulaire de permis :	EXTENDICARE SOUTHWESTERN ONTARIO INC 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE BAYVIEW 550 CUMMER AVENUE, NORTH YORK, ON, M2K-2M2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDY HALL

To EXTENDICARE SOUTHWESTERN ONTARIO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure that all staff participate in the implementation of the infection prevention and control program. Please submit the plan to Monica.Nouri@ontario.ca by April 22/2013.

Grounds / Motifs :

1. The licensee failed to ensure that all staff participate in the implementation of the Infection prevention and control program in following occasions;

On February 5/2013 on South West unit, an identified Personal Support Worker (PSW) was observed not wearing the required Personal Protective Equipment (PPE) and not practicing hand hygiene when going in and out of residents rooms who are on contact precaution isolation and residents rooms who are not on isolation.

On February 5/2013, during the administration medication pass at 10:30h an identified Registered Practical Nurse (RPN) was observed not to practice hand hygiene or to wear PPE when administering medication to a resident who was on contact precaution isolation.

On February 4/2013 an identified staff was observed not to practice hand hygiene or wear PPE when assisting resident #785 on contact precautions. (189)

2. On February 7/2013 at 10:24h an identified PSW was observed providing care in the washroom for resident #00005, on contact precaution isolation, not wearing a gown as required by the type of isolation precautions in place. (193)

3. On February 6/2013 at 17:00h, on South West unit, an identified PSW was observed responding to a call bell for a resident on contact precaution isolation with no PPE in vicinity. PSW did not practice hand hygiene before entering the room, did not wear the required PPE and proceeded to empty the resident's urinal and to arrange the resident's table.

On February 7/2013 at approximately 9:00h on West unit, an identified housekeeping staff A was observed to remove isolation signs while residents were still on isolation with no directions to do so from registered staff.
The same housekeeping staff member was observed not to be wearing PPE while cleaning isolation rooms.
Housekeeping staff B was observed entering an isolation room without wearing PPE and providing cleaning services.
The inspector observed an identified physiotherapy (PT) assistant entering the room of an identified resident on contact precautions isolation without wearing PPE as required by the type of isolation precautions in place.
Staff interview with RPN on duty revealed RPN was providing inaccurate information to staff and visitors related to residents on contact precaution isolation. RPN indicated to use the "Daily tray request form" (the document used to request meal tray for a resident who is having his/her meal(s) in the room) to identify residents on isolation, and not the 24 hour surveillance form or the Enteric outbreak line listing form (documents used to record residents on isolation precaution). There were five residents listed on the "Daily tray request form", while the Enteric outbreak line listing indicated seventeen residents on the list.

On February 7/2013 at approximately 14:00h the inspector observed no PPE available on West Central and North West units, despite the fact that every room on isolation should have its own isolation cart with necessary PPE as per home's Infection Prevention and Control policy. Staff interview with Infection control lead confirmed the absence of PPE on above mentioned units.

On February 7/2013 on East Unit, an identified RPN was assisting resident #00004 on contact precautions without wearing the required PPE. Staff interview revealed that RPN was not aware of the resident being on contact precautions isolation.

(193)

4. On February 5/2013 at approximately 15:00h on West unit an identified Registered Practical Nurse (RPN), after assisting a resident who was on contact precautions isolation, came out of the room and proceeded to use the phone at the nursing station. The staff did not participate in hand hygiene after assisting the resident. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of March, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MONICA NOURI

Service Area Office / Bureau régional de services : Toronto Service Area Office