Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 15, 16, 17, 18, 21, 22, 23, 25, 28, 30, Dec 1, 5, 7, 8, 9, 12, 13, 14, 16, 19, 23, 30, 2011; Jan 3, 4, 5, 6, 8, 9, 12, 13, 16, 17, 18, 19, Feb 8, 10, 14, 15, 16, 22, Mar 8, 14, 20, 23, 27, 29, Apr 26, 2012	2011_070141_0041	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE HAMILTON
90 CHEDMAC DRIVE, HAMILTON, ON, L9C-7S6

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

SHARLEE MCNALLY (141), LALEH NEWELL (147), MICHELLE WARRENER (107), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Food Service Manager, Environmental Manager, Program Manager, Registered Nurse (RN), Registered Practical Nurse (RPN),Personal Support Workers (PSWs), housekeeping, dietary aides, recreational aides, physiotherapy, social work, dietitian, families, and residents.

During the course of the inspection, the inspector(s) reviewed residents records, home's policies and procedures, home's complaint log, and Resident and Family Council minutes. Observed resident care, dining and program activities in the home. Completed physical tour of home and observed care and services provided to the residents and medication passes. Reviewed the homes laundry system and process for resident lost clothing and personal property.

Log# H-002180-11

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

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

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee did not ensure that front fastening seat belts used as physical restraints were applied consistently in accordance with manufacturer's instructions.
Four identified residents were observed wearing loose fitting seat belts while sitting in their wheelchairs on multiple days. One resident was observed to have slid down in their wheelchair while the seat belt was in place.
The Director of Care confirmed the manufacturer informed the home that the appropriate distance between resident and the applied seat belt was "two finger" width and this was the instruction provided to staff of the home. The home was unable to provide manufacturer's instructions regarding the appropriate application of front fastening seat belts on residents. s.110.(1)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

s.3(1) previously issues July 26, 2011

1. An identified resident was not provided care in a manner consistent with their needs. The resident had been assessed as needing assistance with transferring. On an identified date the resident activated their call bell to request assistance with care. A PSW responded 15 minutes after activation to assist with the resident's care needs. The PSW stated another PSW was in the home area but feeding a resident and therefore she was on her own to answer all call bells. s.3(1)4
2. An identified resident was not provided care in a manner consistent with their needs. The resident had been assessed as needing assistance for safe transferring to the toilet. The resident stated they require staff assistance to go to the washroom but has had to wait for periods of up to 30 minutes for staff to respond to their call bell to provide the assistance. The resident further stated if they do not receive assistance to the bathroom, they will fall. s.3(1)4
3. An identified resident was not provided care in a manner consistent with their needs. The resident had been assessed as needing extensive assistance with personal hygiene and preferred to be up before breakfast. The resident stated that once or twice a week it takes a half hour or more for the staff to come and help in the morning which causes them to be late for breakfast. On an identified date they rang the bell at about 0740 hours and staff did not provide assistance till about 0810 hours. s. 3.(1)4
4. An identified resident was not provided care in a manner consistent with their needs. The resident had been assessed as needing assistance for safe transferring and toileting. The resident's family member identified concerns with call bell response time. They stated the resident complained frequently about call bell response time, stating to them it felt like more than half an hour of sitting on the toilet before staff provide assistance.
5. An identified resident was not provided care in a manner consistent with their needs. The resident had been assessed as needing assistance for safe transferring and toileting. The resident expressed concerns about call bell response times at meal times and in the evening. The resident stated it sometimes takes extended time for staff to come to assist with toileting. The staff will respond to the bell sometimes but then tell the resident they will be back to assist with their needs and then the resident may have to wait about 20 minutes for this to happen. The resident expressed that the delay in assistance does cause them distress. s. 3(1)4. (107)
6. The licensee did not fully respect and promote an identified residents right to pursue religious and spiritual interests and the resident was not given reasonable assistance by the licensee to pursue these interests. The resident had a 'Recreation Custom Assessment' completed in 2011 which indicated they wanted to attend spiritual activities. During an interview the resident stated they enjoyed this activity and liked to attend it whenever they could and the resident needed assistance to attend. Out of 32 occasions of the identified program being offered by the home over a 5 month period in 2011, the resident attended only on one occasion and was offered only one other time to attend (as per the resident's recreation attendance records). The resident was not on the list of residents that attended the identified program. The resident's plan of care did not provide direction related to the resident's preference for the identified program. The Recreation Manager confirmed that currently, not all resident's plans of care include preference for the identified program. s.3.(1)(23)
7. The licensee did not ensure every resident was afforded privacy in treatment and in caring for his or her personal needs. On November 22, 2011 an identified resident was sitting on the toilet with a PSW in attendance. The washroom door and the room door were ajar. The resident was visible from the hallway, while receiving toileting care needs.
On November 25, 2011 an identified resident was observed on the toilet with the door open. A PSW confirmed she had assisted the resident onto the toilet and left both the bathroom and bedroom doors open and then proceeded to attend another resident in another room. The resident was fully visible to any person entering the bedroom. The resident confirmed they did like the bathroom door left open so they feel less closed in but did not want the bedroom door left open when they are on the toilet. s.3(1)8
7. On November 16, 2011 three identified residents were not afforded privacy in treatment for their personal needs. All three residents were observed to have blood sugar testing completed while sitting at their assigned dining table in the presence of other residents.
On November 16, 2011 two identified residents were observed to have insulin administered by injection in the dining room with other residents present. s.3.(1)8 (141)

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 rights are fully respected and promoted, 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 subsections:

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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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 did not ensure that the home communication and response system was easily used by residents, staff and visitors at all times. Tour of Battlefield, Concession, Edgemount and Fennel home areas identified that 20 bathroom call bells were wrapped around hand grab bars next to the toilets. Call bells in the bathrooms were of the "break away" type and were unable to separate to activate the system, due to wrapping around the grab bars. Testing of call bells were completed in 4 bathrooms, that had call bells wrapped around the grab bars. These bells did not activate when pulled by the end of the cord. Director of Support Services confirmed that the call bell systems could not be activated in bathrooms if wrapped around grab bars. 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 resident-staff communication and response system can be easily 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. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

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

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

Findings/Faits saillants :

s.6.(10)(b) and s.6.(1)(c)previously issued January 18, 2011

1. The licensee did not ensure that the staff and others involved in the different aspects of care of an identified resident collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with and complemented each other after a diet texture change.
The physician most recent three month medication review sheet listed an identified resident's diet as Regular diet Regular texture, however, the diet was changed to Regular diet with moist minced meats prior to the review. The Registered Dietitian confirmed that the correct diet was minced meats.
2. The licensee did not ensure that the following residents were reassessed and their plans of care reviewed and revised when the care set out in their plans related to hydration were not effective:
a) An identified resident had a plan of care by the Registered Dietitian on November 8, 2011, that identified a target fluid goal per day. The resident met this target on 0/29 days for the month of November, 2011. An interdisciplinary assessment of the poor hydration did not occur, a referral to the Registered Dietitian for assessment was not initiated, and strategies to address the poor hydration were not implemented.
b) An identified resident had a plan of care that identified a fluid goal per day. The resident met this target 2/29 days in November, 2011. An interdisciplinary assessment of the poor hydration did not occur, a referral to the Registered Dietitian for assessment was not initiated, and strategies to address the poor hydration were not implemented.
c) An identified resident had a plan of care that identified a fluid goal per day. The resident met this goal on 0/29 days in November, 2011. An interdisciplinary assessment of the poor hydration did not occur, a referral to the Registered Dietitian for assessment was not initiated, and strategies to address the poor hydration were not implemented.
PSW staff stated that they were to report poor food and fluid intake to the charge nurse each shift. Documentation does not reflect that poor fluid intake was reported or assessed for the above residents.
s.6.(10)(c)
3. An identified resident was not reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective in relation to hydration. The resident's food and fluid intake flow sheets identified they were not meeting their target hydration goals of fluids per day (as identified on the plan of care), however, an interdisciplinary assessment of the poor hydration did not occur. The flow sheets indicated the resident was not meeting their fluid goals on 21/31 days in October, 25/30 days in November, and 8/11 days to date in December, 2011. The Registered Dietitian confirmed the home's expectation was to total the amount of fluids consumed for each day on the flow sheets and report concerns of poor intake to the charge nurse. Fluid intake was not routinely totaled for the resident, concerns were not reported (as per the progress notes), and a referral to the Registered Dietitian related to poor hydration was not completed. s.6(10)(c)
4. The plan of care for an identified resident was not reviewed and revised when the resident's care needs changed.
The resident had surgery and a dressing was observed in place. This dressing was not included in the resident's plan of care.
An assessment in the clinical record stated the resident had pain. The resident stated their pain was a level 3/10 and continuous. The resident stated the pain effected their activities of daily living. The resident also reported it effected their mood and sleep patterns. The resident stated medication was used for pain management and the pain pills worked. The clinical record revealed the resident was receiving the medication every four hours to manage the pain. The plan of care did not include the changes in the resident's care needs related to postoperative care needs. s.6.(10)(b)
5. The licensee did not ensure an identified resident's written record was kept up to date when they had a diet texture change. The physician's most recent three month medication review listed the resident's diet as Regular diet Regular texture, however, the diet was changed to Regular diet with moist minced meats prior to this review. The Registered Dietitian confirmed that the correct diet was regular minced meats. s.231.(b)
6. The licensee did not ensure an identified resident was reassessed and their plan of care reviewed and revised when their care needs changed in relation to hydration. An interdisciplinary assessment of the resident's hydration status did not occur after a decline in hydration status in 2011 and the plan of care was not revised to include strategies to address the poor hydration. The resident was not meeting their hydration target 7% of the time in September 2011, 29% of the time in October, and 50% of the time (to date) in November 2011. PSWs identified the resident required staff assistance with drinking (one staff to sit with the resident during meal times). The plan of care stated the resident required limited assistance with eating and staff were to provide intermittent assistance. The plan of care was not revised to address the decline in hydration and the risk related to requiring more assistance with eating. The Registered Dietitian confirmed that she did not receive a referral for assessment of the poor/decline in hydration and an interdisciplinary assessment of the poor hydration (including nursing and dietary staff) did not occur.

The recreation plan of care for an identified resident was not revised when the resident's care needs changed. The resident had a decline in condition leading to reduced participation in activity programs. The plan of care was not revised to reflect this change in condition and it's effect on the resident's recreational needs. The Recreation Manager confirmed that the plan of care for recreation was not updated to reflect the resident's change in condition and the increased 1-1 visits being offered to the resident.
The plan of care for an identified resident was not revised when the resident's care needs changed in relation to weight monitoring. The resident had an order for weekly weights, however, the plan of care directed staff to monitor weights monthly. The plan was also not revised in relation to the resident's weight status and goals. The plan identified a goal for weight maintenance within his goal weight range, however, the resident fell below this weight in November, 2011 without revision to identified goals. The Registered Dietitian confirmed that the plan was not updated at the assessment in November, 2011 to reflect the change in status. s.6(10)(b)
7. The licensee did not ensure that the care set out in the plan of care for an identified resident was provided to the resident as specified in their plan of care. The plan identified the resident required a pillow, thickened fluids and crustless bread. It was observed on November 28, 2011 the resident did not receive the pillow, received custard that was of mixed consistency (both solid and fluid), was given thin coffee served with a straw, and received bread with crusts. Staff confirmed the coffee being served to the resident was not the appropriate thickened consistency. The Registered Dietitian confirmed that residents requiring thickened fluids should not receive mixed consistency food items. s.6.(7)
8. The licensee did not ensure that the care set out in the plan of care for an identified resident was provided as per the plan. The resident had a plan to provide a diabetic minced texture diet with nectar consistency thickened fluids. The resident was observed on December 12, 2011 with fluids of different consistencies. The resident had a history of aspiration. The resident received a glass of thin water in a regular cup, honey to pudding consistency juice at the afternoon snack pass, and nectar thick orange juice. The Registered Dietitian confirmed that residents requiring thickened fluids would not receive thin water between meals unless ordered by the physician. The resident did not have a physician order for thin fluids between meals. The resident's visitor confirmed the resident's fluids were not consistently thickened following the resident's plan of care. s.6.(7)
9. The licensee did not ensure that the care set out in the plan of care for the following residents was provided as per plan of care at the afternoon snack pass December 7, 2011:
a) an identified resident's plan (diet list) stated to encourage water between meals as opposed to sweet fruit juices. The resident was given cranapple juice and water was not encouraged.
b) An identified resident's plan(diet list) stated to encourage water/diet beverages between meals. The resident was given orange juice and water was not encouraged.
c) An identified resident's plan (diet list) stated they required a no spill sippy cup with lids. The resident was given her beverage in a regular cup with a straw. s.6.(7)
10. The care set out in the plan of care for an identified resident was not provided to the resident as specified. The resident had a physician order and a plan for a minced textured diet with blended soups, however, the resident was provided regular soup and a regular textured entree (stir fry and vegetables) at the lunch meal November 28, 2011. The diet list in the servery which provides direction to staff portioning meals also identified the resident required a minced diet and blended soup. The resident had a physician order for weekly weights, however, weekly weights were not consistently taken and recorded (as per the computerized charting and Resident Recordings binder). A recorded weight was not taken for the weeks of August 14-20, September 11-17, October 9-15, and October 16-22, 2011. Staff confirmed that weekly weights were not recorded as required. s.6(7)
11. The written plan of care for an identified resident did not set out clear directions to staff and others who provided direct care to the resident. The resident wore pull up briefs. The resident's written plan of care and kardex stated the resident was continent. The Facility Resident Profile Worksheet for December 12, 2011 identified the resident as being incontinent and using their own pull up brief and yellow liners. The staff confirmed the resident was incontinent, used pull up briefs, and they needed staff assistance with toileting. The quarterly review of November, 2011 stated the resident was frequently incontinent of bladder. s.6(1)(c)
12. The written plan of care for an identified resident did not set out clear directions to staff and others who provided direct care to the resident. The plan of care, updated on the computer in November, 2011, was not the same as the hard copy for the PSWs, dated September, 2011. PSWs did not have access to the computer. The hard copy did not identify the use of bed rails for the resident when in bed, however the plan of care, available to the registered staff (computerized), identified the resident was to have 2 bed rails up while in bed. The PSWs confirmed they used 2 bed rails when they put the resident to bed and were unaware that their plan of care was not the same as the one used by Registered Staff. s.6(1)(c)

13. The written plan of care did not set out clear directions to staff and others who provided direct care to an identified resident. The resident wore pull up briefs. The resident's written plan of care stated the resident was incontinent but did not identify the incontinent product being used. The resident's kardex stated the resident was occasionally incontinent and wore pads/briefs but did not identify the type of brief. The Facility Resident Profile Worksheet for December 12, 2011 identified the resident as being incontinent and using their own pull up brief. The home's policy "Elimination Bowel and Bladder" (05-04-08) stated that the written plan of care must identify the incontinent product the resident is currently using. The staff confirmed that they applied a pull up brief on the resident.
An identified resident wore pull up briefs. The resident's written plan of care stated the resident was incontinent and wore a yellow liner in their underwear. The resident's kardex stated the resident was incontinent and wore pads/briefs but did not identify the type of brief. The Facility Resident Profile Worksheet for December 12, 2011 identified the resident as being incontinent and using her own pull up brief. The staff confirmed that the resident was incontinent and they applied a pull up brief. s.6.(1)(c)
14. The plan of care for an identified resident did not set out clear direction to staff and others who provided direct care related to continence needs. The quarterly assessment of July 18, 2011 stated the resident was occasionally incontinent of bladder. The quarterly assessment of October 17, 2011 stated the resident was frequently incontinent of bladder. Staff were able to provide reason for the change in incontinence. The resident's written plan of care did not include current interventions for resident's continence needs. s.6(1)(c)
15. Staff and others who provided direct care to a resident did not have convenient and immediate access to an identified resident's written plan of care. In December, 2011 the resident was moved from one home area to another home area. The hard copy of the resident 's written plan of care was not moved to the new home area where it would be conveniently and immediately accessible to the staff. PSWs did not have access to the computerized written plan of care. s.6.(8)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident care needs change or the plan has not been effective, the written plan of care sets out clear directions to staff and others who provide direct care to the resident, and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: 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 subsections:

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.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure residents admitted to the home were screened for tuberculosis (TB test) within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and documented.
Six identified residents admitted to the home in 2010 and 2011 did not receive their TB tests within 14 days of admission and two residents had not received the test at the time of this inspection.
The RN's confirmed the nursing staff document TB testing on the Medication Administration Records (MARs). The Director of Care confirmed all testing related to TB had not been completed in an appropriate time. s.229.(10)1
2. The licensee did not ensure that all staff participated in the implementation of the infection control program. The policy for Hand Hygiene (02-05) stated hands were to be washed before and after any care. A RPN was observed to administer medications to several residents. The RPN was observed giving supplements and medications to residents, wiping their mouth and then returning to the medication cart without washing or sanitizing her hands before proceeding to administer medication to another resident. She was observed to do this between three residents. s.229.(4)
3. The licensee did not ensure that all staff participated in the implementation of the infection control program. The policy for Hand Hygiene (02-05) stated hands were to be washed before and after any care and before handling any food. A PSW was observed removing soiled dishes and cups from the coffee/tea cart at lunch on a home area, then received a bowl of soup for a resident and began to feed him, however did not wash her hands between the two actions. 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 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 this screening are available to the licensee, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. Not all foods were stored using methods which prevented adulteration, contamination and food borne illness on November 28, 2011.
The Home's policy related to the storage of leftovers stated foods should be used within 48 hours or if not used, frozen in the freezer. During the tour of the kitchen the following items were observed in the refrigerators:
a) sandwiches for 5 days
b) butterscotch pudding for 7 days - the pudding was separating with liquid settling on top.
c) strawberry pudding for 9 days- the pudding appeared watery.
During interview, the Cook stated leftovers are kept for 4 days and then discarded. The Food Service Manager confirmed the items were stored too long in the refrigerator. s.72.(3)(b)
2. Not all foods were prepared, stored, and served using methods which preserved taste, nutritive value, appearance and food quality. Foods prepared for the minced and pureed texture meals were prepared too far in advance of meal service. Foods were cooked and ready for hot holding at 10:30 a.m for the 12:00 p.m and 12:30 p.m lunch meals. Interview with the Food Service Manager confirmed that the items were prepared too far in advance of meal service. Hot holding for extended times effects nutritive value and food quality. s.72(3)(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 all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality; and prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee failed to provide a staffing plan which included a staffing mix that was consistent with residents' assessed care and safety needs. An identified resident had been assessed as needing assistance for safe transferring and had a chair alarm in place on their wheelchair. The resident was observed by an inspector attempting to stand and their wheelchair alarm activated and the resident was at immediate jeopardy of falling. It took 10 minutes for a PSW to respond to the resident's safety needs. The PSW stated it took her a long time to respond to the resident's safety needs because she was assisting another resident who required 2 staff, and the remainder of the staff were at break.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

The home failed to ensure that an identified resident was restrained by the use of a physical devise, other than in accordance with section 31. The home failed to ensure the plan of care include an order by the physician for the identified resident for a front fastening seat belt while in wheelchair. The resident was observed on 3 occasions to have a front fastening seat belt while in wheelchair. According to interview with staff on the unit the resident is unable to undo the seatbelt and the seatbelt is not used as a Personal Assistance Services Device (PASD).

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written policy to minimize the restraining of residents and ensure that any restraining that is necessary was done in accordance with this Act and the regulations, and ensure that the policy was complied with. The home's policy related to physical restraints did not include manufacturer's instructions for the safe application of front fastening seat belts.
Four identified residents were observed to have incorrectly applied front fastening seat belts in place on multiple dates during the inspection period. The Administrator confirmed they did not have the current instructions related to the safe application of front fastening seat belts in the home. s.29(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 there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and is complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The home failed to ensure staff used safe positioning techniques when assisting residents. An identified resident was observed on 2 occasions in the main lounge of a home area in a geri chair. On both occasions the resident had slid down in the chair and was in an unsafe position with risk of injury. s.36

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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
(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 did not ensure that topical prescription medications were stored in an area or a medication cart that was secured and locked for 5 identified residents. The topical creams were observed to be stored in these residents' bathrooms, and at the bedside in multiple home areas of the home including the secure unit, making them accessible to other residents. The RN confirmed topical medication creams should be kept in the registered staff medication cart. PSWs confirmed they were aware resident's topical prescription medications were to be stored in an area or medication cart that was locked. s.129(1)(a)

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care