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 |
|---|---|---|---|
| Jul 30, 2014 | 2014_179103_0017 | O-000650-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

THE CORPORATION OF THE COUNTY OF HASTINGS
1M Manor Lane, Box #758, BANCROFT, ON, K0L-1C0

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

HASTINGS MANOR HOME FOR THE AGED
476 DUNDAS STREET WEST, P.O. BOX 458, BELLEVILLE, ON, K8N-5B2

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

DARLENE MURPHY (103), BARBARA ROBINSON (572), GILLAN CHAMBERLIN (593), HUMPHREY JACQUES (599), JESSICA PATTISON (197), MELANIE SARRAZIN (592)

**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): July 14-18, 21-23, 2014**

**During the course of this inspection, a complaint log was also inspected: Log #O-000487-14.**

**During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of the Resident Council, President of the Family Council, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Cooks, Dietary aides, Registered Dietitian (RD), Food Service Manager, Housekeeping staff, Environmental Supervisor, Environmental Manager, Life Enrichment aides, Activity Coordinator, Physiotherapy aides, Public Health Nurse affiliated with the home, Assistant Director of Care, Director of Care, and the Administrator.**

**During the course of the inspection, the inspector(s) completed an initial walkthrough tour of all resident care units, observed resident dining, resident activities, and resident care, observed medication administration including medication storage areas, reviewed resident health care records and home policies related to various practices in the home.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Food Quality**
**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**
**Recreation and Social Activities**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

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

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

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

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

**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 comply with LTCH 2007, s. 6 (7), in that the licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of the Resident's plan of care indicated that Resident #44 was to receive regular consistency fluids. This was confirmed by S#114 who advised Resident #44

was trialled with nectar thick fluids however thickened fluids were not continued. A review by Inspector #593 of the diet roster on the beverage trolley and servery state that Resident #44 was to be provided nectar thick fluids if thin fluids were not tolerated.

On July 17th 2014, Resident #44 was observed to receive a thickened fluid with lunch, Resident #44 was not observed to have been trialled with a thin fluid prior to receiving a thickened fluid. S#124 advised that Resident #44 receives nectar thick fluids and that this was a new dietary requirement as it was only recently that Resident #44 was receiving thin fluids. Inspector #593 observed at this time that S#124 was feeding the thickened fluid to Resident #44 with a spoon and that the fluids appeared to be between honey and pudding consistency.

On July 18th 2014, a PSW was observed feeding Resident #44 a thickened fluid during the breakfast period. The juice was observed to be a consistency between honey and pudding consistency. [s. 6. (7)]

2. Resident #33's current plan of care dated April 8, 2014 was reviewed related to eating and nutritional status.

Resident #33's care plan states the following:
- provide extensive assistance with meals (resident requires some feeding), may feed self some finger foods
- provide meal on a smaller plate as the large plates overwhelm the resident
- serve meals on a lip plate.

On July 21, 2014, Resident #33 was observed at the lunch meal. The resident was given lunch at approximately 1218 hours on a large plate that was not a lip plate. The resident was observed looking at the food for a few minutes and then started to slowly take small bites. At times, the resident was observed to stop eating but would then start again. Staff did not approach resident until 1240 hours to encourage and provide assistance.

On July 22, 2014, Resident #33 was observed at the breakfast meal. The resident was given breakfast on a small plate that was not a lip plate.
The diet sheet at the servery was reviewed and there was no indication that this resident required either a small plate or a lip plate. [s. 6. (7)]

3. Resident #39's plan of care in effect at the time of this inspection related to activities was reviewed. It included:

- One to one therapy will be provided to resident 3x's per week for social, emotional and intellectual wellbeing,
-Offer activity programs directed toward specific interests/ needs of resident,
-Respect resident's choice in regard to limited/ no activities
-Visit once per day with resident to develop or sustain contact using conversation and hopefully establish a relationship of trust,

Observations of Resident #39 were made on July 21, 2014 at 0900 hr, at 1100 hr and at 1600 hr. Resident #39 was observed sitting in the lounge and not involved in any activities at these times. A review of the Multi-Day participation report from Activity Pro for the period of July 7 to July 22, 2014 was completed. Resident #39 was noted as attending the following activities:

-one active participation in bowling,
-one active participation volleyball,
-Average participation for entertainment,
-Active participation in spiritual time,
-Active participation in pet therapy,
-Active participation in folding,
-Active participation in sing along,
-Active participation in spiritual time.

The Multi-Day participation report was confirmed by the Activity Coordinator by interview and record review of the monitoring tool from Activity Pro. For the period of July 7 to July 22, 2014, the tool indicated the resident was not encouraged and did not attend activities as indicated in the plan of care. There was no evidence to support the resident had refused to participate in offered activities.

The plan of care for Resident #37 indicated resident was to attend the following activities:

-One spiritual program per month,
-Pet therapy twice per month,
-One on one visit PRN,
-1-2 activities per week (Musical/reading.

Observations of Resident #37 were made on July 15 and 21, 2014. Resident #37 was not observed in any activities .

A record review of the Multi-Day participation report from Activity Pro for the period of July 7 to July 22 was completed. Resident #37 was marked as attending the following activities:

-One average participation in entertainment,
-One active participation for outdoor entertainment.

The participation record was confirmed by the Activity Coordinator by interview as being correct.

For the period of July 7 to July 22, 2014, the tool indicated the resident was not encouraged and did not attend activities as indicated in the plan of care. There was no evidence to support the resident had refused to participate in activities.

The plan of care for Resident #33 indicated resident to attend the following activities:

-One spiritual program per month,
-Pet therapy twice per month,
-One on one visit PRN,
-1-2 activities per week (Musical/reading).

Resident #33 was observed on July 15, 16 and 21, 2014 and was not noted to be involved in any activities.

A record review of the Multi-Day participation report from Activity Pro for the period of July 7 to July 22 indicated Resident #33 had attended the following activities:

-One active participation in outdoor enjoyment,
-One active participation for spiritual time,
-One low participation for spiritual time,
-One average participation in entertainment.

The information was confirmed by the Activity Coordinator by interview and record review of the monitoring tool from Activity Pro.

For the period of July 7 to July 22, 2014, the tool indicated the resident was not encouraged and did not attend activities as indicated in the plan of care. There was no evidence to support the resident had refused to participate in offered activities. [s. 6. (7)]

4. Resident #17's care plan in effect at the time of the inspection under "Eating" stated resident is to receive a gluten modified, pureed diet (trepuree only to ensure a smooth, consistent texture). Offer 2 choices of trepuree at lunch and supper.

Throughout the inspection period, Resident #17 was not observed to be offered 2 choices at mealtime. [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 Residents #37, #33 and #39 are assisted/encouraged to attend programming as outlined in their plan of care, Resident #44 receives fluids thickened to the consistency outlined in the plan of care, Resident #33 receives assistance at meals in accordance with the plan of care, and Resident #17 receives choices in meals in accordance with the plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

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

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 2 in that a door leading to a non-residential area was not kept closed and locked and was not supervised by staff to restrict unsupervised resident access.

On July 18, 2014 on or about 0940 hr and again on July 22, 2014 on or about 1400 hr, the garbage chute door was found ajar on the Oak Villa. The inspector was able to enter into the room where two chute doors were found. The chutes were closed and latched shut and both chutes were of a size and were located at a height above waist level making accessibility by a resident unlikely. The door handle was locked, however the door had not been pulled shut. There were no residents in the immediate area at the time of the discoveries and registered staff were informed. [s. 9. (1) 2.]

2. On three different dates (July 16, 17 and 21, 2014) the garbage chute door on the Pine Villa (3rd floor) was observed to be left ajar. There was no staff supervising the door on any of these dates. [s. 9. (1) 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 all doors leading to non resident areas are kept closed and locked when not in attendance by staff, to be implemented voluntarily.***

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**WN #3: 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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCH 2007, s. 11 (2), in that the licensee of a long-term care home did not ensure that residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

A review of the Resident's plans of care indicate that Resident's #42 and #43 are required to have nectar thick fluids and Resident #45 is required to have pudding thick fluids. This was confirmed with the home's Registered Dietitian S#114 during an interview on July 21, 2014. This information provided in the care plan was also consistent with the Resident's dietary information provided on the dietary roster located on the beverage trolley and the serving station in the Spruce Villa.

During the lunch period on July 15th 2014, Inspector #593 observed S#124 provide Resident #42 a water that was not thickened. A thickened fluid was then provided to Resident #42 a few minutes later that was the incorrect consistency. S#125 was observed to be providing feeding assistance to both Residents #42 and #45. Both Residents were observed to have a thickened fluids. S#125 advised that both the thickened fluids were honey thickness and that the thickened water provided for resident's is usually a different thickness level than the thickened fruit juices. Inspector #593 observed both resident's to have a thickened fruit juice and thickened water which were both observed to be thickened to honey consistency.

On July 17th 2014, no pre-thickened fluids were observed to be available on the beverage trolley for the lunch period in the Spruce Villa. S#123 advised that the thickened fluids are kept in the refrigerator until the start of the meal period as the thickened fluid starts to thin at room temperature. S#123 was then observed to collect a jug of thickened fluids which was pudding thick consistency and advised that staff will thin this thickened fluid out with water for residents requiring a thinner texture than pudding consistency. Inspector #593 observed two individual cups of thickened fluid which S#123 had previously thinned out for resident's.

On July 18, 2014, during the morning beverage round, S#115 was observed to provide a thin regular textured beverage to Resident's #42 and #43. S#115 was interviewed and stated they did not realize Resident #42 was required to have thickened fluids as this was a new dietary requirement for this Resident and it was not highlighted on the diet roster attached to the beverage trolley.

During an interview on July 21, 2014, the home's Registered Dietitian, S#114 confirmed that Resident #42 was prescribed nectar thickened fluids on June 17, 2014. She stated that when a dietary change is made for a resident, the Registered Dietitian e-mails the food service supervisor who physically highlights the changes on the diet roster. This remains highlighted on the dietary roster for one week and then is changed permanently on the diet roster. The Registered Dietitian advised that dietary

changes are also recorded in the dietary communication log in each kitchen servery on each level of the home by the food service supervisor which is required to be read by dietary staff and additionally this information is also verbally communicated to dietary staff in food service production meetings. [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 #42, #43, and #45 are provided with fluids that are safe, to be implemented voluntarily.***

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**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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007 s. 15 (2) (a) whereby the home, furnishings and equipment are not kept clean and sanitary.

The following observations were made during the inspection:

-The furnishings in the Oak Villa common areas including the sunroom are stained and soiled. The carpets are also stained and discoloured,
-The Spa Room in Oak Villa has brown stains on the floor beside the shower and chair lift #127 has some rusting at the base with white patches to both legs,
-The dining room floors, tables and chairs on Oak Villa had food spills and food crumbs evident three hours after lunch,
-The Spa Room in Maple Villa has some brown spots leading to shower area. The

floor is observed to be dusty,
-The furnishings in the Cedar Villa common areas, sunroom and TV room as well as the chairs outside of the nursing station are stained and soiled. The carpets are also stained and discoloured.
-The Spa Room in Cedar Villa has rust coloured staining within the toilet bowl and at the base of the toilet on the floor. There is loose hair observed in the drawer of the cabinet,
-The Spa Room in Spruce Villa has brown stains on the floor from the toilet to the shower, dust and debris behind the door and black marks on the wall,
-The sunroom in Spruce Villa has stains on the tiles,
-The hallway to room 206 in Beech Villa had a sticky spill on the floor and there were food and drink spills in the dining room, evident three hours after lunch,
-Rooms 206, 304, 508 and 554 had scuff marks and stains on the floor,
-Room 539 had marks on the walls and stains on the tiles behind the toilet, and
-Room 217 had marks on the tiles. [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, 2007 s. 15 (2) (c) whereby the home, furnishings and equipment are not maintained in a safe condition and in a good state of repair.

The following observations were made during the inspection:

- The furnishings in the Oak Villa common areas and sunroom are torn. Carpets are worn through in some areas,
-The carpets have worn areas in the Elm Villa,
-The furnishings in the Cedar Villa sunroom and the chairs outside of the nursing station are torn.
-The Spa Room in Spruce Villa has rust on the handle bar beside the shower, the wall is chipped, and there are strips of paint missing.
-The carpet is worn in the Pine Villa, especially outside the nursing station.
-Room 536A has disrepair on the wall at the end of the bed,
-Room 306 has scarring on the wall in the bathroom and chips out of the drywall near the towel bar,
-Room 217B has chipped paint on the walls,
-Room 516A has disrepair on the wall with a large section of missing paint,
-Room 430A is missing baseboard in the bathroom behind the toilet,
-Room 554A has chipped paint on the walls,
-Room 314A has pieces of drywall missing from the wall and the paint is chipped,

-Room 539A has worn wallpaper and chipped paint on the walls, and
-Room 244A and Room 252A has worn wallpaper and scuff marks on the walls. [s. 15. (2) (c)]

***Additional Required Actions:***

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

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**WN #5: 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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 129 (1) (a) (ii) whereby drugs that are stored in an area or a medication cart are secure and locked.

On an identified date, a registered staff member was observed leaving an unlocked medication cart on the Spruce Villa unattended and out of sight in the common area to answer a phone call. One ambulating resident was present with five other residents in their wheelchairs in the area of the unlocked medication carts. [s. 129. (1)]

2. On another identified date, S#105 was observed administering medications to Residents #48, #49, #50, #52, #53, #54 outside the dining room on Elm Villa on or about 1130 hr. The medication cart was left unlocked and out of her sight as she administered medications in different areas of the dining room.

On another identified date, the Medication Room door was observed open and unlocked on Elm Villa at 1215 hr. The keys were in the Emergency Drug Cupboard so it was unlocked within the room. S#120 stated that she had forgotten to lock the door when leaving the room. [s. 129. (1) (a)]

3. On an identified date, the registered staff member administering the noon medications to the residents on the Cedar villa was observed to leave the unlocked medication cart outside of the resident dining area while giving medications out of sight of the medication cart at the far end of the dining area. A female resident was seated at a counter next to the unlocked cart.

On an identified date, an unlocked medication cart was found on the Pine Villa on a resident hallway with the keys left in the lock. The registered staff was absent from the cart for more than five minutes and was eventually observed exiting a resident room at the far end of the corridor before returning to the medication cart. [s. 129. (1) (a) (ii)]

4. On an identified date, the medication cart on the Pine Villa was observed on or about 1200 hr to be parked outside of dining room. S#104 was observed to leave the area to attend to a medication room out of sight of the unlocked medication cart. S#104 returned to the cart approximately five minutes later. S#104 was observed to leave the area a second time with the ADOC. The medication cart was again left unlocked and out of the sight of the staff member for approximately five minutes. [s. 129. (1) (a) (ii)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all areas where drugs are stored are kept secured and locked when not in use, to be implemented voluntarily.***

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**WN #6: 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. (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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10, s. 229 (4) whereby all staff did not participate in the implementation of the infection prevention and control program.

On July 15 and 16, 2014, numerous unclean and unlabelled combs and brushes with a large quantity of hair evident were observed in the Oak Villa spa room suggesting the shared use of these items among residents. Additionally, soiled, unlabelled nail clippers with evidence of nail clippings in them were found loosely stored in a drawer among nail clippers that appeared to be clean.

Additionally, visibly soiled washroom call bell cords were observed in four resident bathrooms and a portion of two resident call bells were found lying on the bathroom floor.

The ADOC was interviewed in response to these findings. The ADOC stated used nail clippers are to be placed in a separate labelled container and that all used nail

clippers are sanitized on nights by PSW staff. Additionally, the ADOC agreed the shared use of combs and brushes does not support the home's infection prevention and control practices. The ADOC stated the home is currently in the process of replacing the white call bell cords in the resident's rooms and bathrooms with red call bell cords that can be cleaned by housekeeping staff. The ADOC stated the white call bell cords are being eliminated entirely. [s. 229. (4)]

2. The licensee has failed to comply with O. Reg 79/10 s. 229 (10) 1 whereby each resident admitted to the home must be screened for tuberculosis within fourteen days of admission unless the resident has already been screened at some time within the ninety days prior to admission and the documented results of this screening are available to the licensee.

Resident #55 was admitted to the home on an identified date. During a review of the resident's immunization status, it was noted that a symptom checklist was completed on an identified date. Under Chest X-Ray findings, "no record" was indicated.

The DOC and ADOC were interviewed in regards to the home's current TB screening practices. The DOC stated residents under the age of 65 years still receive two step mantoux testing, but resident's over the age of 65 years only have a symptom checklist completed.

The DOC was asked what the local Public Health Unit's recommendations are in regards to the screening of residents over the age of 65 years. The DOC stated the Public Health Nurse had attended a Professional Advisory Committee meeting at Hastings Manor on March 5, 2014. She stated at that time the home was advised that the new recommendations for residents over the age of 65 years was a chest X-ray ninety days prior to admission or within fourteen days after admission to long term care. In addition to the chest x-ray, the physician was required to complete a symptom review tool. A copy of the minutes was reviewed by the inspector and the minutes indicated "effective immediately".

According to the DOC and ADOC, the home raised several concerns during the meeting related to transportation costs, scheduling challenges and the burden this would place on the health care system. Both the ADOC and DOC stated these measures were not yet in effect and that no further direction had been received from the Public Health Unit. The DOC and ADOC stated that all newly admitted residents in 2014 over the age of 65 years have only had a symptom checklist completed and that

chest x-ray's are not being completed.

The Public Health Nurse S#137 was interviewed. She stated the home was advised during the March 5, 2014 Professional Advisory Meeting of the new Public Health Unit recommendations and agreed the home had raised concerns related to these recommendations. She stated the concerns were discussed with Dr. Schabas at the Health Unit who sympathized with the concerns but supported the need for the recommendations to be put into practice. S#137 was also able to provide this inspector with an email that had been sent to the home on March 13, 2014 outlining the need to put the recommendations into place. [s. 229. (10) 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 all staff adhere to the home's infection prevention and control practices related to the use of nail clippers and sharing of resident personal items and that each resident admitted to the home must be screened for tuberculosis within fourteen days of admission unless the resident has already been screened at some time within the ninety days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.***

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**WN #7: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007, s. 3. (1) 11. (iv), whereby the licensee did not ensure that each resident of the home had his or her personal health information kept confidential

On an identified date, S#105 administered medications to Residents #48, #49, #50, #52, #53, #54 outside the dining room on Elm Villa on or about 1130 hr. Residents' personal health information was left visible on the computer screen that is part of the Electronic Medication Management System when S#105 left the cart out of sight to administer the medications.

S#106 on Pine Villa on or about 1200 hr was observed to leave Residents' personal health information visible on the computer screen when S#106 left the cart out of sight to administer medications. [s. 3. (1) 11. iv.]

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**WN #8: 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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 8 (1) (b) in that the home's weight monitoring policy was not complied with.

O. Reg. 79/10, s. 68(2)(e)(i) requires that the home's organized program of nutrition care includes a weight monitoring system to measure and record monthly weights for each resident.

The home's policy/procedure C-25 "Monitoring Residents' Weight and Height" states that resident weights are to be taken by Nursing staff (no later than the 15th of the month) and recorded in the resident's chart.

The May 2014 weight for Resident #17 was not recorded onto the resident's chart until May 27, 2014. This weight triggered a 7.6% weight loss for the resident over a 3 month period. As a result of this late weight entry, the resident's May 2014 weight loss was not assessed until June 2014.

On July 23, 2014, during an interview, the DOC stated it is her expectation that weights are taken and recorded before the 15th of each month and confirmed with the Inspector that there was no documented reason for this late input. [s. 8. (1) (a),s. 8. (1) (b)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10 s. 17 (1) (a) whereby the resident-staff communication and response system was not easily used by residents at all times.

During this inspection, bathroom call bells for Resident's #13, #17, #22, #27 and #35 were observed to be tied several times to the toilet rails such that the call bell could not be activated while seated on the toilet. Additionally, bathroom call bells for Resident's #7 and #28 were found to be hanging behind the toilet and were inaccessible to the resident when seated on the toilet. [s. 17. (1) (a)]

**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference**

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

**s. 27. (1) Every licensee of a long-term care home shall ensure that,**
**(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).**
**(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).**
**(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 27 (1)(a), in that every licensee of a long-term care home shall ensure that a care conference of the interdisciplinary team providing a resident's care is held within 6 weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

Family member #51 was interviewed and advised they had not attended a family care conference within the past year for their family member and that since admission of their family member four years prior, they had attended only two family care conferences.

A review of Resident #38's records indicated the most recent family care conference held was October 2012. Documentation was available for the nursing portion of the care conference however documentation could not be located for dietary, activation and housekeeping/laundry. Previous to this, documentation was available for a family care conference dated February 2012, for nursing, dietary, activation and housekeeping/laundry disciplines. S#120 confirmed that no other family care conference documentation was available in the resident's binder and this information was not stored elsewhere.

On July 22nd 2014, the Director of Care was interviewed and stated the home's process for family care conferences is nursing staff are present for the entire conference and the other disciplines including dietary, activation and housekeeping/laundry attend their relevant section of the conference. The DOC confirmed that a document for each discipline attending the conference should be completed and kept in the Resident's binder or on Point Click Care.

The DOC confirmed that the most recent family care conference held for Resident #38 was October 2012 and no further documentation was available in addition to what was located in the Resident's binder. [s. 27. (1) (a)]

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**WN #11: 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 comply with O. Regs 79/10 s. 37 (1) (a) whereby resident personal items, including personal aides such as dentures, glasses and hearing aides were not labelled within 48 hours of admission and of acquiring, in the case of new items.

The following observations were made during the inspection:

-an identified resident room had an unlabelled soap dish with bar of soap by the sink, as well as an unlabelled hair pick with hair in it,
-The Tub Room in Elm Villa had two unlabelled bars of soap by the sink, one unlabelled men's deodorant, and three unlabelled black combs,
-The Spa Room in Oak Villa had eight unlabelled combs and two unlabelled brushes with visible hair/dander in them, and
-an identified resident room had two unlabelled urinals. [s. 37. (1) (a)]

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

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

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 71(1)(c) in that a resident was not offered an alternative choice of entree and vegetable at lunch and dinner.

The plan of care for Resident #17 last reviewed May 28, 2014 states to provide the resident with a modified diet with honey to pudding thickened fluids.

FSS #S133 confirmed that the resident is sent one modified meal at lunch and supper and is therefore not being offered a choice of entree or vegetable. The FSS further stated that there are eleven varieties of modified meals that the resident could receive, however, the meat, starch and vegetable are all in one dish together, so the resident would have to take whatever vegetable came in the entree as opposed to being offered a choice.

On July 22, 2014, Registered Dietitian #S114 confirmed with the cook via telephone that only one modified meal is sent up to Resident #17 at lunch and supper. The cook, S#136 also stated that she chooses which modified meal to make for the resident based on what the main entree is on the regular menu. For example, if chicken is the main entree for lunch that day, the resident will get a modified meal that contains chicken. [s. 71. (1) (c)]

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**WN #13: 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:**
**1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

**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:**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 73 (1)(1), in that every licensee of a long-term care home has a dining and snack service that includes, at a minimum, communication of the seven-day and daily menus to residents.

On July 14 and 18, 2014, daily and weekly menus were posted in the common areas on Elm, Pine and Spruce Villa's. The observed posted menus communicated to Residents the menu choices for breakfast, lunch and dinner. No snack menus were observed in the Resident common area's within the home.

During an interview on July 21, 2014, S#114 advised that the snack menu is kept in a binder behind the servery on each level of the home.

As such, the licensee has failed to communicate the seven-day and daily snack menus to Resident's within the home. [s. 73. (1) 1.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)10 in that proper techniques were not used to assist residents who require feeding assistance.

The plan of care last reviewed April 8, 2014 for Resident #33 states the following:
EATING:
- provide extensive assistance with meals.

On July 21, 2014 at the lunch meal, a PSW was observed to assist Resident #33 with the meal while in a standing position.

The plan of care last reviewed June 9, 2014 for Resident #16 states the following:
EATING:
- Resident requires assistance to maintain function related to cognitive deficit.
- Resident is at risk for choking.

On July 22, 2014, during the breakfast meal, S#135 was observed to assist Resident #16 to eat toast and drink juice. S#135 was observed in a standing position while assisting the resident. [s. 73. (1) 10.]

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**WN #14: 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,**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10 s. 87 (2) (d) whereby procedures for addressing incidents of lingering offensive odours were not implemented.

On July 17, 2014, a urine odour was noted by Inspector #197 in the third floor lounge located at the end of the hallway by room #320.

On July 18, 2014 on or about 1045, this inspector found the odour was still evident in this lounge area and that the odour was also evident into the hallway outside of rooms #320 and #321. Housekeeping staff had completed the cleaning of this hallway and lounge area at this time. At 1510 hr, the urine odour was still evident in both the lounge area and into the hallway outside of the lounge.

On July 21, 2014 at 1056 hr, the urine odour was detected in both the third floor lounge and into the hallway outside of this lounge. The housekeeping staff had completed the cleaning of this area at this time.

On July 22, 2014 at 0910 hr, the urine odour in the third floor lounge and in the end of this hallway continued to be evident. S#109 was interviewed and stated the urine odour associated with the third floor lounge has been longstanding. The staff member stated it has been reported to housekeeping on several occasions and believed the carpet in that area had been steam cleaned approximately one month ago. S#109 agreed the urine odour was still a problem.

Housekeeping staff S#127 was observed to be working on the third floor and was interviewed. The staff member agreed the lounge area and outside into the hall had a detectable urine odour. S#127 stated the area had been cleaned today and felt there was no improvement in the odour at that time.

The Environmental Services Supervisor, S#116 was interviewed. She stated the housekeeping staff are responsible for responding to staff concerns related to

offensive odours and that the home has a number of products to address the odours. S#116 stated she was unaware of lingering odours associated with the third floor lounge and reiterated the housekeeping staff are responsible for addressing the odours with daily cleaning routine. During this interview, S#127 advised the Environmental Supervisor that a spray on odour eliminator had been used in the third floor lounge and hallway at 1150 hr following the discussion with this inspector.

July 22, 2014 on or about 1230 hr, the odours previously noted in the third floor lounge and hallway were no longer evident. The area was rechecked at 1630 hr and remained odour free.

On July 23, 2014 at 0900 hr, the housekeeping staff had completed the cleaning of the third floor lounge area. There was no evidence of urine odour at that time and when rechecked later that day at 1500 hr.

Hastings Manor's Policy, "Odour control", #HE-95, was reviewed. The policy was developed for the purpose of addressing lingering odours. The policy indicates under Procedure, to utilize an odour counteractant as one of the interventions to control odours.

The home failed to put the procedure into practice in addressing the odours associated with the third floor lounge and associated hallway. [s. 87. (2) (d)]

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**Issued on this 5th day of August, 2014**

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