Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 14, 2014 | 2014_200148_0006 | O-000065-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

GARDEN TERRACE
100 Aird Place, KANATA, ON, K2L-4H8

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

AMANDA NIXON (148), COLETTE ASSELIN (134), MEGAN MACPHAIL (551), WENDY PATTERSON (556)

## 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): February 4-7, and February 10-12, 2014, on site.

This inspection also included two Critical Incidents and a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Clinical Care Coordinator, Resident Assessment Instrument (RAI) Coordinator, Nutritional Manager, Environmental Services Manager, Life Enrichment Coordinator, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), Food Service Workers (FSW), Maintenance Assistant, Laundry and Housekeeping staff, residents and family members.

During the course of the inspection, the inspector(s) reviewed resident health care records, including plans of care and resident flow sheets. Several policies were reviewed including the Physical Restraints policy, Pressure and Wound Management policy, Infection Control and Prevention Management program and related line listings, immunization records and Outbreak Management Data form, the home`s Complaint Procedure policy. In addition drug destruction records, staffing schedules and staff education related to restraints were also reviewed. Inspectors also observed three meal services on two units, medication administration, resident care and staff to resident interactions.

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Food Quality**
**Hospitalization and Death**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Quality Improvement**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.15(2)(c),

whereby the licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following were observed by Inspector #134 on February 4, 2014 on 2nd floor West:
- The red armchair in the sitting room was observed to be soiled. A white stain was observed on the right hand side of the couch cushion. The partial wall was observed to have chipped paint and scratch marks. Several residents' bedroom doors were observed smeared with Purell and stained with finger marks.
- The walls were observed to be damaged in the sitting room
- The lower aspect of the wall close to the television, in lounge area off of dining room, was noted to be damaged
- The lock on the storage cabinet in the tub room was broken, the flooring in the tub room was stained with black marks.
- Dining room chair in the tub room was damaged and not appropriate as it is not made to withstand the moisture.

The following were observed by Inspector #134 on February 4, 2014 on 1st floor West (1W):
- Wall at entrance of sitting room was scratched. Top of half wall was damaged
- The paint in the dining room was scratched and chipped. Wall leading to hallway was scratched and damaged
- Linen room door was damaged and soiled.

The following were observed by Inspector #134 on February 4, 2014 on 3rd floor East:
- The wood surface by the window off the sitting area was damaged. [s. 15. (2) (c)]

2. The following were observed February 5, 2014 on the 4th floor East side by Inspector #148:
- At both lounge areas and in the dining room, the wood paneling that is located under the windows, were observed with extensive wear and scrapes along the surface.
- Throughout the hallway there was visible staining of walls and resident room doors near the location of the hand sanitizer dispenser, near resident room doors and on resident room doors
- At the television area, nearest to the dining room, damage was observed on the wall near the electrical outlet which included small areas of missing paint and exposed drywall.

The following were observed February 5, 2014 in the 4th Floor Shower/Tub Room by Inspector #148:
- Damage was observed at the door entrance, whereby the corner of lower door frame is missing a section of dry wall, exposing a metal surface.
- Within the shower area, two chairs with wooden legs are worn exposing a porous wood surface with visible blackened areas.
- The sliding door that divides the shower area was observed to be off the hinges and is not usable/movable. The floor below this door was worn.

The following were observed February 5, 2014 on the 4th floor West side by Inspector #148:
- Three sitting chairs, located in the lounge area near the administration offices, were observed with the bottom 3-6 inches worn exposing a porous wood surface.
- Throughout the hallway there was visible staining of walls and resident room doors near the location of the hand sanitizer dispenser.
- Outside of room 423, a gouge in wall exposing drywall was observed.
- At the television area, near the dining room the wall was observed with small damaged areas with exposed drywall.
- At the lounge area and in the dining room, the wood paneling that is located under the windows, was observed with extensive wear and scrapes along the surface.
- In the private dining area, off of the main dining room, there was an area of the floor approximately 5x2 inches in size, whereby the laminate surface is missing. [s. 15. (2) (c)]

3. The following were observed on February 4, 2014, by Inspector #556 on the 5th floor:
- Observed damage to the inside half wall in the lounge area by the 5th floor West dining room, and damaged to the table tops on three dining tables.
- The tub room has damage to the lower door jam of the interior door, damage to the wall beside the toilet, and black staining on the floor, in addition there were worn areas of carpeting in the 5th floor hallway between rooms 506-502, and the surface area of the half wall in the 5th West resident lounge area is damaged.
- 5th floor East was also noted to have damage to the surface of the half wall in the resident lounge area.

In addition, Inspector #556 also observed worn legs on arm chairs in the Resident lounge area of the 1st, 2nd, and 5th floors. Resident doors on unit 1 West and East, unit 2 East, and unit 5 West and East were observed to have staining of the paint

under the hand sanitizers as well as on the exterior surface of the resident room doors.

The following were observed on Feburary 4, 2014, by Inspector #556 on the 2nd floor:
-Second floor East dining room was noted to have damage to the surface of the partial wall, and the paint was chipped and faded on the wall in the dining room. All four dining room tables had damage to the surface, and the carpet in the dining room was stained and soiled.
- The second floor shower room was found to have a strong odour, and a cracked area on the sponge seat of the shower chair.
- In addition the finish on the wood surfaces throughout the second floor was noted to be scraped, cracked, and damaged.

The following were observed on February 4, 2014, by Inspector #556 on the 1st floor:
- Observed damage around the small square trap door in the lounge area ceiling, one table top in the dining room had a damaged surface, and there was damage to the paint on the wall in the dining room.
- Shower room was noted to have a strong odour, the floor was scraped and black in places, the caulking around the toilet in the tub room was peeling away and the wall was damaged beside the toilet. [s. 15. (2) (c)]

4. Resident #337, was observed throughout the inspection to be seated in a specialized chair with a tabletop. The resident's plan of care indicates that the resident requires the chair and tabletop for safety and due to disease process. The tabletop was observed with extensive damage. Resident #337's equipment is not in a good state of repair. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.31 (1) and (3), whereby the licensee did not ensure that all requirements were met under section 31 of the Act, as it relates Resident #414 being restrained by a physical device.

Throughout the inspection, Resident #414 was observed to be seated in a wheelchair with a physical restraint applied that prohibited the resident's movement out of the chair. Inspector #148 spoke to the resident who confirmed verbally and by demonstration, that he/she could not physically remove the restraint. Inspector #148 spoke with both a PSW and an RPN, both of whom are regularly responsible for the resident's care. Both staff members indicated that the resident spends most of his/her days seated in the wheelchair with the restraint in place. Both staff members reported that the restraint was not a new device for this resident but rather has been used by the resident for some time. Both staff members indicated that the resident is not able to remove the restraint and were not able to describe the reasons for the use of the restraint.

The health care record of Resident #414 was reviewed. The health care record did not contain reference to the use of a physical restraint for this resident. On a specified date, Inspector #148 spoke with the RAI Coordinator who confirmed that the current plan of care did not include the use of a restraint. She further confirmed that the device in place would be considered a restraint as the resident is not able to remove the device on his/her own.

On a specified date the Clinical Care Coordinator, approached Inspector #148 and reported that the physical restraint for Resident #414 was missed in past resident care audits and indicated that the resident's health care record (i.e physician orders, plan of care, assessment and monitoring) are currently being updated to include the use of the physical restraint.

In accordance with LTCHA section 31(1), the plan of care for Resident #414 did not include the use of a restraint.

In accordance with LTCHA section 31(3), there was no indication that licensee has complied with the requirements of subsection 3, including monitoring, release/repositioning and reassessment/evaluation of restraint in addition. [s. 31. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the physical restraint, currently being applied to Resident #414, comply with all requirements under LTCHA section 31, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

**s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,**
**(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).**
**(b) cleaned as required. O. Reg. 79/10, s. 37 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, s.37 (1)(a), whereby the licensee did not ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and of acquiring, in the case of new items.

The following were observed on the 4th floor by Inspector #148 over the course of this inspection:
-In a shared bathroom, 2 toothbrushes unlabeled, a pair of nail clippers with a label titled "room 107"
-In a shared bathroom, 2 shaving razors unlabeled, toothbrush in resident drawer unlabeled, nail clipper unlabeled
-Tub/Shower room on the 4th floor – unlabeled brush and an unlabeled comb both with visible hair
-In a shared bathroom, toothbrush unlabeled, a pair of nail clippers unlabeled
Within the 4th Floor utility room, a pair of nail clippers with a label titled "423" [s. 37. (1) (a)]

2. The following were observed by Inspector #556:
- In a shared bathroom two toothbrushes exactly the same were sitting on the bathroom counter and neither toothbrush was labeled. In addition three blue disposable razors were also unlabeled and sitting on the counter.
- In a second shared bathroom it was noted that two combs, a razor, and a tube of toothpaste were unlabeled and sitting on the bathroom counter.
- In a third shared bathroom, it was noted that there were two unlabeled combs lying on top of each other, two unlabeled toothbrushes, and an unlabeled tube of toothpaste on the bathroom counter. [s. 37. (1) (a)]

3. Inspector #148 interviewed personal support workers, however, a clear and consistent process for labeling of resident personal items could not be identified. The staff members indicated that the responsibility to label resident personal items is shared between the personal support workers, life enrichment and registered nursing staff.

The home's DOC reported to the Inspector #148 that labeling of personal items is the responsibility of the PSWs. Upon request for the home's policy related to the labeling of resident personal items, a policy reflecting the labeling of dentures was provided. The home's Administrator confirmed that at this time the home does not have a policy related to the labeling of all resident personal items. [s. 37. (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 each resident of the home has his or her personal items, including grooming and hygiene products labeled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with the O. Reg 79/10, s.50 (2)(b)(ii), whereby the licensee did not ensure that Resident #402 received immediate treatment and interventions to promote healing and prevent infection.

The home's policy "Pressure Ulcer and Wound Management # HLHS-SW-3.6" was reviewed. There is an entry under the subsection Infected /Colonized Wound, which indicates the following: "A chronic wound may become contaminated but not infected, the team must continually assess for clinical signs of infection. Under bullet #2 there is a statement which reads as follows: Consider high bacterial level if ulcer is

unresponsive to treatment ...or increased level of exudate /purulent discharge, malodour and hyper-granulation". There is another entry under bullet #5 that specifies to swab the wound using appropriate techniques

Resident #402 has an open wound. According to staff member #124 her dressing is changed every two to three days depending on the amount of exudate. The staff member added Resident #402 has purulent discharge from the wound on and off and it is treated with antibiotic.

Resident #402's wound assessment sheets from the past several months were reviewed. There were observations made during that time, that indicated the wound presented with evidence of infection. According to staff member #S124 the wound was not swabbed when these signs of infection were observed.

According to the home's policy there is an entry that indicates, to refer to Enterostomal Therapist (ET) or Wound Specialist and implement recommendations and to consult the Physician and Enterostomal Therapist to review the treatment if the size of wound has not decreased by 20-30% in 3-4 weeks. According to the wound assessment records, Resident #402's wound increased in size. According to staff member #124, no referral was sent to the ET nurse for an assessment due to a change in the MOHLTC's High Intensity Needs Funds program.

The physician's orders were reviewed by the Inspector and there is a recent medical order for diuretic and antibiotic to address the swelling and signs of infection related to the wound. The physician order was not received until several months after the initial signs of infection were observed by registered nursing staff.

The last ET consult was over 1 year ago. Recommendations were left related to the treatment of the skin wound, including irrigation and dressing. This treatment order was not ordered or renewed by the physician on a quarterly basis and the treatment was not reviewed when Resident #402's skin wound condition deteriorated.

The evening RN #135 and the DOC were interviewed by Inspector #134 and they indicated that the irrigation treatment should be ordered by a physician, as residents may react to it.

During the course of this inspection, Resident #402 was interviewed by the inspector and reported that his/her wound has leaked heavily onto clothing items; the resident

added that his/her pain related to the wound is managed by an analgesic. [s. 50. (2) (b) (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 to ensure residents exhibiting altered skin integrity receives immediate treatment and interventions to promote healing and prevent infection as per the home's policy, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.6(4)(b), whereby the licensee did not ensure that the staff involved in the different aspects of the care of the resident collaborate with each other 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.

The treatment record for Resident #386 for a specified month indicates that the resident is currently provided with treatment for an open wound on a lower extremity. In addition to this wound the observation records for a specified month indicated the resident has two other reddened areas. The most recent Skin Condition Assessment, indicates an open wound on the same lower extremity with the same two reddened areas.

The most recent Minimum Data Set (MDS) Resident Assessment Protocol, also indicated an open wound due to pressure ulcer. The most recent nutritional assessment indicated the requirement for nutritional intervention for wound healing.

The most recent plan of care, for Resident #386 under Skin Integrity, does not indicate an open wound is present for this resident. The goal of this item is for the resident to remain free from preventable skin breakdown.
The plan of care under Altered Skin Integrity indicates two open wounds, one of which does not match the above noted assessments. The goal of this care plan item is to provide the resident with adequate nutrition to promote wound healing with interventions that include nutritional supplements.

The staff did not collaborate with each other in the development of the plan of care, for Resident #386, as it relates to skin integrity and wounds, to ensure that the plan of care is integrated and consistent. [s. 6. (4) (b)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, s.17(1)(a), whereby the licensee did not ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

On a specified date and time, Inspector #551 observed Resident #012's call bell to be tightly wrapped around the right (approximately quarter length) bed rail at the head of the bed which was in the down position. Several minutes later, staff member #S124 entered Resident #012's room. The Inspector asked staff member #S124 if resident #012's call bell was within reach. Staff member #S124 stated that it was not and corrected the situation.

The licensee did not ensure that Resident #012's call bell was easily seen and accessible by the resident. [s. 17. (1) (a)]

**WN #7: 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:**

**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 2007, c. 8, s. 29 (1).**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.29 (1)(b), whereby the licensee did not ensure that their 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, is complied with.

The home's policy #CS-5.6 entitled Personal Assistive Safety Device (PASD) and Restraint Monitoring states that a member of the Registered staff shall reassess the need for a physical restraint every eight hours while the resident is awake, or more often according to the needs of the resident and indicate that this has been done by initialing the Restraint Monitoring Form in the Needs Reassessed column. The policy also states that a member of the nursing and personal care staff shall release, reposition and reapply the physical restraint for the resident's safety and comfort every hour while the resident is awake or more often according to the needs of the resident. All monitoring and repositioning shall be recorded on the restraint monitoring form.

A review of Resident #309's health care record indicates a physician's order for a physical restraint.

The resident's care plan indicates under the problem of Safety Devices/Restraints, that Resident #309 requires a physical restraint and that PSW staff are to complete the restraint sheet each shift and Registered Staff are to sign the restraint sheet each shift.

In an interview, the Clinical Care Coordinator stated that PSW's are required to monitor any resident who has a restraint, the restraint is to be removed every hour, the resident repositioned, and then the restraint reapplied. The PSW's are to complete the restraint monitoring form every shift, and the Registered Staff are required to reassess the restraint and initial the restraint monitoring form at the end of each shift.

In an interview the Director of Care confirmed that the provision of care for Resident

#309's includes the use of a physical restraint.

In an interview staff member #S127 stated that the Registered Staff are to initial the restraint monitoring form following each shift to indicate that they have checked the resident and the restraint is being used and applied appropriately.

In an interview staff member #S108 stated that every hour any resident with a restraint is checked and repositioned, and that the restraint sheet is initialed to indicate that the checking and repositioning has been done.

A review of Resident #309's restraint monitoring form for a specified month indicates that the hourly check documentation was missed on several days including day, evening and night shifts. In addition, Registered Staff initials were missing on the night shift on 10 consecutive days along with 6 other days during the day and evening shifts that month. [s. 29. (1) (b)]

2. A review of Resident #386's health care record indicates a physician's order for more than one physical restraint. The resident's plan of care confirms the need for the physical restraints.
The restraint monitoring form, used by staff members to monitor the application of Resident #386's physical restraints, was reviewed for a specified month. The document indicates hourly monitoring of both restraint devices. However, as required by the home's policy #CS-5.6, registered nursing staff have not initialed the restraint monitoring form in the 'Needs Reassessed' column for any of the physical restraints used during that month for Resident #386. [s. 29. (1) (b)]

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**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).

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Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s.34 (1)(a), whereby the licensee did not ensure that Resident #389 received oral care to maintain the integrity of the oral tissue, including cleaning of dentures in the morning and evening.

On a specified date, Resident #389 was interviewed by Inspector #134 and reported that staff do not always take his/her dentures out at night and do not always wash his/her dentures. The resident indicated that he/she does not like to sleep with dentures in his/her mouth and added that only one staff member on the evening shift brushes and soaks the dentures.

On a specified date, staff member #129, who was self described as a float worker, was told by regular staff that the resident does his/her own mouth care. The staff member reported that he/she had not washed the resident's dentures that morning and had not reminded the resident to do mouth care either.

On a specified date, Inspector #134 inspected the resident's washroom and noted the resident's toothbrush was dry and there was no kidney basin, no toothpaste and no Polydent available.

The "PSW Observational Flow Sheets" for two specified months, were reviewed and there are 3 signatures indicating mouth care was not done.

The Kardex was reviewed and there was an entry indicating the resident has dentures and that the cleaning of dentures or mouth care is provided by the resident or staff, care was described to be provided twice daily.

Staff member #128 was interviewed and indicated Resident # 389's dentures are brushed after meals. She indicated the evening staff will usually soak the resident's dentures in Polydent but there are days where the staff member will find the resident in the morning with dentures in his/her mouth. The staff member indicated the resident does not always want to do his/her own mouth care and requires assistance from staff to brush his/her dentures in the morning. [s. 34. (1) (a)]

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**WN #9: 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:**
**4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10, s.73 (1)4., whereby the licensee did not ensure that the dining and snack service includes monitoring of all resident during meals.

On a specified date, Inspector #551 observed staff member #S119 delivering a meal tray to Resident #012 who was in his/her bedroom. The tray was removed from Resident #012's room several minutes later. Resident #012 was not monitored while eating in his/her room between the time the tray was delivered and collected. Staff member #S119 stated that Resident #012 does not require supervision while eating. Resident #012's care plan under meal location states that Resident #012 eats in his/her room with supervision.

The licensee failed to ensure that that Resident #012 was provided with monitoring during a meal service. [s. 73. (1) 4.]

**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85(3), whereby the licensee did not seek the advice of the Residents' Council in the development and carrying out the survey, and in acting on its results.

The home's Administrator reported to Inspector #148 that the last completed Resident Satisfaction Survey was completed in April 2013, with the next survey planned for the spring of 2014. The Administrator noted that the April 2013 satisfaction survey was not presented to the Residents' Council to seek their advice in the development and carrying out of the survey. The Administrator reported that this deficiency has been identified by the licensee and as such the licensee is currently working to resolve the issue.
The home's Administrator confirmed that the results of the satisfaction survey are shared with the Residents' Council for advice in acting on its results. [s. 85. (3)]

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**Issued on this 19th day of February, 2014**

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

Amanda Nixon RD LTCH Inspector