Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2015	2015_332575_0007	S-000792-15	Resident Quality Inspection

Licensee/Titulaire de permis

FINLANDIA NURSING HOME LIMITED
c/o Sudbury Finnish Rest Home 233 Fourth Avenue SUDBURY ON P3B 4C3

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

FINLANDIA HOIVAKOTI NURSING HOME LIMITED
233 FOURTH AVENUE SUDBURY ON P3B 4C3

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

LINDSAY DYRDA (575), SYLVIE LAVICTOIRE (603), TIFFANY BOUCHER (543), VALA MONESTIME BELTER (580)

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): April 13-17 and 20-24, 2015

In addition, the following Critical Incident log was also inspected: S-000820-15

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Clinical Officer (CCO), Director of Care (DOC), Director of Support Services, Housekeeping and Laundry Supervisor, Manager of Maintenance, Housekeeping Aides, Maintenance Staff, Dietary Aides, Care Plan Co-ordinator, Director of Life Enrichment, Volunteer Program Co-ordinator, Staffing Co-ordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Students, Families, and Residents.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

13 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 set out clear directions to staff and others who provide direct care to the resident.

Inspector #575 reviewed the resident's plan of care regarding skin and wound care. The inspector noted that the resident's care plan indicated that pictures were to be taken weekly of the resident's wound, however, the Treatment Administration Plan (TAR) indicated this was to be done only as needed.

The inspector reviewed the findings with staff member S #100. The staff member stated that they have never taken pictures of the resident's wound and stated that the intervention on the care plan might be old and that they would have to confirm with the RN.

The inspector interviewed the S #101 and they confirmed that the intervention in the care plan regarding taking pictures weekly of the resident's wound should have been removed as it was an old intervention and the picture as needed intervention on the TAR was correct. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #014 set out clear directions to staff and others who provide direct care to the resident.

Inspector #543 reviewed the resident's care plan and identified that it did not indicate that resident #014 displayed wandering behaviours.

Inspector #543 reviewed the resident's Point of Care (POC) documentation for wandering behaviour for a period of approximately three months which identified the following:

Month #1: signs of wandering occurred 43% of the time;
Month #2: signs of wandering occurred 32% of the time;
Month #3: signs of wandering occurred 17% of the time.

Inspector #543 reviewed the resident's POC documentation wandering behaviour and whether or not the behaviour was easily altered, for the same period which identified the following:

Month #1: behaviour was NOT easily altered 84% of the time;
Month #2: behaviour was NOT easily altered 80% of the time;
Month #3: behaviour was NOT easily altered 100% of the time.

Inspector #543 reviewed the home's policy titled 'Prevention and Treatment of Responsive Behaviour' which indicated that the Registered Staff would develop an individual resident's care plan or update the existing care plan to reflect the responsive behaviours displayed by the resident, including behaviour patterns, potential triggers, as well as interventions to manage the behaviours.

Inspector #543 interviewed S #101 who stated that resident #014 wanders on the unit and occasionally will wander in and out of other resident's rooms. They also stated that the resident's care plan should indicate that the resident wanders.

The inspector also interviewed S #102 about resident #014's responsive behaviours and they stated that sometimes the resident can be physically or verbally aggressive, but most of their behaviours are wandering related.

Inspector #543 interviewed S #401 regarding resident #014's care plan not addressing the resident's wandering behaviours. They confirmed after reviewing the resident's care plan that it did not address the wandering. They also confirmed that typically this type of behaviour would be identified in the resident's care plan. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided

to resident #002 as specified in the plan.

Inspector #575 observed resident #002 on several occasions throughout the inspection with facial hair above their top lip and several long hairs on their chin.

The resident's care plan indicated that the resident required assistance for personal hygiene including the daily maintaining of appearance and staff were to provide constant supervision with set up and step by step instructions to wash hands, face, and comb hair and staff were to provide the remainder of care.

On April 17, 2015 during an interview, S #200 caring for resident #002, stated that they did not notice the resident's facial hair. The staff member stated that the expectation for shaving residents is that staff complete the task during bath days or at any time when they notice the resident needs to be shaved.

The inspector interviewed S #201 regarding the expectation of shaving residents' facial hair. The staff member stated that staff are expected to shave residents when they need it and that some staff shave only on bath days. Later, the staff member approached the inspector and stated that they observed the resident and agreed that the resident had facial hair that should be removed.

During another interview, S #202 stated that the shaving of residents is completed during resident bath days or during morning care. They indicated that PSWs document this task on POC under 'personal hygiene'.

The inspector reviewed resident #002's flow sheets for a period of approximately four months. Under personal hygiene, 'was a shave/trim completed' the documentation indicated that this task was only completed on two occasions and was refused on one occasion; all other responses indicated that a shave/trim was not completed or not applicable.

The inspector interviewed S #401 and they indicated that the expectation is that residents are shaved if needed and if they refuse it should be documented as 'refused'. They stated that if it is documented as 'no' or 'n/a', there was no need to shave the resident. They further indicated that if the resident does not prefer to be shaved that it should be documented as such in the resident's care plan.

Inspector #580 observed resident #002 receiving morning care in bed from S #203. The

inspector observed significant facial hair on the upper lip and several very long strands of hair under the chin. The staff member confirmed that the resident had long facial hair that should be shaved. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the plans of care for resident #001 and #014 set out clear directions to staff and others who provide direct care to the residents and that the care set out in the plan of care is provided to resident #002 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy titled 'Skin Care and Wound Management' was complied with.

Inspector #575 reviewed resident #001's health care record and noted that the resident had a wound.

According to the home's policy titled 'Skin Care and Wound Management' last reviewed May 2014, staff are to measure the resident's wound using an accurate and appropriate measuring tool initially, weekly, and as needed and document in Point Click Care (PCC).

The policy further indicated that staff are to assess the wound and document the following information: stage/depth, location, surface area, odour, sinus tracts/undermining/tunneling, exudate, appearance of the wound bed, and condition of surrounding skin and wound edges.

The resident's care plan indicated that staff are to monitor and record the dimensions of the wound, stage, odour, exudate and other relevant characteristics of the wound. The inspector reviewed the 'wound care' progress notes for a period of approximately three months and noted that the resident's wounds were only measured on two occasions.

During an interview, staff member S #106 stated that weekly assessments are to be indicated on the TAR and completed under 'wound care' progress notes. The staff member also stated that they are required to measure wounds but admitted that it does not always get done. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy titled 'Skin Care and Wound Management' was complied with.

Inspector #575 interviewed staff member S #106 who stated that skin assessments are to be completed on PCC under the assessments tab 'skin assessment' within 24 hours of admission and quarterly.

The inspector reviewed the home's policy titled 'Skin Care and Wound Management' last reviewed May 2014 that indicated each resident shall receive a skin assessment and Braden Scale assessment in PCC within 24 hours of admission.

The inspector reviewed resident #008's health care record and noted that the skin assessment was not completed until three days after the resident was admitted and the Braden Scale was not completed until seven days after the resident was admitted). [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's policy titled 'Medication Storage and Insulin Audit' was complied with.

On April 22, 2015, Inspector #575 observed a medication cart. The inspector noted two insulin pens in the cart not labelled with a date. Staff member S #103 confirmed the findings with the inspector and stated that it is the home's policy to label insulin pens when they are removed from the fridge.

The home's policy titled 'Medication Storage and Insulin Audit' last reviewed June 2, 2014 was reviewed by the inspector. The policy indicated that insulin is to be dated to reflect when it was removed from the fridge and/or when opened and is to be discarded after 28 days. [s. 8. (1) (b)]

4. The licensee has failed to ensure that the home's policy titled 'Prevention and Treatment of Responsive Behaviour' was complied with.

Inspector #543 reviewed the home's policy titled 'Prevention and Treatment of Responsive Behaviour' which indicated that registered staff would develop an individual resident's care plan or update the existing care plan to reflect the responsive behaviours displayed by the resident, including behaviour patterns, potential triggers, as well as interventions to manage the behaviours.

Inspector #543 reviewed resident #014's POC documentation for wandering behaviour for a period of three months which identified the following:

Month #1: signs of wandering occurred 43% of the time;
Month #2: signs of wandering occurred 32% of the time;
Month #3: signs of wandering occurred 17% of the time.

The inspector reviewed the resident's care plan, specifically related to wandering behaviours and identified that the care plan did not indicate that this resident displayed these behaviours. [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 ensuring that the home's policies titled 'Skin Care and Wound Management', 'Medication Storage and Insulin Audit', and 'Prevention and Treatment of Responsive Behaviour' are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Nutrition Care and Hydration Program include a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

Inspector #543 conducted a random audit of ten residents' heights, and how often they were measured and recorded and identified that 8/10 residents did not have their height taken on their admission date and 10/10 did not have their height re-taken on an annual basis.

On April 21, 2015, Inspector #543 interviewed S #401 regarding the home's process of measuring residents' heights and they confirmed that heights are to be taken upon the resident's admission as stated in the home's policy.

Inspector #543 reviewed the home's policy 'Height-Recording/Monitoring' which stated that a resident's height is measured and recorded on admission.

Resident's heights were not always completed on admission and annually as required. [s. 68. (2) (e) (ii)]

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 ensuring that that the home's Nutrition Care and Hydration Program includes a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #4: 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: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On April 13, 2015, Inspector #603 observed three residents (#015, #018, #019) who received soup for lunch. The soup was not offered to them (it was just served to them without asking) or other residents and was not an item on the menu.

During an interview, S #104 explained that staff know which resident wants soup for lunch and they know this by having worked in the home area for some time. The staff member also explained that such a preference is indicated on the residents' list for likes and dislikes, which is kept at the servery.

Inspector #603 reviewed the residents' list for likes and dislikes. The inspector noted that the list did not indicate that resident #015, #018, and #019 preferred or required soup at lunch, and yet they all received one. On the same list, resident #020 indicated that they liked soup at lunch and the resident did not receive soup for lunch. The same list also indicated that one resident preferred not to eat a certain food however they were served that food item and observed to pick out that item from their meal and then proceeded to eat. [s. 73. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, 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:

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

Findings/Faits saillants :

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

Inspector #575 observed medication administration in one home area. During this time, the home area was experiencing a respiratory outbreak. The inspector observed S #105 administer medication to resident #002 and no handwashing was observed before or after administration. Then, S #105 administered medication to resident #007 and no handwashing was observed before administration. During the administration, S #105 came out of resident #007's room to apply gloves; one glove was applied, another glove was dropped on the floor, picked up and thrown in the garbage and a new glove applied. No handwashing was observed before applying the gloves. Handwashing was only observed after administration of the medication to resident #007.

The home's policy titled 'Hand Hygiene' last reviewed March 2015 indicated that hand hygiene is required before and after contact with any resident, between different procedures on the same resident, before and after performing invasive procedures, before preparing, handling, serving or eating food or feeding a resident, after assisting residents with personal care, before putting on and taking off gloves, after performing personal functions, and when hands come into contact with secretions, excretions, blood and body fluids. [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 ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to live in a clean environment.

Inspector #603 observed a resident room as having a lingering offensive odour described as a foul smell in the room and a very strong urine smell in the bathroom.

Approximately seven days later, Inspector #543 observed the same room to have a foul odour of urine and feces.

For a period of two days, Inspector #580 observed a piece of vinyl type flooring in the corner of the same room to have a significant amount of dirt under it. The room also had a foul smelling odour, the bathroom smelled heavily of urine and the bathroom floor was stained.

During an interview, S #301 confirmed that the piece of vinyl type flooring in the corner of resident's #003's room was dirty and had not been cleaned in some time. They further indicated that the bathroom smelled of urine, the bathroom floor looked stained, and that the bedroom and the bathroom flooring required a complete cleaning.

During an interview, S #302 confirmed that the room and its bathroom had a strong smell of urine. They also stated that they and the Administrator do monthly walk-throughs of the home and complete audits to identify problem areas. The staff member indicated that they had not entered this specific room in several months, that the housekeeping aide told them that they did not know they had to clean under the vinyl area and that no one had complained of any smell in that room.

Inspector #580 reviewed the home's 'Daily Room Cleaning' policy dated October 2007 that indicated that basic cleaning is to be performed on a daily basis including wipe up spills on the floor, sweep floor from the back of the room and work towards the door, spot

mop if required, remove and clean raised toilet seat and seat below, use the microfiber mop, and start at the back of the room and work towards the door. The home's 'Bathroom Floor Deep Cleaning' policy dated May 2012 indicated that deep cleaning of the bathroom floor is to be completed once a month.

On April 23, 2015 the Administrator confirmed to Inspector #580 that the home's staff signed-off the complete cleaning of the room, however they did not address the lingering odour problem in the room or the bathroom, did not address the floor stain in the bathroom and did not clean under the vinyl flooring. [s. 3. (1) 5.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system can be easily seen, accessed, and used by residents, staff and visitors at all times.

Inspector #575 observed the call bell cord in a shared resident bathroom. The inspector

noted that the call bell cord was wrapped around the towel rack and the call bell was not activated when the call bell cord was pulled by the inspector. Approximately five days later, the inspector observed that the call bell cord remained wrapped around the towel rack.

The inspector and S #106 observed the call bell in the bathroom. The staff member indicated that the cord should not be wrapped around the towel rack and observed that the bell did not work when the cord was pulled. The staff member unraveled the cord and subsequently the call bell worked.

The home's policy titled 'Call Bell Assistance' last reviewed May 2014 indicated that every resident will have access to a call system to request assistance and the the nursing staff will ensure that the call bell cord is secured and within easy reach for the resident while in bed, up in a chair or in the bathroom.

Resident #004 and #011 shared the bathroom. The inspector noted that both residents' care plans indicated that the staff are to ensure the call bell is within reach at all times. [s. 17. (1) (a)]

2. For a period of eight days, Inspector #575 and #580 observed resident #013's call bell cord which was not easily seen or accessed and was placed on the floor past the foot of the resident's bed.

Inspector #580 observed resident #013 lying on their bed and the resident's call bell cord was on the floor at the foot of the bed. Resident #013 confirmed to the inspector that if they wanted the staff to attend to them, they would call them. When asked by the inspector if they would use the call bell, resident #013 said yes, but they were not able to locate the call bell cord.

Inspector #580 reviewed the home's 'Call Bell Assistance' policy dated May 2015 which indicated that every resident would have access to a "call" system to request assistance and that staff are to ensure that the call bell cord is secured and within easy reach for the resident while in bed.

During an interview, S #204 confirmed that the call bell cord should be attached in such a way that the resident could reach it. [s. 17. (1) (a)]

3. For a period of eight days, Inspector #575 and #580 observed resident #009's call bell

cord not easily seen or accessed and was placed on the floor while the resident was lying in their bed.

Inspector #580 reviewed the home's 'Call Bell Assistance' policy dated May 2015 which indicated that every resident would have access to a "call" system to request assistance and that staff are to ensure that the call bell cord is secured and within easy reach for the resident while in bed.

During an interview, S #204 confirmed that a call bell cord should be attached in such a way that the resident could reach it. [s. 17. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

During an interview, S #401 confirmed that a dental hygienist attends to the home, that consent is obtained from the resident and that the hygienist documented in the progress notes. Staff member S #101 confirmed to the inspector that the home offered the services of a dental hygienist to residents upon admission and annually.

During an interview, S #100 confirmed to the inspector that for resident #011, there was no documented evidence of dental hygienist services being offered or a consent form offered or signed.

The inspector reviewed the home's 'Medical/Referral Services' policy dated May 2014 which indicated that a dental assessment and preventative services performed by qualified dental professionals shall be offered to residents annually – a Dental Consent Form is to be completed by the resident/SDM during the admission process and the dental hygienist would be on-site for assessments and treatments accordingly.

The inspector reviewed resident #011's electronic and hard copy health care record and found no documentation of the home offering the services of a dental hygienist to resident #011. [s. 34. (1) (c)]

WN #9: 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, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu substitutions were communicated to the residents and staff.

Inspector #603 reviewed the posted daily and weekly menus in one home area. Both menus had sweet potato fries as an item for lunch, however, these were not served. They had been substituted with hash browns.

During an interview with S #104 they explained that there were no sweet potatoes to serve and that they do not make the changes on the menu as the residents do not read or are not capable of reading the posted menus. Another staff member S #300 confirmed that the sweet potatoes had been substituted with hash browns and that the staff do not typically communicate the changes to the residents.

Inspector #603 also reviewed the posted daily and weekly menus in another home area and again the posted menus indicated sweet potato fries, however, these were not served. They had also been substituted with hash browns and not communicated to the residents and staff.

On April 15, 2015 Inspector #603 interviewed S #303 who explained that any menu substitutions are communicated with the dietary aides, who will then make the changes on the posted menus for residents and staff. [s. 72. (2) (f)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are implemented for cleaning resident bedroom floors.

Inspector #603 observed a resident room as having a lingering offensive odour described as a foul smell in the room and a very strong urine smell in bathroom.

For a period of two days, Inspector #580 observed a piece of vinyl type flooring in the corner of the same room to have a significant amount of dirt under it. The room also had a foul smelling odour, the bathroom smelled heavily of urine and that the bathroom floor was stained.

During an interview, S #301 confirmed that the piece of vinyl type flooring in the corner of the room was very dirty and had not been cleaned in some time. They further indicated that the bathroom smelled of urine, the bathroom floor looked stained, and that the bedroom and the bathroom flooring required a complete cleaning. Another staff member (S #304) confirmed that the housekeeping staff had enough supplies and that supplies are easily accessible to clean the home.

During an interview, S #302 confirmed to the inspector that they and the Administrator do monthly walks through the home and complete audits to identify problem areas. They

indicated that they had not entered this specific room in several months, the housekeeping aide told them that they did not know they had to clean under the vinyl area and that no one had complained of any smell in that room.

Inspector #580 reviewed the home's 'Daily Room Cleaning' policy dated October 2007 that indicated that basic cleaning is to be performed on a daily basis including: wipe up spills on the floor, sweep floor from the back of the room and work towards the door, spot mop if required, remove and clean raised toilet seat and seat below, use the microfiber mop, and start at the back of the room and work towards the door. The home's 'Bathroom Floor Deep Cleaning' policy dated May 2012 indicated that deep cleaning of the bathroom floor is completed once a month.

Inspector #580 reviewed the home's housekeeping cleaning checklist that lists cleaning duties for housekeeping staff. The inspector reviewed the home's WORX report indicating that in-unit cleaning for this room was completed for a period of approximately seven weeks.

The Administrator confirmed to the inspector that the staff signed-off the complete cleaning of the room, however they did not address the floor stain in the bathroom and did not clean under the vinyl flooring. [s. 87. (2) (a)]

2. The licensee failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

Inspector #603 observed a resident room as having a lingering offensive odour described as a foul smell in the room and a very strong urine smell in bathroom.

Approximately seven days later, Inspector #543 observed the same room to have a foul odour of urine and feces.

For a period of two days, Inspector #580 observed that the same room had a foul smelling odour and that the bathroom smelled heavily of urine.

During an interview, S #301 confirmed that the bathroom in this room smelled of urine. During another interview, S #304 confirmed that housekeeping staff had enough supplies, that supplies are easily accessible to clean the home, that staff reported odours to housekeeping staff, that housekeeping staff note lingering odours on their daily cleaning rounds, that they clean and scrub to try to get rid of the odours and that they

use odour eliminating pucks.

During an interview, S #302 confirmed to the inspector that they and the Administrator do monthly walks through the home and complete audits to identify problem areas. They stated that they had not entered this specific room in several months and that no one had complained of any smell in that room.

Inspector #580 reviewed the home's 'Minimizing Odours' policy dated July 2010 which indicated that staff are encouraged to report incidents of ongoing odour problems to the housekeeping and laundry supervisor, that air eliminating discs are used in key areas, that an odour eliminating solution is applied and that lingering odours are a part of regular monitoring.

Inspector #580 reviewed the home's housekeeping cleaning checklist that lists cleaning duties for housekeeping staff. The inspector reviewed the home's WORX report indicating that in-unit cleaning for this room was completed for a period of approximately seven weeks.

On April 23, 2015 the Administrator confirmed to Inspector #580 that the staff signed-off the complete cleaning the room, however they did not address the lingering odour problem in the room or the bathroom. [s. 87. (2) (d)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are implemented to ensure that grab bars are maintained.

Inspector #575 observed the grab bar in the bathroom of a resident room to be loose. Inspector #580 observed and noted the grab bar to still be loose approximately six days later.

During an interview, S #201 confirmed to Inspector #580 that the staff had reported the loose grab bar in the bathroom of the room 'a thousand times', that the grab bar had been like that for at least a month and that it is used by resident #008.

During an interview, S #305 confirmed that any staff in the home can report a maintenance concern through the electronic reporting system called WORX, that repair priorities are resident safety items, that maintenance staff check problems as well by keeping their eyes open and that they did not remember any reports to repair the grab bars in that room.

Inspector #580 reviewed the home's WORX report that indicated for a period of approximately seven weeks there were no maintenance reports of concerns from staff regarding regarding the grab bars in the bathroom of that room.

During an interview, S #306 confirmed that the home relies on staff reports on WORX regarding any problems with grab bars, that the maintenance department does walk-through audits of the home, that during the audits maintenance staff should look at grab bars but that there is no written policy or procedure to review grab bars when doing the audits or at any other occasion, that in 2014 and to-date in 2015 there have been no loose grab bars reported in the audit or in WORX and that the grab bars in that room were assessed and repaired after the inspector brought it forward, but that the staff member did not think the grab bar was loose. [s. 90. (2) (d)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy titled 'Restraints and PASD's: Physical, Chemical, and Environmental' deals with how consent is to be obtained and documented for the use of Personal Assistive Services Devices (PASD).

Inspector #543 reviewed the home's policy titled 'Restraints and PASD's: Physical, Chemical, and Environmental'. Informed consent, as per the policy; a written consent form is signed within one week of restraint application. The policy described how consent is to be obtained for a restraint however, it did not address how consent was to be obtained and documented for the use of a PASD.

During an interview, S #107 confirmed to inspectors #543, #575 and #580 that the home assigned a PASD to a resident on admission based on the information provided in the CCAC package. They further indicated that within 14 days a further informal assessment is to be completed to confirm the continued or new need for a PASD and that during the quarterly care conference the interdisciplinary team reviews the need for a PASD and if there are any changes it would be documented in the quarterly write up; if there are no changes, the quarterly conference date is noted and signed off on the care plan. The staff member confirmed that the home did not have a consent form specifically related to PASDs.

Inspectors #543, #575 and #580 confirmed with S #401 that the home had no formal consent form for residents to sign prior to use of a PASD. The staff member stated that the home would be updating the policy to specifically address how the home will obtain consent for the use of a PASD. [s. 109. (e)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Inspector #575 observed the medication room in one home area with staff member S #103. The staff member stated that the home's emergency supply of controlled substances were not stored in the medication room and that they were stored in the charge RN office. The inspector and S #108 confirmed and observed the controlled substances box in the charge RN office (not stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies). [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #575 and S #103 observed the medication room and medication cart one home area. The staff member stated that controlled substances for resident use are locked in a separate drawer within the locked medication cart and that the home's emergency supply of controlled substances were stored in the charge RN office and additionally, there was an emergency supply of Lorazepam stored in the locked fridge.

The inspector observed the controlled substances box in the charge RN office located under a desk in a safe. During an interview, S #108 indicated that only the RN has the key to the safe and the room is locked when the RN is not present. Additionally, the inspector observed the controlled substance Lorazepam located in the medication area in a locked fridge, however it was not locked within the fridge.

The emergency supply of controlled substances were not locked in a separate, double-locked stationary cupboard in the locked area. [s. 129. (1) (b)]

Issued on this 20th day of May, 2015

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

Original report signed by the inspector.