Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 16, 17, 18, 19, 20, 23, 24, 25, 27, 30, 31, Feb 1, 2, 6, 7, 8, 9, 24, 27, Mar 5, 6, 7, 12, 2012	2012_067171_0002	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

ELISA WILSON (171), ASHA SEHGAL (159), GILLIAN HUNTER (130), MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Business Manager, Dietary Supervisor, Recreation Supervisor, Resident Assessment Instrument (RAI) Coordinator, Housekeeping Supervisor, Maintenance Lead, Registered Staff, Personal Support Workers, Housekeeping Aides, Dietary Aides, residents and residents' family members.

During the course of the inspection, the inspector(s) toured the home, observed meal service, food production, medication passes, medication storage areas and care provided to residents, reviewed resident records and plans of care for identified residents, reviewed policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

For Resident Quality Inspection (H-000023-12) and Critical Incident (H-000181-12).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following subsections:

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

s. 6. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that care set out in the plan of care is provided to the resident as specified in the plan [LTCHA 2007, S.O. 2007, c.8, s.6(7)].

a) During observation of the lunch meal service, it was noted that a number of residents did not receive care as specified in their dietary plans of care.
- two residents' dietary plans of care specified not to serve a particular menu item, however they were served this item at lunch (167, 159).
- another residents' dietary plan of care specified that he was on a specific diet and was to be offered specified portions, however it was noted that he was served a different portion of a menu item at the lunch meal (167).
- plans of care for five residents specified that they were to receive a particular menu item at meals. These residents were all served the incorrect item at the lunch meal (167, 159).
- another resident's plan of care specified a certain consistency of fluids at meals. The resident was served the incorrect consistency of one beverage at this meal (159).
- plan of care for another resident specified a specific beverage for lunch, however the resident did not receive this beverage at the lunch meal.

b) The plan of care for an identified resident indicated the resident be toileted before and after meals, before bedtime and as needed. It was observed that the resident was not toileted before lunch. Staff interviews verified that the resident was not toileted as per her plan of care.

2. The licensee did not ensure that residents were reassessed and their plans of care reviewed and revised at any time when the residents' care needs changed [LTCHA, 2007 S.O. 2007, c.8, s.6(10)(b)].

The licensee has failed to comply with order #001 from Inspection #2011_060127_0031 served on October 31, 2011.

a) A resident returned from hospital. The progress notes completed by nursing staff at the home indicated that the resident was admitted to the hospital with a specific diagnosis. When the resident returned from hospital the plan of care was not updated to include the diagnosis from the hospital and there were no interventions identified to monitor and address this potential problem.

b) Another resident returned from hospital. During the hospital stay, the resident had a procedure that required a specific therapy to be initiated. The document that the home refers to as the care plan was not updated to reflect the resident's condition upon return. No care plan was put in place to address the use of this new therapy and there were no interventions put in place to manage the associated risks.

3. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to restraint use [LTCHA, 2007 S.O. 2007, c.8, s.6(1)(c)].

An identified resident was using a restraint. The document that the home refers to as the care plan indicated under falls that the resident used a specific type of restraint. However, on the same care plan under prevention of injury it indicated that the resident was using a different type of restraint.

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 care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 [LTCHA, 2007 S.O.2007, c.8, s.30(1)3].

a) Staff interviewed and records reviewed confirmed the following for one resident:

i) the plan of care did not include assessments for the use of two restraints to identify the significant risk of bodily harm prior to the application of these devices. The resident was noted to be using the restraints. An interview with the resident confirmed that the resident was unable to undo the restraints and personal support workers interviewed also confirmed this.

ii) the plan of care did not include an order by a physician or a registered nurse in the extended class for the use of the specific restraint the resident was using.

iii) the plan of care did not include consent from the resident or substitute decision maker (SDM) for the use of the specific restraint the resident was using.

iv) the plan of care did not include alternatives to restraining that were considered and tried but that had not been effective. It was noted that the plan of care did not address an assessment of the restraint devices in use prior to their application. The registered practical nurse who was working on the resident's unit confirmed that she was not aware that these devices would be considered a restraint if the resident was unable to undo them or if the device limited or impeded the resident's movement.

v) the plan of care did not include documentation related to assessments or reassessments of the restraint, no flow records to indicate any monitoring or repositioning activities, no reassessment of the effectiveness by registered staff every eight hours and no documentation related to the resident's response to the restraint. (167)

b) Staff interviewed and records reviewed confirmed the following for a second resident:

i) the plan of care did not include an assessment identifying the risk of injury to the resident if the resident was not restrained. The full Minimum Data Set (MDS) assessment section "P4 Devices and Restraints" indicated restraints were not used, however, the resident was observed with a restraint. Staff confirmed the device cannot be undone by the resident.

ii) the plan of care did not include an order by a physician or a registered nurse in the extended class for the use of the restraint.

iii) the plan of care did not include consent from the resident or SDM for the use of a restraint.

iv) the plan of care did not identify alternatives to the use of restraints that were tried and found to be ineffective prior to the application of the device.

v) the plan of care did not include flow records to indicate any monitoring or repositioning activities (130)

c) Staff interviewed and records reviewed confirmed the following for a third resident:

i) the plan of care did not include an assessment identifying the risk of injury to the resident prior to the application of a restraint. Staff confirmed the device cannot be undone by the resident.

ii) the plan of care did not include an order by a physician or a registered nurse in the extended class for the use of a restraint.

iii) the plan of care did not include consent from the resident or SDM for the use of a restraint.

iv) the plan of care did not identify alternatives to the use of restraints that were tried and found to be ineffective prior to

the application of the device.

v) the plan of care did not include flow records to indicate any monitoring or repositioning activities (130)

d) Staff interviewed and records reviewed confirmed the following for a fourth resident:

i) the plan of care did not include an assessment identifying the risk of injury to the resident prior to the application of the restraint. The quarterly MDS assessment section "P4 Devices and Restraints" indicated restraints were not in use, however, the resident was observed with a restraint which the resident could not undo. Staff confirmed the device cannot be undone by the resident.

ii) the plan of care did not include an order by a physician or a registered nurse in the extended class for the use of a restraint.

iii) the plan of care did not identify alternatives to the use of restraints that were tried and found to be ineffective prior to the application of the device.

iv) the plan of care did not include flow records to indicate any monitoring or repositioning activities.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 subsections:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. There has not been an annual survey of residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home [LTCHA, 2007 S.O. 2007, c.8, s.85(1)].

The Family and Resident Council interviews conducted on January 24, 2012 confirmed that satisfaction surveys were not conducted. (159)

This lack of an annual survey was confirmed by the Administrator.

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 an annual survey is taken of all residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee had not ensured the Director was informed of a critical incident no later than one business day after the occurrence of the incident [O.Reg. 79/10, s.107(3)].

The progress notes in an identified resident's record indicated the resident sustained an injury. The resident was transferred to the hospital for assessment that same day. This critical incident had not been reported to the Director as per a review of the Critical Incident System. It was confirmed by the Administrator and the Director of Care that the incident was not reported within one business day.

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 the Director is informed of incidents in the home, as listed in the regulation, no later than one business day after the occurrence of the incident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee did not ensure that the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents were communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis [O.Reg.79/10, s.228.3].

a) Results of audits, quality indicators, and quality improvement initiatives have not been communicated to the Residents' Council or Family Council. Member of the Family Council interviewed stated that the home does not share information related to changes made or quality improvement initiatives (159).

b) A review of the Resident Council and Family Council minutes between January 2011 and December 2011 found no evidence of discussion related to quality improvements made to the accommodations, care, services, programs and goods provided to residents (159).

c) Two of three residents interviewed stated that the home does not share information related to changes made or quality improvement initiatives (159).

d) This lack of communication to the Resident and Family Council's was confirmed by the Administrator.

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 the improvements made to the quality of the accommodation, care, services, programs and good provided to the residents is communicated to Residents' Council, Family Council and staff, to be implemented voluntarily.

WN #6: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home's policy related to medication administration was being complied with by registered staff [O.Reg. 79/10, s.8(1)(b)].

The home's policy (RC-07-02-01) directed registered staff to give the medication to the resident and watch him/her swallow it.

It was noted during the 1200 medication pass, that the registered staff member who was administering the medications placed medications for four residents on the dining room table in front of each of these residents. The registered staff member signed that the medications were given when she initially poured them but did not remain in the dining room to ensure that they were taken by the residents.

2. The licensee did not ensure that 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, that the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with all applicable requirements under the Act. [O.Reg. 79/10, s.8(1)(a)].

The policies and procedures for the dietary department have not been revised since 2005 and do not reflect current legislative requirements. Staff interviewed confirmed that the policies have not been revised to reflect current legislative requirements.

Policy DM- O1-O2-O1 Page 1-4 dated 2005-03-03. Food Service Supervisor and Registered Dietitian staffing requirements:

a) The home's policy stated that the Registered Dietitian of the home is on site at the home for a minimum of 15 minutes per resident per month. The current legislative requirements for the Registered Dietitian of the home is 30 minutes per resident per month.[O.Reg. 79/10, s.74(2)].

b) The home's policy for food handlers staffing indicated a minimum of 0.40 on-site hours per day, per meal day. The current legislative requirements for food service workers is 0.45 hours per day per resident.

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 all policies, plans, protocols, procedures, strategies or systems are in compliance with applicable requirements under the act and are complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (2) The licensee shall ensure that each menu,
(a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

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 did not ensure that the planned menu items are offered and available at each meal and snack [O. Reg. 79/10, s.71 (4)].

The home's planned lunch menu for the minced diet included a minced beef sandwich and coleslaw. An identified resident was not offered the planned menu at lunch and was only served a minced beef sandwich with no vegetable or coleslaw.

2. The licensee did not ensure that each menu, provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time [O.Reg 79/10, s.71(2)(b)].

The home's vegetarian menu cycle is repetitious and lacks variety.

a) Week One: veggie patty is served five times as an entrée within the week. Cheddar cheese three times and vegetarian falafel three times for lunch within the week. The planned vegetarian menu does not include all food groups each day i.e., lack of vegetable and grain servings on Friday Week 1.

b) Week Two: The vegetarian menu for Friday included cheddar cheese for lunch and cheese pizza for dinner. Sunday's menu included a cheese sandwich with a scoop of cottage cheese as an alternate menu choice. The planned vegetarian menu does not include all food groups each day i.e., lack of vegetable and grain servings on Sunday Week 2.

c) Week Three: Vegetable patty served four times within the week. Sunday dinner lacks meat and alternative servings i.e., carrot and potato curry is listed for Sunday dinner with no protein serving.

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 the menu provides for a variety of foods and meets Canada's Food Guide and that planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. 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,
(a) preserve taste, nutritive value, appearance and food quality; and
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all foods and fluids are prepared, stored and served using methods which preserves taste, nutritive value, appearance and food quality. [O.Reg. 79/10 s. 72(3)a]

a) The consistency of the pureed food served to residents at the lunch meal on January 17, 2012 was runny on the plate. The consistency of pureed cucumber, tropical fruit salad, and pureed turkey was very liquid which reduces nutritive value, appearance and increases the residents risk for choking.

b) Portion sizes offered to residents on a pureed diet were smaller than the planned menu portion size (e.g., the serving size of the pureed tropical fruit served in a small plastic cup was less than the #12 scoop portion size listed on the menu). Staff interviewed stated that portion size was not consistent.

c) Dietary staff preparing the lunch meal on January 24, 2012 did not follow recipes consistently. Vegetable soup was prepared for 126 servings, however the recipe available and followed by the cook was for 50 servings. This would affect the nutritive value of the food as the quantities of ingredients, such as vegetables, used for the soup were 50% less than required.

2. The licensee did not ensure that the food production system provided for standardized recipes for all menus [O.Reg. 79/10, s.72(2)(c)].

Not all recipes were standardized and consistent with the planned cycle menu. Recipes were not adjusted/extended for the number of servings identified on the production sheets (e.g., the recipe for vegetable soup available for the cook was for 50 servings, however, on the production sheet 126 servings of soup were identified). The Food Service Supervisor confirmed there were not standardized recipes for all menu items available.

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 standardized recipes are included in the production system for all menu items and that all food is prepared using methods to preserve taste, nutritive value, appearance and food quality, 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 subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(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 did not ensure that residents who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the resident [O.Reg.79/10, s.73(2)(b)].

Lunch was served to an identified resident at 1210. The Personal Support Worker who started to assist the resident with eating left the dining room and the resident had no assistance for approximately 10 minutes. Another staff member came to assist the resident but she also left after 5 minutes and went to serve desserts. The resident did not receive the assistance required until 1245 hours and she did not complete intake of her main entree.

2. Not all residents were provided with eating aids or assistive devices as identified in their plans of care [O.Reg. 79/10, s.73(1)9].

During the lunch meal two residents were not provided with lip plates as identified in their plans of care.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are provided with assistive devices at meal times and that meals are not served to residents requiring assistance until someone is available to provide the assistance, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

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.
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.
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.
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).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has not ensured that any actions taken with respect to a resident under the skin and wound care program were documented [O.Reg. 79/10, s.30(2)].

A resident was documented as having a wound. Weekly reassessments were not documented as required by regulation 50(2)(b)(iv). This missing documentation was confirmed by registered staff. The expectation that this documentation should be completed was confirmed by the registered staff and Director of Care.

2. The licensee did not ensure for each organized program required under sections 8 to 16 of the Act and section 48 of the regulations, that there is a written description of the program that includes it's goals and objectives [O.Reg. 79/10, s.30(1)1].

The Director of Care confirmed that the home does not have a formalized skin and wound care program that includes goals and objectives and relevant policies.

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 there is a skin care policy that includes goals and objectives and relevant policies, procedures and protocols, and that any actions taken in respect to a program are documented, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

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 :