Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 2014	2014_214146_0024	H-001419-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF HALDIMAND COUNTY
45 Munsee Street, Box 400, Cayuga, ON, N0A-1E0

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

GRANDVIEW LODGE / DUNNVILLE
657 LOCK STREET WEST, DUNNVILLE, ON, N1A-1V9

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

BARBARA NAYKALYK-HUNT (146), MICHELLE WARRENER (107), THERESA MCMILLAN (526)

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): October 20, 21, 22, 23, 24, 27, 28, 29, 30, 2014 & November 6, 2014. Rebecca Wylie

The RQI was conducted concurrently with CI inspections #005753-14 and #000685-14; Complaint inspections H-000314-14, 000126-14, 001562-14 and 3 follow-up inspections H-000612-13. Findings of non-compliance are included in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Program Manager, Registered Dietitian (RD), Food Service Manager (FSM), Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Coordinator, Facility Operations Supervisor, registered staff, Nursing Quality Assurance nurse, Personal Support Workers (PSW's), scheduling coordinator, housekeeping staff, dietary staff,residents and family members.

During the course of the inspection, the inspector(s) toured the home; reviewed policies and procedures, meeting minutes, resident health records and observed residents in care areas and dining rooms

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
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 VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out, (c) clear directions to staff and others who provided direct care to the resident. 2007, c. 8, s. 6 (1).

A) Resident #050's progress notes indicated that the resident was found off the unit on three occasions and was injured on the third occasion. After the third occasion, a safety device was applied to monitor exiting attempts. Registered staff confirmed that the resident's care plan was not revised to address the changing needs or the new device.

B) In resident #002's plan of care, under the problem of resisting treatment, staff were directed that the resident was to be up in chair for two meals only. Under the focus of activity, the staff were directed that resident is up for one meal only. The care plan directions to staff were unclear.
This was confirmed by registered staff. (146)

C) Resident #030's RAI MDS assessment dated August 5, 2014 indicated that the resident was frequently incontinent of urine. The document the home referred to as the "care plan" for resident #030 indicated that the resident was on a scheduled toileting plan. The scheduling plan could not be located when the resident's clinical record was reviewed. Registered staff confirmed that resident #030's plan of care did not set out clear direction to staff who provided direct continence care to the resident.

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) Resident #002 was assessed by physio as having pain currently and for the past several months. The resident's most recent nursing assessment indicated the resident had no pain. The PSW's flow sheets for the month of October indicated that the resident had a sad/ pained facial 50% of the month. When interviewed, a PSW stated this was documented when the resident demonstrated pain by facial grimacing. This information was confirmed by registered staff. The physio and nursing assessments are not collaborative with each other.(146)

B) Resident #038's MDS assessment indicated that the resident did not use bed rails for bed mobility or transfer. A different section of the same MDS Assessment indicated that the resident used bed rails. Interview with registered and non registered staff indicated that the resident used rails for bed mobility. The RAI Coordinator confirmed that the assessment of resident #038's use of side rails was not consistent. (526)

C) Resident #038 used several devices for care needs. The resident's assessments were not consistent in their assessed use of devices.
The RAI Coordinator confirmed that inconsistencies in assessments were present in resident #038's plan of care. (526)

D) Assessments of resident #060's bowel management did not collaborate with each

other so that their assessments were integrated, consistent with and complemented each other. The assessments stated, in different areas, that the resident was both continent and incontinent of bowel; and constipated and not constipated.

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

A) Resident #002's plan of care indicated that an identified treatment could be administered every 4 hours as needed for expressed pain or observed signs of pain x 48 hours then reassess. The resident was observed to have expressed signs of pain. The treatment was not administered as per the care plan. This information was confirmed by the DOC and registered staff. (146)

B) Resident #030 was not provided toileting care as per the care plan. Registered staff confirmed that the resident was not toileted as specified in the plan of care.

C)Resident #038's plan of care directed staff to provide specific care at mealtimes. Care was not provided as per the plan of care. (107) [s. 6. (7)]

4. The licensee has failed to ensure that the plan of care was revised when the resident's care needs changed.

A) Resident #019's RAPS dated September 2014 indicated that the resident was a high falls risk. The current care plan (August 2014) being used by direct caregivers indicated that the resident was a low falls risk. The RPN stated that the care plan had not been updated since the resident's falls risk had increased and confirmed that the care plan needed to be revised. (146)

B) Resident #019's current care plan which was reviewed in September 2014 indicated that the resident was not to use a specific device because family requested that the resident not use the device. The progress notes from October 2014 indicated that nursing requested and received permission from the family to use the device. The resident was observed using the device. The resident's care needs had changed but the current care plan had not been revised. This information was confirmed by registered staff. (146)

C) Resident #30's mobility care needs changed and were not reflected in the current care plan. Interview with the physiotherapist indicated that as of October 2014,

resident #30 was able to ambulate using a device and with the assistance of one staff person to the bathroom and in the hallway. Resident #030's RAI MDS dated August 2014 indicated that the resident required limited assistance from one person while walking in their room. The document the home referred to as the "care plan" last completed on August 25, 2014 indicated that the resident required supervision with set up only for walking. Observation and interview with the resident confirmed that the resident required limited assistance rather than set up only as the resident was unsteady on their feet and had been asked by staff to wait for assistance when the resident wanted to get out of bed.
Registered staff confirmed that the plan of care had not been changed when resident #030's care needs changed. (526)

D) According to registered and non registered staff, resident #027 had required total care for dressing, bed mobility, bathing and shampooing and personal hygiene for approximately six months. Resident #027's RAI MDS assessment completed in August 2014 indicated that the resident had total dependence on staff for bed mobility, dressing, personal hygiene and bathing. The document the home referred to as "the care plan" completed in September 2014 indicated that the resident required extensive assistance (rather than total care) for dressing, bed mobility, bathing and shampooing and personal hygiene. Non registered staff confirmed that the resident required total care. Registered staff confirmed that the plan of care had not been updated when the resident's care needs changed at least six months ago. (526)

E) Documentation in the progress notes of resident #045, on a date in September 2014 identified that: the resident was choking at lunch and supper. The resident's diet texture was not assessed with action taken after choking on both the lunch and supper meals. The next day, the resident choked on lunch. Staff documented they put the resident on the physician's list for assessment of cold symptoms. The resident's diet texture was altered by staff for the supper meal on the second day; however, was returned back to regular texture on the third day.
On the third day the progress notes identified a hoarse voice, runny nose.
On the fourth day at the breakfast meal the resident was noted to have swallowing difficulties and a trial pureed texture menu was implemented and a referral made to the RD.
The resident passed away on the fourth day.
The RD stated that the home's procedure was to immediately notify the RD (on first incident) of any swallowing difficulties with action taken (diet texture/fluid consistency downgrade) if there was a risk to the resident's safety with the resident's current diet

texture or consistency of fluids. The plan of care was not revised when the resident's care needs changed.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that: (4)(a) the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (7) the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the right of every resident to have his or her personal health information kept confidential was fully respected and promoted, in relation to the following.

Between October 20 and 28, 2014, as part of the resident's activity program, a resident was observed shredding sheets of paper from boxes of paper sitting beside the shredding device. The boxes of papers were located in a common area that was accessible to residents, family members, and the public.
At 1630 hours on October 28, 2014 inspectors noted the contents of the boxes to include resident names with financial information and personal health information in progress notes, wound assessment reports, wound tracker, bath sheets, capillary blood glucose monitoring flow sheets, medication administration records, and resident care plans.

The DOC and the Program Supervisor confirmed that residents' personal health information was located in an area accessible to residents, family and the public, and was being accessed by at least one resident for shredding. [s. 3. (1) 11. iv.]

2. The licensee has failed to ensure that residents' rights to participate in the Residents' Council was fully respected.

A) Review of Residents' Council meeting minutes between September 26, 2013 and September 25, 2014 indicated that there were council meetings from September 2013 to June 2014 and that two of these meetings were open to all residents in the home. The remainder of the meetings were called "Regular" meetings where only members who had been nominated to the council attended. The Program Supervisor/assistant to the Residents' Council confirmed that nominated members acted as representatives of the residents in the home. All residents were invited to attend "Open" Residents' Council meetings.

B) During interviews on October 24, 2014, three out of four residents stated that residents needed to be invited to attend the monthly Residents' Council meetings and could only attend the "Open" meetings without being asked to attend. One of these residents was currently on the council and the other three residents stated that they would like to attend more meetings that the two "Open" meetings per year if they were allowed to do so.

The interviews confirmed that the residents' rights to fully participate in Residents Council were not respected and promoted. The Program manager confirmed that the process would be changed. [s. 3. (1) 20.]

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 to participate in the Residents' Council are fully respected, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a registered nurse on duty and present in the home at all times.

A) The staffing scheduler provided a report which indicated the following:

i) in January 2014 - there were 12 shifts with no RN onsite
ii) in February 2014 - there were 9 shifts with no RN onsite
iii) in March 2014 - there were 15 shifts with no RN onsite
iv) in April 2014 - there were 13 shifts with no RN onsite
v) in May 2014 - there were 6 shifts with no RN onsite (started using agency nurses)
vi) in June 2014 - there were 7 shifts with no RN onsite
vii) in July 2014 -there were 4 shifts with no RN onsite
viii) in August 2014 - there was 1 shift with no RN onsite
ix) in September 2014 - there were 2 shifts with no RN and
x) in October up to October 26, 2014 - there were no shifts without an RN

The DOC confirmed the above data and also confirmed that the home had hired three RN's in the past 3 months and has interviewed two more in the past 2 weeks. The home is still actively recruiting. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a registered nurse on duty and present in the home at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. The home's nursing policy for Medication Errors and Adverse Drug Reactions number 21-1.10 was last reviewed on June 2014. The policy included "wrong drug time" in the definition of a medication and instructed staff to notify the DOC and document a medication error on the Medication Incident Report.

Resident #038 had a controlled medication left at the bedside by a nurse. The resident reported that the nurse left without ensuring that the pain medication had been administered and the resident did not know that the medication was there. A few hours later a non registered staff noticed the medication on the resident's table and the resident took the medication. The resident reported that less than one hour later, a second nurse entered the room to administer the next dose of medication. The resident informed the second nurse that they had just taken the last dose. The second nurse assessed the resident, did not administer the next dose of medication and did not notify the DOC as per policy.
The DOC confirmed that the Medication Incident Report had not been completed for the missed dose as per the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, a) the resident was assessed and his or her bed system evaluated in accordance with evidence based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A)Resident #038's assessment indicated that the resident had side rails in place. The resident was observed to have two rails in the up position while the resident was in bed.
Review of the resident's health record indicated that it did not contain an assessment or evaluation of the resident and their bed system currently in place. The DOC confirmed that the home had not conducted an assessment or evaluation of residents in their bed systems according to prevailing practices.

B) Resident #014 was observed with two rails in the raised position several times during this inspection. The rails were not identified on the resident's plan of care or on the most current RAI-MDS assessment. Registered staff confirmed that an assessment of the resident in relation to the bed rails was not completed. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #6: 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:

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; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(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 O. Reg. 79/10, s. 31 (3).
(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 has failed to ensure that the staffing plan (d) included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

Between May 1, 2014 and October 12, 2014, the home has worked short of PSW staff on days and/or evenings every weekend except two. The staffing scheduler stated that the shifts were originally filled but staff called in. When a full shift PSW calls in, the short shift bathing PSW is moved into the full shift, leaving the bathing shift vacant. The staffing plan advises that no overtime be booked to fill in for a bathing shift. The plan did not include a list of casual PSW's for last minute call-ins. As of October 27, 2014, the home had one PSW on their casual list.

The staffing plan did not include a back-up plan for the direct care givers when working short. There was no direction to staff as to how they should prioritize the care of the residents' needs. This information was confirmed by direct care staff and registered staff. As a result, the residents often do not receive their baths. Out of five residents reviewed, four did not receive their baths as follows:
on September 20, 2014, a PSW called in for evening shift and on that shift, three residents did not get their baths and they were not made up;
on October 15, 2014, a PSW called in for the evening bath shift. As a result, at least one resident did not get her bath and it was not made up.
This information was confirmed by interviews with the DOC, staffing scheduler, direct care staff and review of health records. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan (d) includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) Resident #002 had been receiving treatment from physio three times per week for pain for 7 months. The PSW's had documented on the resident's flow sheets for October 2014 that the resident grimaced and has a sad and pained facial expression on 15 of 31 days. The family and PSW's confirmed that the resident had frequent pain. The resident ha not been assessed with the home's assessment tool, the Abbey Pain Scale, since August 16, 2014.
This information was confirmed by registered staff, the health record and the physio aide. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered and available at the lunch meal on a date in October 2014 in the Creekview dining area.

A) The home's "Resident Hydration" policy III-75, revised and reviewed May 2014, stated the home offered 125 ml of water, 250 ml milk, and 125 ml of juice for the lunch meal. Residents receiving thickened fluids (#018, #017, #041) had their fluids pre-prepared in the servery prior to the meal. Only thickened juice was prepared and ready for the meal service. Residents were not offered a choice of beverage and were provided 250 ml of thickened juice only. Residents requiring thickened fluids were not offered milk, as per the planned menu, resulting in reduced nutritional value of the meal.

B) Resident #017 had a plan of care that stated the resident was to receive a special beverage. The resident was not offered the special beverage at the noon meals October 20 or 24, 2014.

C)Residents #018 and #041 required high protein snacks to prevent weight change, which were not provided.

D) Residents on regular texture menus were offered hot beverages, however, residents requiring pureed menus and thickened fluids were not offered hot beverages.

E) Not all residents were asked or offered a choice of beverage, entree or dessert at the observed meal. The home's policy, "Meal and Nourishment Services", policy 23-1.4, revised February 2013, directed staff to ensure that residents were offered choice of meals by the showing of the main course and the alternate meal plates. The policy stated that all residents were to be encouraged to choose their meal. The home's policy, "Dining Room Supervision", policy IV-150, revised September 2014, stated the Dining Room Supervisor would ensure that residents were given a choice at meals. Residents who required a pureed texture menu were not offered a choice of entree or dessert. Dietary staff interviewed stated that none of the residents requiring a pureed menu were able to make meal choices. Resident #057's plan of care identified the resident only spoke when spoken to and to allow the resident time to respond and encourage resident attempts at communication and a PSW interviewed stated the resident would be able to choose a meal by looking at one of the choices longer than the other; Resident #044's plan of care directed staff to make requests simple and clear and a staff member stated the resident would be able to make food choices;

Resident #042's plan of care directed staff to allow time for a response when residents was asked a question, staff speak slowly and make request simple and direct, the resident usually understands the message; Resident #043's plan of care directed staff to allow resident to choose their clothes every day and to give simple one step instructions. Staff were asking residents #042, #043 and #044 if they liked the items (after they were provided) and the residents were able to agree or disagree. Resident #043 did not like the dessert that was provided and staff had to get the alternate which the resident consumed. The resident was not asked their preference prior to serving the first dessert. Residents requiring thickened consistency fluids were not offered a choice of beverages. Resident #018's plan of care directed staff to provide a choice at every meal. The resident was not offered a choice of beverage. [s. 71. (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 planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the lunch meal was served course by course on October 24, 2014 in the Creekview dining area. Two residents were served their entree while they were still consuming their soup (#044, #052), some residents were served their dessert while they were still consuming their entree (#053, #041, #052, #054, #044, #055, #056, #057, #058, #059) and one resident was served their dessert while still consuming both their soup and entree (#044). Resident #044 had their entree (hot item) placed on the table while they were consuming their soup and they were still consuming their soup and entree when their dessert was placed on the table. The resident had not requested their entree or dessert when it was placed on the table. Resident #059 had their dessert placed on the table and they stopped eating their entree. The home's policy "Dining room Service", policy IV-155, last reviewed September 2014, stated that meals were to be served one course at a time unless individual residents requested otherwise and that dishes were to be picked up in between courses of meals. The policy also stated that desserts would be served at the end of the meal when the entree plates had been removed. [s. 73. (1) 8.]

2. The licensee has failed to ensure that residents who required assistance with eating or drinking were served a meal only when someone was available to provide the assistance at the lunch meal October 24, 2014. Resident #041 was served their soup at 1210 hours, and sat without consuming it until staff provided assistance at 1215. The resident was provided their entree at 1230 hours and sat without eating the entree until assistance was provided at 1245 hours. The resident's dessert was also placed prior to assistance being provided 5 to 10 minutes later. The resident's plan of care required physical assistance by one staff for eating. Resident #042 had their entree and dessert placed on the table prior to assistance being provided 10 minutes later. The resident's plan of care required total assistance for eating. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that meals are served course by course for each resident unless otherwise indicated by the resident or the resident's assessed needs, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

On October 20, 2014 at approximately 1015 hours, inspector observed four resident care area storage room doors to be unlocked making hazardous substances accessible to residents. The following doors were unlocked:
i) Door RSE36 leading to clean utility room contained five bottles of isopropol alcohol 70% (corrosive)
ii) Door RSE21A leading to soiled utility room contained ant exterminator chemical (toxic)
iii) Door RSW28 leading to housekeeping closet contained several bottles of liquid virox (toxic, corrosive)
iv) Door RSE26 leading to utility room contained bottles of "Every Day" disinfectant (toxic)

On October 21, 2014 doors RSW21A, RSW36 were unlocked.

The door lock mechanisms failed to lock after inspector exited from the rooms. In each case staff confirmed that the doors should lock when the doors closed. Staff confirmed that residents with altered cognitive functioning were ambulatory on the relevant resident care areas. The ESM was interviewed on October 22, 2104 and stated that the home had been having difficulty ensuring that the doors remained locked. The ESM confirmed that hazardous substances should be inaccessible to residents at all times. [s. 91.]

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 hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident. On August 18, 2014, resident #030 was prescribed a medication to be administered for seven days. There were no further physician orders for this medication to be extended past the seven days. Resident and non registered staff confirmed that staff continued to administer the medication as requested by resident with no order in place.

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 no drug is administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #12: 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 clearly indicated when activated where the signal was coming from.
The home's resident-staff communication response system was designed to be activated at a station and then communicated to staff by i) a light that would flash silently in the hall; ii) a quiet alarm that would sound at the nursing station; and iii) triggering a staff person's paging device to inform the staff of the source of the alarm activation. Inspectors observed that resident bed and washroom stations were triggering staff paging devices inconsistently.

The resident-staff communication response system did not indicate where the signal was coming from by not triggering staff paging devices for the following: on October 21, 2014 Bridgeview room 9A bed and washroom stations did not trigger two PSW staff paging devices and Bridgeview room 4A bed and bathroom stations did not trigger for one PSW staff paging device but triggered for another PSW paging device; on October 22, 2014 Bridgeview room 4A bed stations did not trigger for one PSW staff paging device and Creekview room 11A and B bed and washroom stations did not trigger for one PSW paging device, but did trigger for a different PSW. PSW staff confirmed that their pagers were not triggered when the system was activated at these call stations. They stated that the batteries might have been exhausted or that the paging devices were broken. Two PSWs went to the nursing station to replace the unit's batteries at which time one of the pagers began to functioning. Three PSW's confirmed that if they were in another resident's room, they would not have known if a resident in rooms Bridgeview 4A/B, 9A and Creekview 11A/B had activated the system since their paging devices had not triggered. Staff confirmed that they were not directed to regularly monitor the functioning of the paging devices. [s. 17. (1) (f)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program as an interdisciplinary programs required under section 48 of this Regulation:
3. Is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's policy for Continence Care and Bowel Management Program 05-1.0 last reviewed June 2013 stated that the home was to annually evaluate the program and the effectiveness of the continence care and bowel management and that a written record of the program review would be maintained. During interview with the DOC on October 28, 2014, it was confirmed that the home had not evaluated the continence care and bowel management program in a least the past two years. The DOC could not provide evidence of an evaluation that had been completed. [s. 30. (1) 3.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice during the months of September and October 2014.
According to the home's staffing schedule, there were 39 weekend bathing shifts that were vacant between May 3 and October 12, 2014. Staff interviewed on October 29, 2014, stated that when staff were not available for the bath shifts the baths would not be done as staff were working short. Staff stated that residents might receive a bed bath on those days, or refuse their bath, however, it would be documented as such on the flow sheets.

A) Resident #048 did not receive a minimum of two baths per week during the month of September, 2014. For the month of September, the resident did not receive a bath on four occasions(at least 13 days between bathing). PSW flow sheets were recorded as bathing "did not occur".

B) Resident #049 did not receive a minimum of two baths per week during the month of September, 2014. For the month of September, the resident did not receive a bath on two occasions (at least 7 days between bathing). PSW flow sheets were recorded as bathing "did not occur" on the scheduled dates.

C) Resident #024 did not receive a minimum of two baths per week for the month of September, 2014. The resident did not receive a bath in September on three occasions (at least 7 days between bathing). PSW flow sheets were documented as bathing "did not occur".

D) Resident #014 did not receive a minimum of two baths per week for the month of October, 2014. The resident was missed on two occasions. Records reflected a staff shortage on one of the occasions. The resident had greasy hair noted on October 20 at 1404 hours and October 22 at 1520 hours. [s. 33. (1)]

WN #15: 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 has failed to ensure that resident #016 was offered an annual dental assessment and other preventive dental services.
The resident was noted to have significant mouth odour on a date in October 2014. PSW's stated that the resident had frequent mouth odour that did not diminish after mouth care due to decaying teeth (resident had four remaining teeth). Documentation did not reflect that an annual dental assessment was offered and interview with staff and the DOC could not confirm that an annual dental assessment had been offered to the resident. The resident was unable to recall if they were offered an annual dental assessment. [s. 34. (1) (c)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents who were incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) Resident #030's RAI MDS assessment dated August 2014 indicated that the resident was a low risk for urinary incontinence but was frequently incontinent of bladder in the previous 14 days.
When interviewed, the Registered Nurse (RN) indicated that the cause, patterns, type, and potential to restore function of resident #030's incontinence had not been assessed. The home's DOC confirmed that residents in the home who were incontinent were not assessed for causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. (526)

B) Resident #014 had a change from continent of bowels in August 2014 to usually continent of bowels identified on the resident's plan of care in October 2014. An assessment of the change using a clinically appropriate assessment instrument, including the identification of causal factors, patterns, type of incontinence and potential to restore function was not completed. Staff interviewed stated that the home did not currently have an assessment instrument for bowel and bladder continence when changes were identified. (107)

C)Resident #060's RAI MDS assessments completed in March 2014, June 014 and September 2014 indicated that the resident was usually continent of urine but had episodes of urinary incontinence once per week or less. Interview of registered staff indicated that the resident was also incontinent of bowels. When interviewed, the resident stated that they were able to void in the bathroom but needed a brief for occasional urinary incontinence and for bowel incontinence related to a bowel related disease. Review of the resident's health record indicated that a continence assessment of causes, patterns, type, and potential to restore function for resident #060 was not found. When interviewed, the home's Nursing Quality Assurance staff person confirmed that resident #060's continence had not been assessed for causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. (526) [s. 51. (2) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food was served using methods that preserved taste, appearance and food quality.

At the lunch meal October 24, 2014, staff assisting resident #017 mixed the resident's pureed corned beef sandwich and pureed sweet potato salad together. The resident was unable to voice their preference and had not asked the staff member to mix their food together. The staff member assisting the resident stated they thought that the sweet potato salad was a condiment. The RD confirmed that the resident was not to have their meal mixed together. [s. 72. (3) (a)]

WN #18: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of resident care equipment such as tubs on the Hillview and Creekview resident home areas.

A) The smaller sit in tub/shower was dirty with residue (appeared to be razor/shaving residue) on the bottom (tub was dry) in the Creekview area on October 20, 21, 22, 2014. The smaller sit in tub/shower on Hillside appeared dirty with multiple areas of a dried on brown substance that appeared to be feces on the tub surface under the seat area on October 21, 22, 23, 2014. On October 23, 2014 at 1105 hours, the tub was wet and staff stated they used the tub on the night shift to clean wheelchairs. A dirty brush was left in the tub on all days observed. Staff confirmed they were to clean the tubs before and after use. Staff stated that the tub was not currently being used for resident bathing, however, confirmed the tub should have been cleaned after use and ready for a resident if needed.

B)The grey stretcher/shower trolley device, used for bathing and stored in the Hillside home area, had multiple areas of brown residue, a dirty toothbrush, and visible food residue (corn kernels) on the surface of the device on October 21, 22, 2014. Staff stated the device was to be cleaned before and after use and confirmed the device was not cleaned. The home's policy, "Cleaning of Nursing Equipment", Policy 07-1.0, stated that tubs, chair lifts, shower chairs and stretcher and shower trolleys were to be cleaned and disinfected after each use. The home's policy "Century Tub - Cleaning of", policy number 07-1.3 directed staff to scrub all interior surfaces of the tub and chair and to ensure the tub and chair were cleaned after each bath. [s. 87. (2) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, (b) there were schedules and procedures in place for routine, preventive and remedial maintenance of the home's paging devices as part of the resident-staff communication response system.

The home's resident-staff communication response system was designed to be activated at a station and then communicated to staff by i) a light that would flash silently in the hall; ii) a quiet alarm that would sound at the nursing station; and iii) triggering a staff person's paging device to inform the staff of the source of the alarm activation. Inspectors observed that resident bed and washroom stations were triggering staff paging devices inconsistently.

The resident-staff communication response system did not indicate where the signal was coming from by not triggering PSW staff paging devices on six out of eight monitored occasions on October 21, 2014 and on four out of 14 monitored occasions on October 22, 2014. PSW staff confirmed that their paging devices had not triggered and thought that the batteries might have been exhausted or that the paging devices were broken. Two PSWs went to the nursing station to replace the unit's batteries at which time one of the pagers began to functioning. Two PSW staff stated that the home did not require them to audit the functioning of the paging devices to ensure that they triggered when the resident-staff communication response system was functioning.

The Facility Operations Supervisor confirmed that the home did not have schedules and procedures in place for routine, preventive and remedial maintenance of the home's paging devices as part of the resident-staff communication response system maintenance. He stated that he was putting this process in place as he recognized the omission as a deficiency in the maintenance of the system. [s. 90. (1) (b)]

WN #20: 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 did not ensure that drugs were stored in a medication cart that was secure and locked on October 24, 2014 at 1210 hours and again at 1220 hours in the Creekview home area. The inspector was able to access the cart while the registered staff was at the back of the dining room with their back to the inspector. [s. 129. (1) (a) (ii)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76(7) of the Act, staff training regarding continence care and bowel management had not been provided to all staff who provided direct care to residents, annually or based on staff's assessed training needs.

During interview on October 28, 2014 the DOC and the Nursing Quality Assurance staff person confirmed that staff who provided direct care to residents had not received annual training regarding continence care and bowel management during at least two years prior to October 7, 2014. The Nursing Quality Assurance staff person also confirmed that staff training needs had not been assessed during that time. The home's policy for Continence Care and Bowel Management Program 05-1.0 last reviewed June 2013 stated that direct staff must receive annual retraining on continence care and bowel management. [s. 221. (1) 3.]

WN #22: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents have been offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
This information was confirmed by the health records and the DOC. [s. 229. (10) 3.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2013_201167_0021	146
O.Reg 79/10 s. 42.	CO #002	2013_201167_0020	146

Issued on this 7th day of December, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BARBARA NAYKALYK-HUNT (146), MICHELLE WARRENER (107), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2014_214146_0024
Log No. / Registre no:	H-001419-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 2, 2014
Licensee / Titulaire de permis :	THE CORPORATION OF HALDIMAND COUNTY 45 Munsee Street, Box 400, Cayuga, ON, N0A-1E0
LTC Home / Foyer de SLD :	GRANDVIEW LODGE / DUNNVILLE 657 LOCK STREET WEST, DUNNVILLE, ON, N1A-1V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOANNE JACKSON

To THE CORPORATION OF HALDIMAND COUNTY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2013_201167_0020, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.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).

Order / Ordre :

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, (b) the resident's care needs change or care set out in the plan is no longer necessary.
The licensee shall review each resident's plan of care and revise the plan as necessary to reflect each resident's current assessed needs.
The licensee shall provide education to nursing staff (registered and front line) in relation to the identification of chewing and swallowing problems, signs and symptoms of aspiration, and action to be taken when concerns are identified.
The home shall update their policies to include direction for staff when chewing or swallowing concerns are identified, including roles and responsibilities for various staff members.

Grounds / Motifs :

1. Previously issued December 2013 as a VPC; July 2013 as a CO; July 2013 as a VPC; and January 2013 as a WN.
The licensee has failed to ensure that the plan of care was revised when the resident's care needs changed.

A) Resident #019's RAPS dated September 2014 indicated that the resident was

a high falls risk. The current care plan (August 2014) being used by direct caregivers indicated that the resident was a low falls risk. The RPN stated that the care plan had not been updated since the resident's falls risk had increased and confirmed that the care plan needed to be revised. (146)

B) Resident #019's current care plan which was reviewed in September 2014 indicated that the resident was not to use a specific device because family requested that the resident not use the device. The progress notes from October 2014 indicated that nursing requested and received permission from the family to use the device. The resident was observed using the device. The resident's care needs had changed but the current care plan had not been revised. This information was confirmed by registered staff. (146)

C) Resident #30's mobility care needs changed and were not reflected in the current care plan. Interview with the physiotherapist indicated that as of October 2014, resident #30 was able to ambulate using a device and with the assistance of one staff person to the bathroom and in the hallway. Resident #030's RAI MDS dated August 2014 indicated that the resident required limited assistance from one person while walking in their room. The document the home referred to as the "care plan" last completed on August 25, 2014 indicated that the resident required supervision with set up only for walking. Observation and interview with the resident confirmed that the resident required limited assistance rather than set up only as the resident was unsteady on their feet and had been asked by staff to wait for assistance when the resident wanted to get out of bed. Registered staff confirmed that the plan of care had not been changed when resident #030's care needs changed. (526)

D) According to registered and non registered staff, resident #027 had required total care for dressing, bed mobility, bathing and shampooing and personal hygiene for approximately six months. Resident #027's RAI MDS assessment completed in August 2014 indicated that the resident had total dependence on staff for bed mobility, dressing, personal hygiene and bathing. The document the home referred to as "the care plan" completed in September 2014 indicated that the resident required extensive assistance (rather than total care) for dressing, bed mobility, bathing and shampooing and personal hygiene. Non registered staff confirmed that the resident required total care. Registered staff confirmed that the plan of care had not been updated when the resident's care needs changed at least six months ago. (526)

E) Documentation in the progress notes of resident #045, on a date in September 2014 identified that: the resident was choking at lunch and supper. The resident's diet texture was not assessed with action taken after choking on both the lunch and supper meals. The next day, the resident choked on lunch. Staff documented they put the resident on the physician's list for assessment of cold symptoms. The resident's diet texture was altered by staff for the supper meal on the second day; however, was returned back to regular texture on the third day.
On the third day the progress notes identified a hoarse voice, runny nose.
On the fourth day at the breakfast meal the resident was noted to have swallowing difficulties and a trial pureed texture menu was implemented and a referral made to the RD.
The resident passed away on the fourth day.
The RD stated that the home's procedure was to immediately notify the RD (on first incident) of any swallowing difficulties with action taken (diet texture/fluid consistency downgrade) if there was a risk to the resident's safety with the resident's current diet texture or consistency of fluids. The plan of care was not revised when the resident's care needs changed. (107)

(146)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 2nd day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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