Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2014	2014_248214_0024	H-001113-14	Resident Quality Inspection

Licensee/Titulaire de permis

UNGER NURSING HOMES LIMITED
312 Queenston Street, St. Catharines, ON, L2P-2X4

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

HAMPTON TERRACE CARE CENTRE
75 PLAINS ROAD WEST, BURLINGTON, ON, L7T-1E8

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

CATHY FEDIASH (214), CATHIE ROBITAILLE (536), GILLIAN TRACEY (130)

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): August 18, 19, 20, 21, 22, 25, 26, 27 and 28, 2014.

Please Note: The following critical incident inspections were conducted simultaneously with this inspection: H-000712-14 and H-000757-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager, Resident Assessment Instrument (RAI) Coordinator, Activity Manager, registered staff, Health Care Aides (HCA)/Personal Support Workers (PSW), dietary staff, maintenance lead, housekeeping lead, residents and families.

During the course of the inspection, the inspector(s) interviewed staff, residents and families; reviewed clinical records, relevant policies and procedures, home's investigative records,minutes of meetings, employee records and observed care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Critical Incident Response
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident had his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date in August 2014, the medication carts on Lilac Lane and Primrose were observed to have garbage bins which contained discarded medication pouches which identified residents by name and their prescribed medications. Two registered staff confirmed the medication pouches were disposed of with the regular garbage and not separated to protect residents' personal health information. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident has his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) A review of resident #104's Minimum Data Set, completed on a specified date in July 2014, indicated under Physical Functioning and Structural Problems that the resident required extensive assistance of at least two persons and that bed rails were used, for bed mobility. A review of the resident's written plan of care indicated that the resident required extensive assistance of two staff for turning and repositioning while in bed; however, did not include the use of the bed rails. The DOC confirmed that bed rails were used by the resident for the purpose of bed mobility and that the care set out in the plan of care was not based on the assessed needs of the resident.

B) A review of resident #105's Minimum Data Set, completed on a specified date in August 2014, indicated under Physical Functioning and Structural Problems that the resident was assessed as total dependence of at least two persons for bed mobility. A review of the resident's current written plan of care indicated that the resident

required two staff to provide extensive assistance to turn and reposition every two hours when in bed. The DOC and RAI Coordinator confirmed that the resident was totally dependent upon at least two staff for bed mobility and that the care set out in the plan of care was not based on the assessed needs of the resident.

C) A review of resident #105's Minimum Data Set, completed on a specified date in December 2013, indicated under Communication/Hearing Patterns that the resident heard adequately; rarely or never understood; rarely or never understands and demonstrated no speech – absence of spoken words. A review of the narrative resident assessment protocol (RAP) indicated that the resident's communication ability is severely impaired due to their diagnosis of dementia and that the care plan goal will be to keep the resident safe and well-cared for. A review of the resident's written plan of care, dated December 2013 indicated that the communication goal would be to maintain eye contact while conversing and the interventions indicated that staff would assist in making proper, appropriate daily decisions. An interview with the RAI Coordinator confirmed that the resident rarely or never understood; was unable to assist in making proper, appropriate daily decisions and that the care planned goal and interventions were not based on the assessed needs of the resident. [s. 6. (2)]

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

The plan of care for resident #108 indicated the resident was to have a seatbelt restraint applied and that the device should be "placed under the anti-tipper on the right side then done up as this will keep the belt from riding up towards". On an identified date in August 2014, the resident was observed in their wheelchair with their seatbelt restraint applied too loose. The PSW and the RAI Coordinator confirmed the seatbelt was applied too loose because it was not placed under the anti-tipper, as per the instructions in the plan of care. (Inspector #130) [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #3: 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 failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A) A review of the home's policy, Responsive Behaviour-Resident(R-02-01-01 and dated August 2014) indicated the following:

- "Risk Assessment will be initiated immediately after an aggressive or violent outburst to identify triggers to the behaviour and care plan updated accordingly".
- "The Charge nurse/Registered Staff will review the Resident's Care & Observation Record on a daily basis (night Reg. Staff) and ensure than any identified unusual behaviours are documented in 24 hour shift report and Point Click Care (PCC)".

i) A review of resident #104's progress notes specified on an identified date in August 2014, that the resident was verbally and physically aggressive towards staff while in the dining room and on the following day, the resident was combative with staff and was hitting and grabbing staff in an aggressive manner. A review of the resident

clinical record indicated that a Risk Assessment had not been completed for these aggressive outbursts demonstrated. The DOC confirmed that the Risk Assessment had not been completed and that the home had not complied with their policy.

ii) A review of resident #104's Resident Care & Observation Record for the month of August 2014 indicated that responsive behaviours of verbally abusive, physically abusive and complaints of pain had been demonstrated by the resident on 12 specified dates in August 2014. A review of the documentation in PCC indicated that no documentation had been recorded for these behaviours. An interview with the DOC confirmed that these unusual behaviours had not been documented in PCC and that the home did not comply with their policy.

B) A review of the home's policy, Resident Behaviour Observation Record(R-02-01-02 and dated August 2014) indicated the following:

• "The Home will ensure that Behaviour Observation Record is initiated for any resident exhibiting sign and symptoms of unusual/inappropriate or responsive behaviour".

i) A review of resident #104's clinical record indicated that responsive behaviours of being verbally abusive, physically abusive and complaints of pain were demonstrated by the resident on 12 identified dates in August 2014. A review of the Resident Behaviour Observation Record indicated that this form had not been initiated on the identified dates. An interview with the DOC confirmed that the form had not been initiated and that the home did not comply with their policy.

C) A review of the home's policy, Resident Behaviour–Agitation Assessment–PCC (R-02-01-03 and dated August 2014) indicated the following:

• "Registered Staff will ensure that Agitation Assessment is completed for every resident exhibiting episode of responsive behaviour".

i) A review of resident #104's clinical record indicated that responsive behaviours of verbally abusive, physically abusive and complaints of pain were demonstrated by the resident on 12 identified dates in August 2014. A review of the assessment's completed in PCC for the resident indicated that no Agitation Assessment's had been initiated for the behaviours demonstrated by the resident on the identified dates. The DOC confirmed that the Agitation Assessment's had not been initiated and that the

home did not comply with their policy.

D) A review of the home's policy, Skin and Wound Care Program (ND-S-06-01-01 and dated May 2014) indicated the following:

• "Charge Nurse/Registered staff will ensure the Pressure Ulcer Tracking Form is completed and submitted to Director of Care on a monthly basis".
• "Health Care Aides(HCA) /Personal Support Worker (PSW)will reposition any resident who is dependent on staff for repositioning every 2 hours depending on the resident's condition and the tolerance of tissue load during waking, including chair positioning and a minimum of 2 times per night if clinically indicated. Follow positioning frequency instructions on resident's Turning and Positioning Record and enter your initials for procedures performed".
• "Charge Nurse/Registered staff will review Turning and Positioning Record on each shift and as per the home's policy, Skin Care Program Turning & Positioning Monitoring Record (ND-S-13-01-01) will sign the record at the end of each shift indicating that the assessment was completed".

i) A review of resident #105's clinical record indicated that they had a stage 3 pressure ulcer. The resident's plan of care indicated that the resident was on a turning and positioning program and required to be turned and repositioned every two hours and when needed whether in bed or wheelchair. It was clinically indicated that the resident also required to be turned and repositioned every two hours while asleep. A review of the resident's Turning and Repositioning Record for the month of August 2014, indicated that the form had not been completed 10 times, over three specified dates in August 2014.

ii) This record review also indicated that the Turning and Repositioning Record had not been initialed by the HCA or PSW on three identified shifts in August 2014 and had not been initialed by the Charge Nurse/Registered staff on 17 identified shifts in August 2014.

iii) A review of the Pressure Ulcer Tracking Form over an identified period of three months in 2014, indicated that the form had only been completed on one identified month in 2014 and not monthly.

An interview with the DOC confirmed that the resident required to be turned and repositioned every two hours, including while sleeping. The DOC confirmed that the

form was not completed on the dates identified; that the Pressure Ulcer Tracking form had not been completed monthly and that the home had not complied with their 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 is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with food and fluids that were adequate in quantity.

On an identified date in August 2014, during lunch service on Ivy Lane/Rose Arbour Lane, the dietary staff were observed using incorrectly sized serving utensils. The diet spreadsheet called for the cottage cheese for regular, minced and pureed diets to be served with a #eight-4 ounce scoop. In its place a #twelve-2.67 ounce scoop was being used. The diet spreadsheet identified that 15 milliliters (mL) of dipping sauce was to be served with the chicken dippers. In its place a squirt of dipping sauce was placed on each plate from a squeezable bottle. The diet spreadsheet also called for soup to be served with a four ounce ladle and in its place a six ounce ladle was used. On an identified date in August 2014, during lunch observation on Primrose Lane, the diet spreadsheet called for the regular greek salad to be served with an eight ounce spoodle. In its place the dietary staff was observed using a #eight-4 ounce scoop. This was confirmed by both the dietary staff and the Nutrition Manager. [s. 11. (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 residents are provided with food and fluids that are adequate in quantity, 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 failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) A review of resident #104's written plan of care indicated that they required the use of bed rails in the raised position for safety, when in bed. A review of the resident's clinical health record did not include an assessment of the bed rails being used.

B) A review of resident #105's written plan of care indicated that they required the use of bed rails in the raised position for safety, when in bed. A review of the resident's clinical health record did not include an assessment of the bed rails being used.

The DOC confirmed that the home did not have a formalized assessment for the use of bed rails, in place. [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 when bed rails are used, 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to ensure that supplies were readily available at the home to meet the nursing and personal care needs of residents.

During a walk-through of the home on an identified date in August 2014, it was noted that the clean utility rooms on each of the four home areas had little to no personal care supplies available. The following was observed:

A) Lilac Lane: one tube toothpaste, one box denture tablets and two deodorant. There were no hairbrushes, combs, mouthwash, body lotion or toothbrushes.

B) Rose Arbour Lane: no personal care supplies available.

C) Ivy Lane: eight boxes Kleenex, two boxes lemon swabs. There were no toothbrushes, toothpaste, mouthwash, body lotion, deodorant, shaving cream, brushes or combs available.

D) Primrose Lane: one box lemon swabs, two cans shaving cream, three toothbrushes, two denture cups, two combs and one toothpaste. There were no brushes, combs, mouthwash, body lotion or deodorant available.

An interview with PSW's confirmed that there were little to no supplies available if needed. Staff reported that when they do not have sufficient supplies that they "borrow them". A review of the clean utility rooms on all four areas as well as the central supply room in the home where stock supplies were kept was conducted with the Administrator on an identified date in August 2014. The Administrator confirmed that there were little to no supplies available at the home. [s. 44.]

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 supplies are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #105's clinical record indicated that they exhibited a stage 3 pressure ulcer. A review of the resident's Weekly Wound Treatment Assessment's in Point Click Care (PCC) for a specified period of four months in 2014, indicated that weekly re-assessments of their wound had only been completed nine times. An interview with the DOC confirmed that the resident had not been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: 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,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

On an identified date in August 2014, it was observed that there were no incontinent products available on the Primrose unit for the start of the afternoon shift at 1500 hours. Staff on the unit were interviewed and confirmed that their supply of incontinent products had not been delivered to the unit. On another identified date in August 2014 at 1520 hours it was observed on the Lilac Lane unit that there were no incontinent products available on the unit for staffs use. The Administrator conducted a walk-through with the Inspector and confirmed that there were none on the unit. Staff interviewed have reported that they frequently have no incontinent products available and that they have to leave their unit and request registered staff unlock the supply cupboard where the incontinent products are stored because they are inaccessible to them. [s. 51. (2) (f)]

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 range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

A tour of the home was conducted on August 19 and 22, 2014 and indicated the following:

A) Rose Arbour Lane unit:
i) the carpet in the main hallway of the unit had several areas of stains throughout the hallway. A piece of this hallway carpet had been removed and replaced and was noted to have a white coloured stain.

B) Ivy Lane unit:
i) the carpet in the main hallway of the unit was observed to have several areas of stains throughout the hallway.
ii) the carpet in the Ivy Sun Lounge was observed to have several stained areas.
iii) the bathroom of room #214 was observed to have dried yellow stains around the perimeter of the toilet; blackened floor tiles in front of the toilet and an odour of urine was noted in the bathroom.
iv) the dining room floor was observed to have blackened marks, sporadically throughout.

C) Primrose Hill Lane unit:
i) the carpet in the main hallway of the unit was observed to have several areas of

stains throughout the hallway.
ii) the Primrose Sun Lounge carpet was observed to have stains throughout the lounge.
iii) the dining room on the unit contained an organ that was observed to have a thick layer of dust covering the top and keyboard.

A review of the home's organized program of housekeeping indicated that on a quarterly basis, a housekeeping audit was to be conducted to monitor, evaluate and resolve the above identified areas. A tour of the home was conducted with the Administrator and housekeeping lead who confirmed the identified areas were not clean and that the housekeeping audit had not been conducted to date, for the 2014 year. [s. 87. (2) (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 as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #10: 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 failed to ensure as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures

in place for routine, preventive and remedial maintenance.

A tour of the home was conducted on August 22, 2014 and indicated the following:

A) Rose Arbour Lane unit:
i) throughout the main hallway of the unit, various scrapes to the wallpaper on the walls were noted and many areas of the wallpaper were noted to be bubbled.
ii) room's #102 and #107 were observed to have scrapes and scuff marks to the bedroom and bathroom walls.
iii) the bathroom in room #103 was observed to have several areas of dried drywall compound on the walls, the wall joints and the ceiling.
iv) room #110 was observed to have scrapes to the bathroom wall and scrapes and a hole in the drywall to the bedroom wall.
v) room#114 was observed to have scrapes and scuff marks to the bedroom walls.

B) Ivy Lane unit:
i) throughout the main hallway of the unit, it was observed that the walls had various degrees of scrapes and bubbling of paint.
ii) room #202 and #212 had scrapes on the bathroom walls.
iii) room #213 had scrapes on the bedroom walls and scrapes and gauges to the bathroom walls.
iv) room #200 had scrapes and gauges to the bedroom walls.
v) room #204 had scuff marks and scrapes to the bedroom walls and scuff marks on the bathroom walls.
vi) room #210 had scrapes and gauges on the bathroom walls.
vii) the dining room was observed to have varying degree of scrapes to the walls throughout.

C) Primrose Hill unit:
i) the wall adjacent to the dining room entrance was observed to have a hole in the drywall.
ii) the dining room was observed to have varying degree of scrapes and scuff marks to the walls.
iii) room #411 was observed to have scrapes and gauges to the walls in the bedroom and scrapes to the walls in the bathroom.
iv) room #403 was observed to have bedroom and bathroom wall scrapes.
v) room #401 was observed to have bathroom wall scuff marks.
vi) the shower on the unit was observed to have three areas around the inside bottom

perimeter that were worn and in two of these areas, blackened stains were noted.
vii) the walls in the Activity room were observed to have varying degrees of scuff marks and scrapes.

D) Lilac unit:
i) throughout the main hallway of the unit, it was observed that the walls had various degrees of scuff marks.
ii) the Lilac Sun Lounge was observed to have scuff marks and scrapes to the walls and scrapes to the radiator.
iii) room #310 was observed to have scuff marks and scrapes to the bedroom walls and scuff marks and bubbled paint to the bathroom walls.
iv) room #309 was observed to have scuff marks to the bedroom walls and scuff marks and dried drywall compound to the bathroom walls.
v) room #308 was observed to have scrapes and scuff marks to the bedroom and bathroom walls.
vi) room #311 was observed to have scrapes and scuff marks to the bedroom walls and three holes in the drywall behind the bed.
vii) room #306 was observed to have scrapes and scuff marks to the bedroom walls.
viii) the dining room walls were observed to be scraped and the baseboard edging beside the door that leads outside, was noted to be coming away from the wall.
ix) the shower room was noted to have a few cracked wall tiles.

An interview conducted with the maintenance lead in the home indicated that the home's organized program of maintenance services was to conduct a maintenance audit on a quarterly basis and that this audit was used to monitor, evaluate and carry out required repairs. The maintenance lead confirmed that the audit had not been conducted to date, for the 2014 year. The maintenance lead also confirmed that staff had submitted maintenance requisitions, however these requisitions were in relation to nursing equipment repair and not to environmental repairs. A tour of the home was conducted with the Administrator and maintenance lead who confirmed they were aware of some of the identified areas that were in disrepair and that the home would be looking into obtaining sufficient resources to complete these projects. [s. 90. (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 as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care."

On August 20, 2014, PSW's were observed completing laundry duties (delivering personal laundry to resident home areas). Staff interviewed verified that PSW's on the afternoon shift were required to deliver residents' personal laundry and hang it outside the residents' rooms and that the PSW's on night shift were required to put the laundry away. The Administrator confirmed that personal support workers are paid from NPC Funds. (Inspector 130) [s. 101. (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 the licensee complies with the conditions to which the licensee is subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care", to be implemented voluntarily.

WN #12: 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. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the interdisciplinary team that co-ordinates and implements the Infection Prevention and Control program met at least quarterly.

An interview conducted with the DOC indicated that the interdisciplinary team that co-ordinates and implements the Infection Prevention and Control program does so through the Professional Advisory Committee (PAC). The DOC confirmed that the PAC had only met once, to date this year, on April 16, 2014 and has not met on a quarterly basis, as required. [s. 229. (2) (b)]

2. The licensee failed to ensure that all staff participated in the implementation of the infection control program.

A) The home did not ensure that residents' personal care supplies were stored properly to prevent cross contamination, and labeled when the supplies were kept in a communal setting.
i) On August 18, 2014, five unlabeled deodorant sticks were observed in the Lilac Lane unit shower room.
ii) Two unlabeled stick deodorants and an unlabeled urinary collection container were stored on the vanity next to the hand sink in the Primrose unit shower room.
iii) One unlabeled nail brush was observed in the Ivy Lane unit shower room.
iv) In room 113, bar soap was observed in an unlabeled soap dish in the shared resident bathroom. Hairbrushes were stored in the same basket as uncovered toothbrushes and an unlabeled urinary collection container was stored on the back of the toilet.
v) In room 103, soiled linen and a soiled incontinent product were found on the bathroom floor.
vi) In room 412, an unlabeled urinal was observed on the counter next to the hand sink.(130)

B) It was observed on a specified date in August 2014, that resident #400 had their uncovered toothbrush stored in their care caddy along with their hairbrush, comb and other hygiene products. An interview with PSW's confirmed that the uncovered toothbrush should not be stored with other hygiene products.(214) [s. 229. (4)]

3. The licensee failed to ensure that the following immunization and screening measures were in place: 1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident had already been

screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

A) A review of resident #401's clinical record indicated that they were admitted to the home on a specified date in 2014. Consent was obtained to receive the tuberculosis screening approximately five weeks later on a specified date in 2014. A review of the resident's clinical record indicated that they had not received the tuberculosis screening to date.

B) A review of resident #402's clinical record indicated that they were admitted to the home on a specified date in 2014. Consent was obtained to receive the tuberculosis screening four days later. A review of the resident's clinical record indicated that they had not received the tuberculosis screening to date.

An interview with the DOC confirmed that the home's process for screening for tuberculosis was the two-step tuberculin testing unless the resident had already been screened at some time in the 90 days prior to admission. The DOC confirmed that the two residents noted, had not been screened for tuberculosis within 14 days of their admission and that the home currently did not have a supply of tuberculin in the home. [s. 229. (10) 1.]

4. The licensee failed to ensure that any pet visiting as part of a pet visitation program had up-to-date immunizations.

An interview conducted on August 26, 2014 with the Activity Manager indicated that the home has a pet visitation program. A review of the immunizations records for the pet's that visit the home, indicated that no immunization records were available for two of the three dogs that visit the home as part of the visitation program and the one immunization record that was available, indicated that the immunizations were not current. [s. 229. (12)]

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 interdisciplinary team that co-ordinates and implements the Infection Prevention and Control program meet at least quarterly, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

On August 18, 2014, the shower room doors on Ivy Lane and Primrose units were noted to be propped open. Both rooms contained bottles of "Virox 5" disinfectant spray. Staff confirmed the chemical should be inaccessible to residents and the shower room doors kept locked when not in use. [s. 5.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of resident #104's Minimum Data Set, annual assessment completed on a specified date in July 2014, indicated that the resident demonstrated responsive behaviours of verbal abuse, physical abuse and was resistive to care. A review of the resident's current, written plan of care had not identified these behaviours. An interview with the DOC and the RAI Coordinator confirmed that these behaviours were assessed, still present and not included in the resident's plan of care. [s. 26. (3) 5.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

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, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all menu substitutions where communicated to residents and staff.

On a specified date in August 2014 during observation of the lunch meal on Lilac Lane, the menu identified ham sandwich with a side of romaine salad as one of the main entrees. Salami sandwiches were substituted for the ham sandwich and the posted menu had not been updated. Also observed during the same lunch meal that the second main entrée was to be green beans served with the pasta primavera. Mixed vegetables were substituted for the green beans and the posted menu had not been updated. The Nutrition Manager confirmed that the changes to the menu had not been done prior to the meal service. [s. 72. (2) (f)]

2. The licensee failed to ensure that all foods were prepared, stored and served using methods which prevents contamination.

On a specified date in August 2014 during lunch service on Rose Arbor/Ivy dining room, the dietary staff were observed using their fingers when picking up lettuce that was being used to hold portions of cottage cheese. Also noted during the same lunch service, the dietary aide was observed to have peeled off muffin wrappers while holding the muffin with their fingers. At no time during this observation did hand washing occur. The cook confirmed that these items should have been served using utensils. [s. 72. (3) (b)]

WN #16: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food being served was at a temperature that was both safe and palatable:

During interviews, resident #102 indicated that at times the food was not served at the correct temperature. The homes Food Temperature Audit indicated that hot items must be served at a minimum of 145 degrees Fahrenheit (F) and cold items at a maximum of 45 degrees F. Temperatures were taken during lunch service on Primrose Lane on August 21, 2014. The temperature of the probed items at start of meal service were as follows: pureed greek salad 70 degrees F, minced greek salad 71 degrees F and regular greek salad 64.7 degrees F. At the end of meal service the temperature of the probed items were as follows: pureed cauliflower 142 degrees F, minced cauliflower 139 degrees F and regular cauliflower 140 degrees F. These temperatures were confirmed by the Dietary Aide and the Nutrition Manager. [s. 73. (1) 6.]

WN #17: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to 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.

An interview conducted with the Family Council lead and the Residents' Council lead on an identified date in August 2014, indicated that the Satisfaction Survey was distributed in October 2013 and that the Family Council and the Residents' Council were not sought out for their advice in developing and carrying out the Satisfaction Survey. The Administrator confirmed that the advice of the Residents' Council and the Family Council was not obtained in developing and carrying out the Satisfaction Survey as the survey is developed by the corporation and sent out by the home. [s. 85. (3)]

2. The licensee failed to ensure that the results of the survey were documented and made available to the Residents' Council and the Family Council, if any, to seek their advice about the survey.

An interview conducted with the Family Council lead and the Residents' Council lead on an identified date in Augustv2014, indicated that the Satisfaction Survey was distributed in October 2013 and that the Family Council and the Residents' Council had not reviewed the results of the Satisfaction Survey, to seek their advice. An interview with the corporate representative, who was the Acting Administrator at the time the survey was conducted, indicated that the results of the survey had not been documented and made available to the Family Council or the Residents' Council. [s. 85. (4) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On August 28, 2014, it was observed that the narcotics were stored in a separate fixed cupboard located in the medication room, however, registered staff confirmed the fixed cupboard was not double locked as required. [s. 129. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

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

A review of resident #104's clinical record indicated that on a specified date in July 2014, the physician ordered an increase to the resident's antipsychotic medication. A review of the resident's clinical record indicated that no monitoring or documentation of the resident's response and the effectiveness of this medication was completed. An interview with the DOC confirmed that the resident remains on the prescribed dose of antipsychotic medication and that no monitoring or documentation of the resident's response and the effectiveness of this medication had been completed to date. [s. 134. (a)]

Issued on this 23rd day of September, 2014

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