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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 6, 2018	2018_484646_0009	013939-18	Resident Quality Inspection

Licensee/Titulaire de permis

Harold and Grace Baker Centre
1 Northwestern Avenue TORONTO ON M6M 2J7

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

Harold and Grace Baker Centre
1 Northwestern Avenue TORONTO ON M6M 2J7

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

IVY LAM (646), MATTHEW CHIU (565), NATALIE MOLIN (652), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 19, 20, 21, 22, 25, 26, 27, 28, and 29; July 3, 4, 5, and 6, 2018.

During the course of the inspection, the following inspections were also conducted:
Follow-up inspection Log #024954-17 related nutrition and hydration,
Critical Inspection Log # 008921-18 related to alleged abuse, and
Complaint Log# 009501-18 related to adequate staffing hours.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Social Worker (SW), Registered Dietitian (RD), Director of Food Services (DFS), Director of Environmental Services, Housekeeping Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Assessment Instrument (RAI) Coordinator, Resident's family members, Family Council Representative and Residents' Council President, Residents, Substitute Decision Makers (SDM), and family members.

During the course of the inspection, the inspectors conducted a tour of the home, observations of residents and home areas, observations of the dining rooms, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

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. 6. (4)	CO #001	2017_646618_0018	646

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and

friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in

order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected and promoted.

Critical incident system (CIS) report #2732-000008-18 was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date regarding alleged staff to resident abuse. Resident #045's family members provided the home video recordings of staff providing care to resident #045.

Record review of the home's Client Services Response Form (CSR) on an identified date indicated the home received a complaint from resident #045's family member, who indicated PSW #128, was disrespectful to resident #045 and that the resident had to wait a long time for PSW #128 to answer the call bell. This form also indicated resident #045 waited an identified period of time for RPN # 123 to provide a specified care activity. The summary of this CSR indicated an investigation was conducted with the abovementioned identified staff members, and all allegations were denied.

Review of video #2 of an identified date and time indicated resident #045 was in a specified area as PSW #128 entered the room. Resident #045 made an identified statement, but there was no evidence in the video to support that PSW #128 or a nurse had returned to assess resident #045 based on their statement. PSW # 128 also told the resident that they are giving the resident a particular piece of clothing, and left the identified area without providing assistance to the resident to change into the clothing item.

Review of video #6 of an identified date and time indicated resident #045 was sitting in an identified area, wearing a particular piece of clothing and calling someone on their telephone stating, "No one came in to help me."

Review of picture #8 of an identified date and time indicated a particular care item for

resident #045's that needed to be changed.

Record review of the home's follow-up to the complaints regarding resident #045's care indicated the home has received statements from resident #045's friend who indicated there was an instance where resident #045 had to wait for an identified period of time for RPN #123 provide assistance with care. The complaint also indicated another instance where resident #045's friend found the resident required assistance with a specified care activity, but after waiting for an identified period of time, the friend provided the resident with assistance. The complaint also detailed that RPN #123 had a verbal confrontation with resident #045's friend, and the friend was hesitant to visit resident #045 afterward as they did not want to see RPN #123. A statement was also received by resident #045's family member, where on an identified date, resident #045 requested assistance with a specified care activity. The family member went to inform RPN #123 directly and continued to wait until resident #045 rang their call bell after another identified period of time. The RPN did not provide the identified care until about two hours since the first request. A statement from another family member of resident #045 indicated they received multiple calls regarding the resident's urgent need for assistance with an identified care activity; one hour later the resident still hadn't received assistance. The record review indicated on another occasion, resident #045 requested the assistance with the above mentioned care activity and waited over an hour and no one helped, even after pressing the call bell.

Interview with PSW #128 acknowledged that there was an occasion when resident #045's friend had assisted the resident with care, and RPN #123 had a conflict with the friend. PSW #128 and RPN #123 stated there were times resident #045 had to wait to receive assistance with the above mentioned care activity as staff were attending to other residents.

Review of the videos with DOC # 110, and in an interview, DOC #110 stated resident #045's was not treated with dignity and respect. [s. 3. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is fully respected and promoted, 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complement each other.

This inspection for resident #004 was initiated related to weight loss. Review of resident #004's weight record showed there was weight loss since the resident's admission.

Review of the home's Nutritional Care and Hydration policy titled LTC - Nourishments, Supplements and Prescribed items' last reviewed March 31, 2018 (Index: CARE7-

O10.04) showed that all unconsumed nutritional supplements and prescribed items were to be documented and communicated to the Registered Dietitian (RD) or the Nutrition Manager (NM).

Review of the resident's current care plan indicated that the resident receives an identified prescribed snack at identified times for additional calories and protein. Observation of resident at snack service on two identified dates showed that resident #004 did not consume the identified prescribed nutritional supplement that was in the cart for the resident.

PSW #104 stated in an interview that resident #004 has not been receiving their identified prescribed nutritional supplement for about two or three months, because the resident's substitute decision maker (SDM) had requested for the resident not to have it, and the resident received another snack instead. PSW #104 stated that they had reported to RPN #111 that the resident was refusing the prescribed nutritional supplement.

RPN #111 stated that they had not received any report from PSW #104 regarding resident #004's refusal of the prescribed nutritional supplement, but the resident's SDM had notified the RPN that resident #004 was not taking the prescribed nutritional supplement for a while. The RPN had forgotten to send the referral to the RD. RPN #111 was unable to recall the time when the conversation with the SDM occurred.

The SDM of resident #004 stated in an interview that they had told the staff they did not have to give resident #004 the prescribed nutritional supplement because the resident was not taking it and did not want it.

Interview with the Director of Food Services (DFS) and RD #106 indicated that they were not aware resident #004 was not receiving their prescribed nutritional supplement, and they have not received any report or referrals from the registered staff or the PSWs.

The DFS, RD #106, and the DOC stated that PSWs were expected to notify the registered staff, and registered staff to refer to the RD if nutritional supplements and prescribed items have not been consumed. It was to be communicated to the RD or NM, and that this was not done. In this case, PSW #104 did not collaborate with RPN #111, and RPN #111 did not collaborate with RD #106 so that their development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other. [s. 6. (4) (b)]

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

This nutrition and hydration inspection was initiated for resident #002 related to weight loss from the census review.

Review of resident #002's weight records showed the resident experienced fluctuating weight over an identified period of time. Resident #002's written plan of care stated that the resident requires an identified level of assistance with eating, and to offer the resident an identified intervention for eating.

Observations of the resident on two identified dates during two identified meal services showed that the resident was provided with the abovementioned identified level of feeding assistance, but the identified intervention was not provided. Observations showed that the resident was assisted with eating by PSW #101 and RPN #103 without using the abovementioned identified eating intervention. PSW #108 was also observed to provide feeding assistance to resident #002 at snack time without using the abovementioned identified intervention.

The DFS stated in an interview that if a resident required an identified level of eating assistance, it is the home's expectation for staff to use the identified intervention indicated in the resident's plan of care.

The DFS and the DOC stated that the care set out in resident #002's plan of care for eating assistance was not provided as specified in the plan. [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:
1) staff involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other, and
2) the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 has failed to ensure that each resident who is incontinent has received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

During stage one of the Resident Quality Inspection (RQI), review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment for an identified date indicated resident #005 was at a specified risk for incontinence.

Review of resident #005's plan of care and RAI-MDS assessments further indicated the resident was at an identified level of continence of bladder and bowel when they were admitted on an identified date. The resident's level of bladder and bowel incontinence

had changed since their admission on separate identified dates.

Review of the assessment records revealed resident #005 had received an identified number of continence assessments since admission. These assessments did not include the identification of causal factors, patterns, type of incontinence and potential to restore function.

Interviews with PSW #104 and RN #107 indicated resident #005 was at an identified level of incontinence for bladder and bowel. PSW #104 stated the resident had been at this level for an identified period of time. RN #107 stated they recalled the resident was at an identified level of continence for bladder and bowel since admission, but the resident's level of bowel incontinence had changed since.

RN #107 further indicated the first two continent assessments that the resident received at two separate identified dates were completed using the home's previous continence assessment tools and they did not include the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and they did not include assessment of the resident's bowel incontinence. The third continence assessment at a later date was completed using the home's current assessment tool but the bowel and bladder sections were not completed, and therefore the assessment did not include the above mentioned assessment parameters.

Interview with the ADOC who is the Continence Care Program Lead of the home indicated the home uses the new continence assessment tool to include the above mentioned assessment parameters. The assessment also included the use of a toileting pattern diary on paper and/or in Point Click Care (PCC) to track the pattern of incontinence. The ADOC acknowledged that resident #005 was incontinent of bladder and bowel and had never received an assessment for their bowel incontinence. The ADOC further confirmed the above mentioned continence assessments that the resident received since admission did not include the identification of causal factors, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

2. During stage one of the RQI, RAI-MDS assessment revealed resident #003 was at a specified risk for incontinence.

Review of resident #003's plan of care and RAI-MDS assessments indicated the resident was at an identified level of continence for bladder and bowel when they were admitted on an identified date. The resident's level of bladder and bowel incontinence had

changed to another identified level of incontinence since the admission date.

Review of the assessment records revealed resident #003 had received a continence assessment approximately one month after admission. This assessment did not include the identification of causal factors, patterns, type of incontinence and potential to restore function.

Interviews with PSW #117 and RPN #111 indicated resident #003 was incontinent of bladder and bowel. PSW #117 stated the resident had been incontinent since they were admitted to the home on an identified date. RPN #111 stated the resident received a continence assessment using the previous continence assessment tool when they were admitted, and no other continence assessments have been done since then.

Interview with RN #107 indicated the previous continence assessment tool did not include the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Interview with the ADOC who is the Continence Care Program Lead of the home indicated the home uses a new continence assessment tool to include the above mentioned assessment parameters. The assessment also included the use of a toileting pattern diary on paper and/or in PCC to track the pattern of incontinence. The ADOC acknowledged that resident #003 was at an identified level of continence for bladder and bowel as mentioned above. The ADOC further confirmed the above mentioned continence assessment that the resident received since admission did not include the identification of causal factors, type of incontinence and potential to restore function with specific interventions. [s. 51. (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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During stage one of the RQI, the following disrepairs were observed on an identified date:
- In an identified resident's room: The padding on the handle of an identified equipment was broken and wrapped with duct tape, and
- In another identified resident's room: An identified item on wall was broken and covered with red tape.

Further observations on two other identified dates, indicated no significant changes to the above mentioned disrepairs.

Interview with Housekeeping Aide (HA) #114 indicated they were not aware that the padding on the handle of the identified equipment in the first identified room was broken, and they did not know who taped it with the duct tape. The staff member indicated they will report it to the charge nurse and get it fixed.

Interview with RN #120 indicated they were not aware the handle of the identified equipment had been broken or how long it had been broken. The staff member further stated after it was reported to them by HA #114, they submitted a maintenance request to the maintenance department.

Interview with a family member indicated the second item in the second identified room had been broken for an identified period of time, but they did not know if the home's maintenance staff knew about it.

Interview with HA #116 indicated the second identified item had been broken for an identified period of time and the staff member had reported the disrepair to the former Director of Environmental Services (DES) who no longer works in the home. The staff stated they were not aware of any repair had been done.

Interview with DES #119 indicated they were not aware that the first identified care equipment in the first identified room was broken until RN #120 submitted the maintenance request. DES #119 further stated they were not aware that the second identified item in the second identified room was broken and no record of the maintenance request was found. DES #119 acknowledged both the identified care equipment and the identified item in identified residents' rooms were not in a good state of repair. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that that each resident of the home had his or her personal items, including glasses, labelled within 48 hours of admission and of acquiring in the case of new items.

During stage one of the RQI, the RAI-MDS assessment indicated a lack of corrective action for visual problems for resident #003.

Review of resident #003's plan of care and RAI-MDS assessment on an identified date indicated the resident had cognitive, physical, and visual impairments. The records further revealed the resident had eye glasses for their visual impairments.

On two identified dates, resident #003 was observed wearing glasses on the unit. Further observations on the second identified date, together with PSW #117 revealed the glasses were not labelled.

Interviews with PSW #117 and RPN #111 indicated resident #003 had visual impairment and wore glasses for activities. The staff members stated the resident had more than one pair of glasses, and the glasses that the resident had been wearing were there for a long time. PSW #117 acknowledged that the pair of glasses that resident was wearing was not labelled.

Interview with ADOC indicated they were aware that resident #003 wore glasses and all glasses should be labelled. The ADOC acknowledged resident #003's glasses was not labelled as required. [s. 37. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities.

An anonymous complaint was submitted to MOHLTC in relation to staff hours in the home.

Of the staffing hours reviewed, with reference to regulation 75(5)(a)(b): When considering the hours in a week devoted to producing meals and other food and beverages for non-long term care home (LTCH) residents, the minimum staffing hours for the Long-Term Care Home (LTCH) nutrition manager under subsection (3) were not provided. Based on 120 LTCH residents and an average of 82 Retirement home residents consuming three meals daily during a 12-day period, the Long-Term Care Homes Financial Policy "LTCH Level-of-Care Per Diem Funding Policy" section 4 and 4.1 required a minimum of 64 hours per week for the home's Nutrition Manager for the management of all resident and non-resident nutritional care and dietary service programs, where staff are involved in activities in addition to food preparation for non-LTCH residents.

Interview with the Administrator indicated the licensee provided an identified number of hours per week for the LTCH Nutrition Manager (because the regular Nutrition Manager was on vacation and not replaced), resulting in a shortfall of an identified number of hours per week for the above mentioned period. [s. 75. (3)]

Issued on this 25th day of September, 2018

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

Original report signed by the inspector.