Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 18, 2015 | 2015_321501_0017 | 025549-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

KENNEDY LODGE
1400 KENNEDY ROAD SCARBOROUGH ON M1P 4V6

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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589), STELLA NG (507)

### 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): September 29, 30, October 1, 2, 5, 6, 7, 8, 9, 13, and 14, 2015.**

**The following intakes were inspected concurrently:**
**Complaint #007663-15, #024803-15 and #009274-14;**
**Critical Incident #009769-14 and #024552-15; and**
**Follow Up #012764-15.**

**During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Care (DOC), Associate Director of care (ADOC), Minimum Date Set- Resident Assessment Instrument(MDS-RAI)Coordinators, Registered Dietitian (RD), Social Worker (SW), Staff Educator (SE), Environmental Service Manager (ESM), Dietary Manager (DM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aides, Dietary Aides, students, Family Council member, Resident Council president, residents and Substitute Decision Makers (SDMs).**

**During the course of the inspection, the inspector(s)conducted a tour of the home, observed meal service, medication administration system, staff and resident interactions and the provision of care, and reviewed health records, complaint and critical incident record logs, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.**

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

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Residents' Council**
**Responsive Behaviours**
**Training and Orientation**

**During the course of this inspection, Non-Compliances were issued.**
- **11 WN(s)**
- **6 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. 19. (1) | CO #001 | 2014_280541_0040 | 600 |

| 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. 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 its equipment is maintained in a safe condition and in a good state of repair.

On October 2, 2015, observation revealed a cracked plastic cup at a table in the third floor dining room just before lunch. Interview with the Dietary Manager revealed this should never have been placed at a resident's place setting.

On October 5, 2015, observations just before lunch revealed that in the servery area there were six plastic lipped plates that had damaged areas. Interview with the Dietary Manager revealed that these plates should not be in circulation.

Interview with the Dietary Manager confirmed that cracked cups and damaged plastic plates should be taken out of circulation as they could pose risks to residents in terms of plastic pieces getting into their food and hot beverage spilling from cracked cups. [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 that its equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

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

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

**Findings/Faits saillants :**

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

Record review of an assessment from an identified date revealed an identified resident was diagnosed with various medical conditions. Record review of progress notes and staff interview revealed the family indicated that when the resident experienced pain, he/she would show specific signs and symptoms. Review of the physician's orders revealed the identified resident was to receive an identified analgesic medication as needed for pain/fever.

Further record review of the progress notes revealed the identified resident had exhibited the above mentioned signs and symptoms of pain on an identified date and staff had administered an identified anti-anxiety medication. On this day, after several hours, record review indicated the resident was still showing signs and symptoms of pain and staff had given him/her another dose of anti-anxiety medication.

Record review revealed no indication that a pain assessment had been conducted using a clinically appropriate assessment instrument when the resident began exhibiting signs and symptoms that had been previously identified as indicators for pain.

The home's policy titled ”Pain Assessment and Symptoms Management” number LTC-E-80 revised August 2012, stated all residents will be assessed and systematically monitored for pain using an evidence informed approach. The resident’s pain will be measured using a standardized, evidence informed clinical tool. The nurse will determine what tool is most appropriate for accurate pain assessment, based on the resident’s cognitive, physical and behavioral characteristics.

Interview with an identified RPN revealed registered staff perform pain assessment on a form titled, “Pain Assessment in Advanced Dementia”, on admission, quarterly and when the resident's condition changes.

Interview with the DOC confirmed every resident should be assessed for pain on admission, quarterly and when a resident's condition changes or a resident complains or experiences signs of pain. [s. 52. (2)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that strategies have been implemented to respond to the resident demonstrating responsive behaviours.

On an identified date and time, the inspector observed an identified resident in a hallway experiencing responsive behaviours. At the other end of the hallway, an identified PSW was pushing another resident in a wheelchair and indicated no sign that he/she heard the identified resident having responsive behaviours.

Record review of the most recent written plan of care indicated that when the identified resident exhibited any signs of discomfort, physical or emotional, the registered staff was to be informed immediately.

Interview with the identified PSW revealed he/she heard the identified resident having responsive behaviours earlier. He/she went and tried to console resident, but realized it was not helping so proceeded to provide care to the other resident. The identified PSW did not notify the registered staff and was not aware that he/she should have.

Interview with two other PSWs revealed they were not regular staff on this unit and they were also not aware that when the identified resident experienced responsive behaviours the registered staff were to be notified. Both PSWs stated they relied on the registered staff to inform them when they need to provide specific intervention to residents experiencing responsive behaviours and had not been informed of the identified resident's plan of care.

Interview with the Executive Director confirmed that all staff are responsible to be aware of strategies developed for residents demonstrating responsive behaviours and to implement these strategies when appropriate. [s. 53. (4) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that strategies have been implemented to respond to the resident demonstrating responsive behaviours, to be implemented voluntarily.***

**WN #4: 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: 4. Monitoring of all residents during meals. 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: 7. Sufficient time for every resident to eat at his or her own pace. 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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents are monitored during meals.

On an identified date, during the lunch meal in the dining room observation revealed an identified resident was served an extra serving of dessert by a tablemate who had helped himself/herself to an unattended dessert cart. Record review revealed the identified resident was on a diabetic diet. Interview with the RD revealed the identified resident should not normally receive two desserts.

On an identified date, during the breakfast meal in the dining room, observation revealed an identified resident was eating regular textured mandarin oranges. Record review revealed the identified resident was on a textured modified diet and had a history of swallowing difficulties. Interview with the Dietary Manager revealed the identified resident took his/her tablemate's mandarin oranges. Interview with the RD revealed the identified resident is at high risk for choking and is followed regularly by a speech language pathologist.

Interview with the Dietary Manager revealed that even though there are registered

nursing staff in the dining room, they are often not able to monitor all residents due to being engaged in other activities such as administering medication and assisting residents with feeding. The Dietary Manager confirmed that the monitoring of all residents during meals is an area that the home could improve upon. [s. 73. (1) 4.]

2. The licensee has failed to ensure that sufficient time is provided for residents to eat at their own pace.

On an identified date, observations revealed an identified PSW rushing an identified resident to finish his/her meal. While the identified resident held onto his/her dish, the PSW tried to take it away and stated "let's go". The resident still held onto the dish and, not until the inspector pointed out that the resident appeared to still want to finish, did the PSW let go. The identified PSW continued to hover over the resident while he/she slowly finished his/her meal.

Interview with the Dietary Manager confirmed that the above mentioned incident should not have happened and it is the home's expectation that residents are provided sufficient time to finish their meals and eat at their own pace. [s. 73. (1) 7.]

3. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date, observations revealed an identified student PSW standing while assisting an identified resident to eat in the dining room at lunch. The resident was coughing. The PSW was not aware why he/she should not be standing while assisting residents to eat or drink.

On an identified date, observations revealed an identified PSW standing while assisting an identified resident to drink at nourishment time. PSW stated he/she was aware he/she should be sitting while assisting residents to eat and drink but since he/she was in the hallway, he/she did not get a stool to do so. Record review revealed the identified resident had an identified medical condition and was at high risk for choking and aspiration pneumonia.

Interview with the RD revealed that staff should be at eye level and not standing while assisting residents to eat and drink. The RD stated that when staff stand, it encourages residents to tip their head upward, which opens the airway and could cause aspiration. The RD confirmed that the above mentioned staff did not use proper techniques to assist

the above identified residents with eating and drinking. [s. 73. (1) 10.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are monitored during meals, sufficient time is provided for residents to eat at their own pace, and proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

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

Record review revealed an identified resident was diagnosed with various identified medical conditions. Further record review revealed the resident had experienced episodes in need of medication and the physician had ordered medication as needed. Record review of the medication administration record (MAR) indicated the identified resident had received medication for such episodes eleven identified times.

Further record review revealed no documentation if the resident was monitored for his/her response to the medication and the effect of the medication regarding the above identified times.

Interview with an identified RPN revealed that the identified resident had received the above mentioned medications and his/her response to the medication should have been documented in the progress notes. The RPN confirmed that for the above identified times, a response was not documented.

The home's policy titled "Interprofessional Clinical Program - Dementia Care", number LTC-E-100, revised August 2012, stated that the use of pharmacological interventions to manage responsive behaviour will include documentation of the target behaviour being treated and regular evaluation of medication side effect and effectiveness.

Interview with the DOC confirmed registered staff are expected to document in the progress notes the effect of medications given to the residents as needed and their response to it. [s. 134. (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, 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).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

a) On an identified date and time, the inspector observed an identified PSW coming out from an identified resident room holding soiled briefs with gloved hands. The PSW took off the gloves after placing the soiled briefs in the hamper outside the room in the hallway. The PSW then took the clean towel and brief from the care cart by the hampers, and entered the resident room without washing his/her hands.

Interview with the identified PSW confirmed that he/she should have performed hand hygiene after putting the soiled briefs in the hamper and before picking up the clean towel and brief, but failed to do so.

b) On an identified date and time, the inspector observed an identified PSW coming out of a resident's room holding soiled towels with gloved hands. The PSW placed the soiled towels in the hamper outside the resident's room, and took the hamper to the laundry chute room. The PSW opened the laundry chute room with his/her gloved hands.

Interview with the PSW revealed that his/her gloves were dirty after assisting a resident with toileting, and he/she should have taken the gloves off before opening the laundry chute door.

After the inspector indicated the laundry chute door was dirty, the PSW then took the gloves off and went to get a wipe to clean the laundry chute door without performing hand hygiene.

Interview with the identified PSW confirmed that he/she should perform hand hygiene prior to cleaning the laundry chute door, and had failed to do so.

Review of the home's policy titled, "Routine Practices & Additional Precautions" (Index: IPC-B-10, revised December 2014), indicated that when using gloves, staff are required to:
• remove gloves and dispose into a hands free waste receptacle immediately following their intended use, and
• perform hand hygiene immediately after removing gloves, before leaving the resident's environment and before touching clean environmental surfaces.

Interview with an identified ADOC, who is responsible for the Infection Prevention and Control Program revealed the following procedure should be followed when assisting residents with toileting:

-Staff should get supplies, such as briefs and towels ready and perform hand hygiene before entering the resident's room. Upon arriving at the resident, staff should put gloves on, remove the soiled brief, place it in the garbage bin, and then put the resident on the toilet.
-While the resident is on the toilet, staff should take the gloves off and perform hand hygiene while allowing the resident time and privacy for toileting. When the resident is finished with toileting, staff should put gloves on, provide peri-care to resident, put a clean brief on for the resident, and dress the resident.
-Staff should remove gloves and place gloves in the garbage bin in the washroom, and perform hand hygiene. Then, staff should wrap the clear plastic garbage bag containing the soiled brief gloves and take the bag to the hamper. The hamper should be outside the resident's room.
-Staff may need to go back to pick up the soiled linen with gloves, and place in hamper if towels were used for peri-care. Once the soiled linen is placed in the hamper, staff should remove gloves and place them in the garbage bin in the resident's room, and then

perform hand hygiene.

The ADOC confirmed that PSWs in the above mentioned scenarios had not met the expectations of the home's hand hygiene guidelines. [s. 229. (4)]

2. On an identified date, an identified registered staff was observed performing a blood sugar test on an identified resident and was not wearing gloves while performing the procedure.

On an identified date, an identified student nurse was observed to hold an insulin pen ready to give an insulin injection to an identified resident and the student nurse was not wearing gloves.

Interview with an identified staff revealed staff do not wear gloves when they perform blood sugar tests or when they give insulin to the residents.

Interview with the identified student nurse indicated that gloves should be worn when performing blood sugar tests or giving insulin, but had forgotten to do so.

Review of the home's policy titled, "Routine Practices & Additional Precautions" (Index: IPC-B-10, revised December 2014), indicated that non-sterile gloves are to be worn for contact with blood and body fluids.

Interview with the DOC confirmed staff must wear gloves when performing blood sugar tests or when giving insulin. [s. 229. (4)]

3. On an identified date, observation revealed that there was an unlabelled used tube of barrier cream and jar of petroleum jelly in the shared washroom of an identified room. Interview with an identified PSW revealed that these items needed to be labelled for the prevention of transmission of infections from resident to resident.

On an identified date, observation revealed a used unlabelled plastic cup containing used combs, toothbrush and toothpaste as well as an unlabelled soap dish containing a used bar of soap in the shared washroom of an identified room. Interview with an identified ADOC confirmed that these items should be labelled and left at the resident's bedside.

On an identified date, observation revealed an unlabelled cup with a used hair brush, toothbrush and toothpaste in the shared washroom of an identified room. Interview with

an identified ADOC confirmed that these items should be labelled and left at the resident's bedside.

Interview with an identified ADOC confirmed that personal items should be labelled and left at the residents' bedside because other residents could inadvertently use these unclean items which may cause the spread of infection. [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, 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:**
**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).**

**Findings/Faits saillants :**

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

On an identified date, during the lunch meal, observations revealed that in the dining room, residents at an identified table were served their desserts with dirty plates stacked on top of one another and at one place setting, there were large chicken bones and pieces of carrot coins discarded onto the table cloth. The inspector and Dietary Manager viewed the table and the Dietary Manager confirmed that the table was in disarray and he/she would not like to eat there.

The Dietary Manager later revealed that dietary aides usually clear the plates before dessert is served but due to the late service of lunch, they were unable to do so for the above mentioned meal. The Dietary Manager confirmed that residents' dignity at the above mentioned table had not been fully respected. [s. 3. (1) 1.]

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

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

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs.

Record review of the MDS assessment from an identified date, revealed an identified resident had various identified medical conditions. Record review from the progress notes and staff interview revealed family indicated that when resident had pain, he/she would have show specific signs and symptoms. When asked if he/she had pain, the resident only responded with very basic answers. The progress notes indicated the resident had exhibited specific signs and symptoms and had received anti-anxiety medication on identified dates for these identified behaviours.

Record review identified there was no written plan of care for the identified resident's pain. There was no description of how the resident expressed pain and no interventions to guide staff when the resident experienced pain.

Interview with an identified RPN revealed that when the resident had specific signs and symptoms, the registered staff would administer medication for anxiety. The RPN did not recognize that these episodes were symptoms of pain and since there was no written plan of care to properly address these symptoms, the RPN administered anti-anxiety medication.

Interview with the DOC confirmed the identified resident's written plan of care should be based on an assessment of the resident and the resident's needs. [s. 6. (2)]

2. The licensee failed to ensure that the plan of care is revised at any time when the resident's care needs change.

On an identified date, observation at breakfast revealed an identified resident was served an identified menu item and was not eating. Record review revealed resident had a history of poor intake and weight fluctuations over the past year. Review of the diet list revealed the resident disliked the identified menu item.

Interview with with an identified Dietary Aide revealed the resident liked the identified menu item prepared in a specific way. Interview with the RD revealed that the resident does like the identified menu item and this was brought forward at a care conference in 2013 and confirmed by the family on an identified recent date.

The RD confirmed that the diet list which is part of the plan of care had never been revised in 2013 to indicate that the resident liked the identified menu item. The RD further confirmed that updating and revising preferences for those with poor intake was important. [s. 6. (10) (b)]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

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

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The licensee failed to respond to the Family Council in writing within 10 days of receiving the advice of any concerns or recommendation about the operation of the home.

Review of the Family Council meeting minutes revealed that concerns regarding the menu and a suggestion to provide locked bedside tables were raised at the July 2015 meeting. Suggestions for providing advance notice of the cleaning/waxing floor schedules and placing small box traps in the entire building were raised in the August 2015 meeting.

Interview with a Family Council member revealed that the home usually responded to the Family Council regarding concerns/suggestions raised at the Family Council within 10 days verbally, but not in writing.

Interview with an identified Social Worker and the Executive Director confirmed that the home did not respond to the Family Council in writing within 10 days of receiving the advice of any concerns or recommendation about the operation of the home. [s. 60. (2)]

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

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

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

**Findings/Faits saillants :**

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

On September 29, 2015, observation during the lunch meal revealed that squash was being served instead of peas. According to the menu board, peas were to be served with the quiche entrée. Interview with the Dietary Manager confirmed that squash was prepared for lunch due to an error made by a novice cook and the menu board was not changed and, as a result, the above mentioned menu substitution was not communicated to residents and staff. [s. 72. (2) (f)]

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

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

**s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On an identified date, the inspector noted prescription topical ointment for an identified resident in his/her room.

Interview with an identified registered staff revealed the resident's private caregiver administered the topical ointment to the resident and returned the ointment to the registered staff at the end of the shift.

Interview with the private caregiver confirmed that he/she administered the ointment to the resident due to the resident's preference.

Interview with the DOC confirmed the home expects registered staff to administer all prescription medication including topical ointments and this registered staff should not have delegated this to a private caregiver. [s. 131. (3)]

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**Issued on this 22nd day of December, 2015**

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

**Original report signed by the inspector.**