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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 13, 2015	2014_298557_0023	T-53-14	Resident Quality Inspection

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

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

VALERIE PIMENTEL (557), ANN HENDERSON (559), DIANE BROWN (110)

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): November 28, December 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15 and 16, 2014.

During the inspection the inspectors reviewed the following Intakes: T-706-13, T-721-13, T-493-14, T-843-14, T-1126-14, T-1366-14.

During the course of the inspection, the inspector(s) spoke with administrator, advisory physician (AP), physician assistant (PA), director of care (DOC), acting co-doc (ADOC), registered dietitian (RD), food service manager (FSM), resident family service co-ordinator (RFSC), life enrichment co-ordinator (LEC), volunteer co-ordinator, environmental services manager (EMS), registered staff, personal support workers (PSW), housekeeping aide, laundry aide, educator, cook, food service worker (FSW), substitute decision maker (SDM).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
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
Snack Observation
Sufficient Staffing

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

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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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).

Findings/Faits saillants :

1. Every licensee failed to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

In November 2014, during the initial resident quality inspection tour, the inspector and staff members witnessed on an identified home area, resident #30 was observed to be treated in an undignified manner.

Interviews with identified staff revealed whom the man was, the administrator revealed the incident was reported to the Director and an investigation was initiated.

The administrator confirmed the home had failed to treat the resident with courtesy and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident has the right to be protected from abuse.

In November 2013, record review revealed resident #52 attempted to sexually abuse

resident #10 in a resident room. An identified PSW and an identified registered nursing staff member observed resident #10 trying to pull away from resident #52.

Interviews with a PSW and a registered nursing staff confirmed they had witnessed the interaction between resident #10 and #52 as they were waking in the hallway of the identified home area. The staff confirmed that they intervened and removed resident #52 from resident #10.

Interviews with identified staff and the DOC confirmed the home had failed to protect resident #10 from abuse and that every resident has the right to be protected from abuse. [s. 3. (1) 2.]

3. In August 2014, record review revealed resident #17 was approached from behind by resident #52. Resident #52 was observed to physically assault resident #17. Resident #17 was checked by the PSW to ensure he/she was safe and proceeded to get help from the registered nursing staff. Resident #17 was sent to the hospital for an assessment.

Interviews with identified staff and DOC confirmed that resident #17 was not protected from abuse and that every resident has the right to be protected from abuse. [s. 3. (1) 2.]

4. The licensee of a long-term care home failed shall to ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted.

In December 2014, during breakfast service resident #33 was approached by an external consultant (EC) to have a specific test performed after gaining consent from an identified registered staff member. The EC stated the test was necessary as the resident was sick, however, the nurse confirmed to the DOC the test was the resident's regular monthly test. The nurse revealed to the DOC there were no residents eating in the dining room at that time. The DOC and inspector observed seven residents in the dining room at the time of the test. The DOC confirmed that the test in the dining room failed to ensure that the resident is afforded privacy in caring for the resident's needs. [s. 3. (1) 8.]

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 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, has the right to be protected from abuse and that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to shall ensure that there is a written plan of care for each resident

that sets out clear directions to staff and others who provide direct care to the resident.

Record review of resident #52's kardex for physical care directs the staff to have two staff assist or one staff assist, an external consultative service suggestion in February 2014: two staff in room while providing care.

The written plan of care revealed two staff in room while providing care. The resident's records were different in the kardex and written plan of care when providing physical care to the resident, identifying one staff to provide care.

Interviews with identified staff members confirmed the resident required two staff to provide care for safety. The kardex and written plan of care did not set out clear directions to those that provide direct care to the resident. [s. 6. (1) (c)]

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

Resident #42, with cognitive impairment was observed over the course of the inspection to continuously wander throughout residents home area and was not offered to participate in program activities on and off the unit.

Nursing staff interviews identified that resident #42 is not asked or taken to programs and "does nothing". The family member of another resident who regularly participates in programs revealed that he/she has not observed resident #42 taken to or engaged in programs.

Record review of the most recent quarterly assessment for activity pursuits and patterns identifies that the resident's average time involved in activities is most to more than 2/3 of the time.

An interview with the activity aide identified that the resident seldom goes to any programs anymore.

An interview with the life enrichment manager revealed that it is very hard to program for resident #42 and that the resident's current plan of care is not based on his/her current needs. [s. 6. (2)]

3. The licensee failed to ensure that the care set out in the plan of care is provided to the

resident as specified in the plan.

In November 2014, resident #30 was being walked to his/her room for a haircut. A few feet from the door the resident began to exhibit responsive behaviours. As witnessed by the inspector, the identified person physically restrained the resident. The plan of care directs staff not to physically restrain the resident when he/she is exhibiting behaviours.

The identified person confirmed this was an instinctive reaction and he/she should not have attempted to restrain the resident. [s. 6. (7)]

4. Resident #43's plan of care identifies a goal for the resident to participate in two activities per week and to give resident verbal reminders of activity before commencement of activity.

Record review identified resident's SDM would like the resident to be encouraged to attend more activities. Resident interview reveal that in December 2014, a program was running which the resident stated he/she would have attended if invited or asked.

Observations and staff interview revealed the resident was not asked to attend. An interview with the life enrichment coordinator confirmed that the resident should have been asked to attend.

Record review revealed that one week in November 2014, the resident attended one program. [s. 6. (7)]

5. Record review revealed that resident #9's plan of care indicated to put one side rail up when the resident is resting/sleeping.

The inspector observed on four occasions in December 2014, both side rails up at the head of bed.

Interviews with identified staff members confirmed that the two side rails were up on the resident's bed. The DOC confirmed that the care set out in the plan of care is not followed. [s. 6. (7)]

6. Resident #42's written plan of care identifies a goal to maintain residents involvement in recreational activities. The plan of care includes providing resident with invitations of events as they happen as per calendar of events and that the resident enjoys attending

programs.

Staff interviews and observations revealed that resident #42 is not encouraged to participate, "does nothing" according to staff and wanders continuously around the home area. A record review of December attendance in programs identified that resident seldom participates in programs. [s. 6. (7)]

7. The licensee shall ensure that the following are documented: the provision of the care set out in the plan of care.

Record review revealed that resident #52's kardex and care plan stated to monitor and record the resident's wandering every hour. The resident was also to be monitored every 30 minutes for safety. The dementia observation system (DOS) tool was used for this purpose.

The inspector observed that the DOS tool was incomplete over a period of time from November 2013 to August 2014. During this time period there were 20 weeks of DOS documentation. During the 20 weeks that DOS was documented there were 35 days out of 140 days that the staff completed the documentation for a 24 hour period.

Interviews with the responsive behavior team lead and the DOC confirmed that the staff did not ensure the DOS tool was completed and the DOS tool was not documented on as identified in the provision of the care set out in the plan of care. [s. 6. (9) 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 the plan of care set out clear directions to staff and others who provide direct care to the resident; based on an assessment of the resident and the resident's needs and preferences, staff and others involved in the different aspects of care of the resident collaborate with each other 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 and that the care set out in the plan of care is 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system required by the Act or Regulation to be put in place is complied with.

Resident #30 was involved in an emotional and physical abuse incident in November 2014. The home's policy Resident Rights, Care and Services - Abuse, effective 09/16/2013, directs the resident family service worker to arrange a multidisciplinary meeting as soon as possible to discuss prevention and resulting resident care needs. The RFSC confirmed in an interview this meeting has not been arranged. [s. 8. (1) (b)]

2. The home's policy Medication Risk Management, Policy #8.14.3, Subject: Recommended Expiry Dates, revised March 2009, indicated that Ophthalmic/Optic products to be discarded 28 days from the date opened.

In December 2014, the inspector observed in an identified home area the medication cart, eye drops were ordered in September 2014, and the treatment was initiated the following day for 30 days.

Interview with the registered nursing staff and DOC confirmed that the home did not comply with removing expired drugs from the medication cart. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that the plan is complied with, 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 failed to ensure the furnishings and equipment are maintained in a safe condition and in a good state of repair.

In November 2014, during the initial tour the inspector observed the following in different home areas:
identified sinks and laminate counters were in a state of disrepair; tiles were cracked and damaged on the surfaces; a tub was missing the metal strip around the circumference and the tub had been patched; broken tiles and corner bead exposed and the floor dirty; dirty and stained floor in a tub room and the activity room ceiling had water damage and was in a state of disrepair.

In December 2014, following an inspection of the above areas; the ESM and administrator confirmed the areas were not in a good state of repair. [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 furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: 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 failed to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed used by residents.

Record review revealed resident #30 had an assigned bed in an identified home area. An interview with an identified staff member revealed the resident had been set up with a bed in a conference room for approximately nine months. This room is not equipped with a resident-staff communication and response system and this was confirmed by an identified nurse and DOC. [s. 17. (1) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed used by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

In August 2014, resident #17 was approached from behind by resident #52. Resident #52 then proceeded to abuse resident #17. The home did not report this incident to the Director immediately. [s. 24. (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 shall immediately report the suspicion and the information upon which it is based to the Director, abuse of a resident by anyone that resulted in harm or risk of harm, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Record review revealed that resident #14, in November 2014, did not receive a bath. On six occasions from May to November 2014, the resident received a bed bath. The resident's plan of care indicates that his/her choice is a tub bath.

Interview with the resident and his/her SDM confirmed that the resident's choice is a tub bath and he/she does not like a bed bath. Interviews with identified staff members confirmed the resident did not receive his/her choice of a tub bath but did receive a bed bath. [s. 33. (1)]

2. Resident #45's plan of care requires the resident to be bathed twice each week on specific days and staff are to ensure resident's hair is washed and nails are manicured on bathing day.

Record review and staff interview confirmed that resident #45 was not given a bath, by the method of his/her choice twice in December 2014.

An interview with the DOC confirmed that resident #45 did not receive two baths one week in December.

Resident #44's plan of care requires the resident to be bathed once a week and occasionally on a second day when necessary as per request of family.

Record review and staff interviews confirmed that resident #44 was not offered his/her

scheduled bath on a specific day in November 2014.

An interview with the DOC confirmed that resident #44 did not receive two baths the one week in December 2014.

Resident #9's plan of care requires the resident to be bathed two times each week.

Record review and staff interview confirmed that resident #9 was not offered his/her scheduled bath on three occasions between November and December 2014.

The DOC confirmed that resident was not bathed, by the method of his/her choice. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review revealed a clinically appropriate assessment instrument that is specifically designed for falls was not used post-fall for resident #32 in June 2014. In an interview the DOC revealed it is the expectation the Falls Incident note is used to assess a resident after a fall to ensure all relevant details are collected. The DOC confirmed this had not occurred. [s. 49. (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 has fallen, has the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff.

The home uses two different types of assessment for skin and wound, one is titled skin note and the other is titled wound assessment.

Record review of resident #8 revealed a skin note in July 2014, that indicated the resident's skin was breaking down. MDS from September 2014, indicated the resident had two stage one sites and one stage two ulcer. The resident had a wound assessment completed on 5 occasions between September and December 2014. The resident was to receive a weekly skin/wound assessment on an identified day weekly.

Interviews with identified staff and DOC confirmed the resident did not receive a weekly wound assessment. [s. 50. (2) (b) (iv)]

2. Record review of resident #16 revealed a skin note in November 2014, identifying the resident had four bruises of unknown etiology. The resident's care plan identifies the resident is to have a weekly skin assessment. Review of the medication administration records/treatment administration records identified the resident did not receive his/her weekly assessment.

Interviews with identified staff and DOC confirmed the resident did not receive a weekly wound assessment. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #10: 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 failed to 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.

In December 2014, the inspector interviewed resident #8. The resident stated that he/she had pain on his/her bottom. The resident indicated that he/she sometimes received medication for pain but not all the time. In December 2014, resident #8's relative was visiting, the resident indicated that he/she still had pain and the relative confirmed this.

Record review revealed the resident received a prescribed analgesic once daily for pain. The resident had a an order for a prescribed pain medication that was to be administered every four hours for pain or fever. The resident received a prescribed medication on five occasions in November 2014. The care plan addresses pain related to different diagnosis but not wounds. On two occasions back to back dates in November and December 2014, documented in the wound note was an entry indicating the resident had pain. An interview with a registered nursing staff confirmed that the home has a pain assessment tool but no pain assessment tool was initiated.

Staff interviews with the registered nursing staff and DOC confirmed that the resident's wound pain was not being managed and resident #8 was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [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 a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The home's evaluation of the matters referred in subsection (1)(responsive behaviours) did not identify a summary of changes made or the date the changes were to be made. An interview with the administrator confirmed that this did not occur. [s. 53. (3) (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 a written record is kept relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

Interviews with identified staff members confirmed that they were not advised at the beginning of every shift about residents who required heightened monitoring because of responsive behaviors. Some staff members indicated that they may review the written reports that are left in the report binder when they have time. Interviews with the registered nursing staff confirmed that the registered staff give report to each other and that the PSW's do not participate in their report but when they arrive on the home areas they go about their duties of caring for residents. [s. 55. (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 all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's program include the assistance and support to permit the residents to participate in activities that may be of interest to them.

Staff interviews revealed that residents with cognitive impairment are not taken to programs and weeks could go by with no support or assistance to attend an activation program. Furthermore, staff identified it is the same small group of residents that are taken and that all residents are not asked or encouraged to go.

Record review and observations revealed an activities program was being offered in December 2014, on an identified home area (HA). Interview with front line staff and life enrichment coordinator indicated that programs on all floors are available to residents.

In December 2014, residents were observed in an identified HA. Observations and staff interviews confirmed that the HA residents including resident #43 were not invited to attend or assisted to the activity program.

An interview with resident #43 revealed that he/she would be interested in the activity program, however he/she was not aware that the program was available.

Record review revealed documentation that resident #43's SDM would like his/her relative to be encouraged to attend more activities.

A family interview confirmed that his/her relative who resides in an identified HA and attends most programs expressed concern that it is the same group of residents that are taken all the time to programs, and that more residents could benefit from attending the program. [s. 65. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that home's program include the assistance and support to permit the residents to participate in activities that may be of interest to them, to be implemented voluntarily.

WN #14: 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,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are standardized recipes for all menus.

An interview with the food service manager revealed that standardized recipes are to include the cooking method and the cooking temperature. A review of a few of the home's recipes revealed that the recipes requiring oven cooking did not include an oven temperature in the standardized recipe. An oven temperature was not identified in the recipe for roast beef, farmer sausage, chicken teriyaki, pork schnitizel, turkey burger and pork souvaki. [s. 72. (2) (c)]

2. The licensee failed to ensure that all food and fluids are prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.

Resident #14 interview identified that the food quality has decreased and the meats, like roast beef, are tough and sometimes can not even be cut with a knife.

An interview with the food service manager and cook identified that cooking methods and reheating can contribute to the toughness of meats. Further, interviews identified that staff cook a roast a day ahead and reheat/retherm the roast prior to service. The food service manager confirmed that instructions related to reheating meats are not available, to direct food service staff on proper reheating methods to preserve taste, nutritive value, appearance and food quality of prepared meats.

Observations of food production in December 2014, revealed a food service worker boiling peameal bacon for the peameal bacon sandwich on the lunch menu. A review of the available recipe identified that the peameal bacon was to be oven baked.

An interview with the food service manager revealed that staff are expected to follow recipes and confirmed that boiling peameal bacon could negatively affect the quality of the menu item.

Observations of pureed food preparation identified staff preparing pureed peameal bacon by adding a commercial thickener.

A review of the recipe and interview with food service manager confirmed that recipe does not require staff to add thickener. The unplanned use of commercial thickener will negatively impact the nutritive value and food quality of the pureed product. [s. 72. (3) (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 there are standardized recipes for all menus. An interview with the food service manager revealed that standardized recipes are to include the cooking method and the cooking temperature, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are measures in place to prevent the transmission of infections.

In October 2014, laboratory results confirmed resident #3 as having an infectious disease. Staff interviews revealed staff used alcohol based hand sanitizer on a paper towel to clean and disinfect the sit stand lift after use by this resident. Approved best practice document by Provincial Infectious Diseases Advisory Committee (PIDAC), a hand based sanitizer is not approved for cleaning of equipment.

The acting co-DOC in an interview revealed he/she had given the staff a fact sheet that failed to identify how to clean the sit stand lift used by this resident.

The acting co-DOC confirmed this cleaning measure would not prevent the transmission of infection to other residents if they used the same sit stand. [s. 86. (2) (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 there are measures in place to prevent the transmission of infections, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including the following: all areas where drugs are stored are kept locked at all times, when not in use.

In December 2014, the inspector observed a plastic three drawer unlocked container sitting on top of a linen cart. Inside and on top of this container were topical medicated creams contained in zip lock bags for different residents. This cart and topical creams were observed outside of two different rooms, fifteen minutes later the same cart had been moved outside of the second room with no staff to be seen.

An identified PSW was interviewed and confirmed topical medicated creams should not have been left unsupervised on the linen cart in a residential hallway.

Interviews with the registered nursing staff and DOC confirmed topical medicated creams are to be locked when not in use and should not be left unsupervised in the hallways. [s. 130. 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 steps are taken to ensure the security of the drug supply, including the following: all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #17: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a member of the registered nursing staff permits a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical just if the staff member has been trained by a member of the registered nursing staff in the administration of topicals.

In December 2014, an interview with an identified PSW, revealed he/she applies topical creams. He/she stated that training was not provided on administration of topicals.

An interview with the registered nursing staff confirmed he/she did not observe the particular staff member apply topical creams to the resident. The DOC confirmed PSWs should not apply topical creams to the residents if they have not been trained and confirmed not all staff had been trained. [s. 131. (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 a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical if the staff member has been trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.

WN #18: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

In October 2014, laboratory results confirmed resident #3 as having an infectious disease and this information was added as a medical diagnosis in October 2014.

Staff interviews revealed contact precautions were not implemented until November 2014 . During staff interviews in December 2014, identified staff revealed they are still unsure

what the precaution signage meant and what supplies to use from the isolation cart. An identified PSW revealed in an interview he/she used gloves only during personal care, a second identified PSW revealed he/she used gloves, gown and a mask and a third identified PSW revealed he/she only used gloves and a gown but did not wear the mask as he/she wore glasses.

A chart note reveals a registered member of staff removed the contact precaution signage and isolation cart as the member of staff could not identify a reason for precautions.

An identified housekeeper revealed he/she had not been given clear direction how to clean the resident's room. The ESM was unaware of this infection and confirmed housekeeping staff had not been given clear direction as to how to clean the resident's room.

The infection control and prevention lead confirmed not all staff participated in the implementation of the infection control program. [s. 229. (4)]

2. The licensee failed to ensure that on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Record review identified resident #34 as having an infectious disease and the resident was on contact precautions until the resident moved to a different home area in June 2014. At this time the resident was not monitored, contact precautions were not implemented and the resident was not entered onto the infection control surveillance tool until December 2014.

Interviews with registered nursing staff and the acting co-DOC confirmed the home area did not ensure that on every shift symptoms for resident #34 were monitored.

Laboratory results confirmed resident #3 as having an infectious disease in October 2014 . Review of the infection control surveillance tool on an identified home area revealed the October, November and December infection control surveillance tools were not completed and registered staff failed to monitor or record the symptoms.

The acting co-DOC confirmed the infection control surveillance tools had not been monitored. [s. 229. (5) (a)]

3. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

Laboratory results confirmed resident #3 as having an infectious disease in October 2014 . Review of the infection control daily surveillance tool in an identified home area revealed the October, November and December infection control daily surveillance tools were not completed and registered staff failed to monitor or record the symptoms.

The acting co-DOC confirmed the infection control daily surveillance tools had not been completed. [s. 229. (5) (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 ensure that on every shift symptoms indicating the presence of infection in residents are monitored; staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius.

In December 2014, an interview with a PSW identified that resident #46 had complained that his/her room temperature was too cold. An interview with resident #46 confirmed that he/she felt the room was cold and has been for the past two weeks.

In December 2014, the air temperature in resident #46's room was observed and confirmed by nursing staff to be 20.0 degrees Celsius.

An interview with the newly hired ESM confirmed that he has received complaints from residents and families of those residing in rooms in the short hall, east where resident #46's room is located. The ESM also confirmed that daily temperature audits are taken at each nursing station within the home but that there was not a system in place to confirm if resident's rooms are maintained at a minimum temperature of 22 degrees Celsius.

On December 16, 2014, an interview with resident #46 confirmed that his/her room temperature was now comfortable. [s. 21.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

An interview with the administrator confirmed there was not a written record of the annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 31. (4)]

WN #21: 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 the resident who is incontinent received an assessment that:
* includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
* is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Record review and staff interviews identified resident #4 was incontinent of urine on admission and it had become worse over the past four weeks. An identified staff member revealed it is the expectation PSWs will do a three day voiding observation and this is the assessment.

The DOC confirmed it is the expectation an assessment for continence is completed on admission and this had not occurred. [s. 51. (2) (a)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations.

A review of the Resident Council minutes for their October 15, 2014, meeting revealed four items of concern and for their November 26, 2014, meeting revealed three items of concern.

An interview with the administrator confirmed written responses for the seven identified concerns were not responded to in writing within 10 days. [s. 57. (2)]

WN #23: 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 ensure a written response was received within 10 days of receiving advice related to concerns or recommendations from the Family Council.

A review of Family Council meeting minutes of September 25, 2014, revealed concerns regarding oral care at the home. Record review and an interview with the administrator confirmed that a response was not provided to the Family Council until the meeting of November 25, 2014.

An interview with the administrator further confirmed that a written response to the Family Council within 10 days of the concern or recommendation being raised does not regularly occur. [s. 60. (2)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee failed consult regularly with the Family Council and in any case at least every three months.

Record review of the Family Council meetings minutes between January 25, 2014, and November 25, 2014, revealed that the administrator attended the February 15, 2014, meeting upon invitation to discuss LTC funding.

An interview with the administrator confirmed that she does not consult regularly with the Family Council at least every three months. [s. 67.]

WN #25: 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,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the menu cycle was reviewed by the Residents' Council.

Interviews with the president of the Residents' Council and the Residents' Council assistant revealed the menu cycle was reviewed at the food committee which is not a sub-committee of the Residents' Council.

The president and assistant confirmed the menu cycle had not been reviewed at the Residents' Council. [s. 71. (1) (f)]

WN #26: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

Interviews with the president of Residents' Council and the council assistant revealed the meal and snack times are reviewed at the food committee which is not a sub-committee of the Residents' Council.

The president and assistant confirmed the dining and snack service including a review of the meal and snack times had not occurred at Council. [s. 73. (1) 2.]

WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, mental health training, including care for persons with dementia, at times or at intervals provided for in the regulations.

Review of employee training records for mental health issues including care for persons with dementia identified that 28 per cent of the staff did not receive the training.

The educator and administrator could not validate that all direct care staff received the training. [s. 76. (7) 2.]

2. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in behaviour management at times or at intervals provided for in the regulations.

Review of employee training records for behavior management identified that 28 per cent of the staff did not receive the training.

The educator and administrator could not validate that all direct care staff received the training. [s. 76. (7) 3.]

WN #28: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

An interview with the administrator and a review of the home's current process for determining satisfaction revealed that the home uses the standardized stage 1 questions from abaqis plus three additional questions regarding satisfaction with the facility and likelihood of recommendation by residents and family members.

The administrator and a record review confirmed that the home's current survey is an audit and does not determine satisfaction with all programs and services, such as physiotherapy, continence care, and skin and wound program. [s. 85. (1)]

2. The licensee failed to ensure that the Residents' Council's advice was sought in developing and carrying out the satisfaction survey, and in acting on its results.

The administrator confirmed that the home's current survey is a corporate tool and advice was not sought by the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

3. Interviews conducted with a Family Council representative and the Administrator confirmed that the Family Council was not involved in the development or carrying out of the satisfaction survey in 2013. A review of Council meeting notes for April 26, 2014, failed to provide evidence that the licensee sought the advice of Family Council in acting on the survey results. [s. 85. (3)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a process to report and locate residents' lost clothing and personal items.

An interview with resident #14 and SDM identified the resident had clothing that went missing in May 2014. An interview with a PSW who works on the resident's home area, and a laundry staff member along with the administrator and ESM revealed that they had no knowledge of the missing item.

A review of resident #14's health record identified an entry in May 2014, related to his/her clothing item was reported missing by the SDM. The resident and SDM were not notified of the process or outcome of the reported missing clothing.

Record review revealed that the 2013 Resident and Family Satisfaction Survey Results identified a concern that clothing does not always get returned from laundry.

An interview with the administrator revealed that the process to report and locate residents' lost clothing and personal items was for staff to complete a complaint form and the process was not followed. [s. 89. (1) (a) (iv)]

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time.

In December 2014, the inspector observed in an identified home area medication room, 18 boxes of eye drops in the stock cupboard, with an expiry date of December 2014 on the boxes.

Staff interview with the registered nursing staff identified that there was a minimal number of residents on these eye drops. The identified staff member and DOC confirmed that there was more than a three month supply of eye drops in the stock cupboard. [s. 124.]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Family Council.

An interview with a Family Council representative identified that to their knowledge the licensee has not communicated improvements made through the quality improvement and utilization review system to the Family Council.

Record review and an interview with the administrator confirmed the improvements made through the quality improvement review system have not been communicated to the Family Council. [s. 228. 3.]

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

Issued on this 17th day of February, 2015

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

Original report signed by the inspector.