Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 1, 2014	2014_275536_0023	H-001248-14	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRAMPTON WOODS
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

CATHIE ROBITAILLE (536), DIANNE BARSEVICH (581), LEAH CURLE (585), VALERIE GOLDRUP (539)

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 23, 24, 25, 26, 27, 28, 29, 30 and October 1, 2, 3, 2014.

During this RQI Inspection, a Complaint Inspection H-000807-14 and Critical Incident System(CIS)inspections H-001118-14, H-001153-14, H-000865-14, H-000692-14, H-000036-14, H-000385-14, H-000572-14 and H-000579-14 were conducted simultaneously. There were findings of non-compliance in both the Complaint and the CIS inspections.

During the course of the inspection, the inspector(s) spoke with residents, families, regulated and unregulated workers, Registered Staff, Resident Assessment Instrument (RAI) Coordinator, dietary staff, the Registered Dietitian (RD), Food Service Manager (FSM), the Environmental Manager (EM), the Director of Programs and Admission, activation staff, the Resident Relations Coordinator, the Occupational Therapist (OT), the office manager, the Associate Directors of Care (ADOC), the and the Director of Care (DOC)/Acting Executive Director.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council

During the course of this inspection, Non-Compliances were issued.

19 WN(s)
8 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be properly sheltered, fed,clothed, groomed and cared for in a manner consistent with his or her needs.

On an identified date in 2012, a visiting family member of another resident observed resident #302 being roughly transferred to bed by a PSW. The resident was wandering in the halls and brought to their room by the PSW who then put the resident to bed. The resident was heard to be yelling at this time. The family member who witnessed the event felt that the resident was being forced. The family member became extremely upset at how the resident was being treated and reported it immediately to the registered staff. The home's investigation confirmed the following: the PSW was unaware of the resident's care needs as they had not reviewed the resident's plan of care. The written plan of care stated that "If resident is agitated when staff approach for care, leave and return at a later time". The PSW also received a written discipline from the home. The home did not ensure that the resident was properly cared for in a manner consistent with his or her needs. [s. 3. (1) 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 and ensuring that all residents are properly cared for in a manner consistent with his or her needs, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 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 failed to ensure that there was a written plan of care for each resident

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

The plan of care for residents #023, #029 and #034 was reviewed and indicated that the residents used bed rails for bed mobility. The PSW's stated that the residents were to have their bed rails raised when in bed and that there was no clear direction in the written plan of care or kardex to instruct them when to raise the rails. The Resident Assessment Instrument (RAI) Coordinator confirmed that there was no clear direction to PSW's. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #041 so that their assessments were integrated, consistent with and complemented each other.

A Minimum Data Set (MDS) assessment completed on an identified date in 2014, identified resident #041 as being "independent" for self-performance with eating. A MDS assessment completed on an identified date in 2014, identified the resident as requiring "supervision" for self-performance with eating. The assessment also noted that the resident's needs had not changed from the last assessment, and they were responding to the interventions as outlined in their plan of care. Interview with registered staff confirmed that the assessment completed on an identified date in 2014 was not consistent with the previous assessment. [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident, the Substitute Decision Maker (SDM), and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

On an identified date in 2014, resident #302 was transferred to hospital after becoming unresponsive in the home, and subsequently died in hospital. It was documented that full cardiopulmonary resuscitation (CPR) had been provided to the resident during the incident, as per the advanced directives in the resident's chart, dated on an identified date in 2011. Afterward, the family noted they did not want full CPR to occur if the resident became unresponsive. No documentation could be found to indicate that the care directive had been reviewed with the resident's family. It was identified that a review of the care directive had not occurred since admission, though it was on the care conference form to review and complete annually. This was confirmed by an ADOC and the resident's Power of Attorney. [s. 6. (5)]

4. 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 of care.

During the evening shift, on an identified date in 2014, during the provision of care in the bathroom, Resident # 300 complained that one of two personal support workers who provided care pinched their buttocks. The resident identified that it was a male Personal Support Worker (PSW). The resident's written plan of care dated on an identified date in 2014 stated that the resident preferred only female personal support workers to give care, no male PSW to give care and directed two staff to assist the resident with toileting. The critical incident report identified that a male PSW was present when care was provided to the resident. An Associate Director of Care confirmed that staff were not clear on what defined the provision of care. The home did not follow the resident's wishes that no male PSW provide care to the resident. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

A) The plan of care on an identified date in 2014 for resident #400 identified they were to be transferred to the toilet with the sit stand lift. The PSW's stated that the resident was transferred on and off the toilet with one or two staff. Registered staff confirmed that the written plan of care was not updated, when care needs changed and the plan was no longer necessary. (581)

B) The plan of care for resident #401 indicated they used a wheelchair for locomotion on the unit and were able to wheel themselves. On an identified date in 2014, the resident was observed walking on the unit with a lumex walker. The Physiotherapist and the PSW's stated that the resident walked with a walker and did not use a wheelchair for mobility. The Physiotherapist confirmed that the written plan of care was not updated, when care needs changed and the care was no longer necessary. (581)

C) The plan of care for resident #402 identified they fell on identified dates in 2013 and sustained a fractured of an identified area. The resident was to have a sling in place to support their arm as recommended by the physiotherapist and physician. A PSW stated the resident wore a sling after their fracture was identified for approximately one month. Review of the written plan of care indicated the application of the sling was not documented to give clear directions to the PSW's when the sling was to be applied. RAI Coordinator confirmed that the plan of care was not updated when the residents care needs changed. (581)

D) On an identified date in 2014, during the day shift, resident #303 was noted to be walking unsteady. The clinical record noted the resident did not have difficulty walking until an identified date in 2014. The registered staff who observed the resident walking with difficulty during the day shift did not complete an assessment to determine the reason for the resident's unsteady gait. The resident was assessed at 2030 hours that evening and was unable to walk and required transfer to hospital. The resident was diagnosed with an identified fracture. The home completed an investigation and confirmed that the registered staff on the day shift had not completed an assessment of the resident's condition. The home did not ensure that the resident was assessed when and that the current plan of care was not effective for safe transferring of the resident. (539) [s. 6. (10) (b)]

6. The licensee failed to ensure that the resident was reassessed and the plan of care updated and revised at least every six months.

A) On an identified date in 2014, during the provision of care and the transferring of resident #301 to bed using a sit/stand lift, the resident sustained an abrasion to their lower leg. The resident reported the injury to management and xrays were obtained and wound treatment was initiated for a scrape on their shin. On an identified date in 2014, the progress notes indicated that the resident was observed during care with both legs lifted, "kneeling on the knee guard on the standing lift". The clinical record noted that the PSW confirmed to the registered staff that they felt this was how the resident obtained old scratch marks to both shins. The sit to stand lift instruction guide stated that if the resident is not actively participating and required passive lifting, another type of lift is recommended. The Director of Care confirmed that no interdisciplinary referral was completed to ensure the safest transfer equipment was used to prevent further injury to the resident. (539)

B) On identified dates in 2014 resident #400 was observed sitting in their wheelchair and the chair alarm was not in place. Review of the written plan of care indicated the wheelchair alarm was to be applied when resident was sitting in their wheelchair for falls prevention. Registered staff and PSW's indicated that the resident did not want the chair alarm, consistently removed it from their clothing, and could become agitated from the alarm. The resident stated they did not want the chair alarm on as it restricted their movement and they had reported it to staff. Registered staff confirmed that other interventions have not been discussed or initiated and that the care set out in the plan had not been effective. (581) [s. 6. (10) (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 and ensuring that written plans of care set out clear directions to staff and others who provided direct care to residents; staff collaborate with each other in the assessment of residents; residents/SDM are provided the opportunity to participate in the development and implementation of the plan of care; residents are reassessed and their plans of care are reviewed and revised at least every six months and at any other time when, the care set out in the plan is no longer necessary, and when the plan has not been effective, 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 the homes policies were complied with.

A) The home's policy, [Falls Prevention Program, #V3-630] last revised November 2013 stated that registered staff "will document a head to toe physical assessment at least q shift x 3 days following a fall."
i) On an identified date in 2014, resident #401 fell and sustained a fracture. Review of the clinical records indicated that the head to toe assessment was not completed and documented every shift for three days following a fall. This was confirmed by the registered staff.
ii) On identified dates in 2013, resident #402 fell and sustained a fracture. Review of the clinical record indicated that the head to toe assessment was not completed and documented every shift for three days following a fall. This was confirmed by the registered staff. (581)

B) The home's policy, [Personal Care–Hygiene and Grooming V3-212], last revised April 2013, stated, "All personal items such as eyewear will be labelled".
i)Resident #010's plan of care stated they wore glasses for reading, and included that staff were to ensure they were properly labelled to prevent accidental loss. On an identified date in 2014, two pairs of unlabelled glasses were observed in the resident's room. The resident confirmed they owned both pairs of glasses. Registered staff confirmed the glasses belonged to the resident, and it was the home's expectation for glasses be labelled. (585)

C) The home's policy, [Meal Service–Eating Assistance protocol for residents requiring total assistance at meals and snacks – V0-305], last revised February 2013, stated, "no more than two residents should be provided total assistance with meals by one staff member".
i) On an identified date in 2014, during lunch meal service, in the third floor west dining room, one PSW was observed assisting resident #014, #021, and #400. The PSW reported the three residents required total assistance with eating, and that they provided total assistance to all three residents during the meal. Registered nursing staff confirmed the three resident's required full assistance with eating. (585) [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 and ensuring that all policies and procedures are followed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails were used, the resident was assessed in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) A review of resident #034's written plan of care indicated that they required the use of one three quarter bed rail in the raised position for repositioning and turning in bed. On an identified date in 2014, the resident was observed in bed with one three quarter bed rail raised. Review of the clinical record indicated there was no bed rail assessment completed. This was confirmed by the DOC and Occupational Therapist (OT).

B) A review of resident #023's written plan of care indicated they required the use of one three quarter bed rail and one quarter assist bed rail in the raised position to assist in bed mobility. On an identified date in 2014 the resident was observed in bed with both bed rails raised. Review of the clinical record indicated there was no bed rail assessment completed. This was confirmed by the DOC and OT.

C) A review of resident #029's written plan of care indicated that they required the use of one three quarter bed rail and one third bed rail (assist) in the raised position to assist in bed mobility. On identified dates in 2014 the resident was observed in bed with both bed rails raised. Review of the clinical record indicated there was no bed rail assessment completed. This was confirmed by the DOC and OT. [s. 15. (1) (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 and ensuring that where bed rails are used, residents are assessed in accordance with evidence-based practice or prevailing practice to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care was based on, at a minimum, an interdisciplinary assessment of safety risks.

A) On May 1, 2014, resident #401 fell and sustained a fracture. Review of the clinical records indicated that the head to toe assessment was not completed and documented every shift for three days following a fall. This was confirmed by the registered staff.

B) On identified dates in 2013, resident #402 fell and sustained a fracture. Review of the clinical record indicated that the head to toe assessment was not completed and documented every shift for three days following a fall. This was confirmed by the registered staff.The plan of care for resident #402 indicated the resident fell on identified dates in 2013. An xray done on an identified date in 2014 identified that the resident sustained a fracture of the clavicle. The clinical records did not indicate that any falls prevention interventions were put in place after the first fall, and that a chair and bed alarm were not put in place until an identified date in 2014. This was confirmed by the DOC.(581) [s. 26. (3) 19.]

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 and ensuring that residents plans of care are based on, at a minimum, an interdisciplinary assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:

1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A) Resident #034 was observed in bed on an identified date in 2014 with one three quarter bed rail raised. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consents approvals for its use. The DOC and OT confirmed that the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint nor did they have documented consent or approval for the bed rail in place.

B) Resident #029 was observed in bed on an identified date in 2014 with one three quarter and one quarter bed rail raised. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rails nor any documented consent or approvals for its use. The DOC and OT confirmed the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint nor did they have a documented consent or approval for the bed rails in place.

C) Resident #023 was observed in bed on an identified date in 2014 with one three quarter and one quarter bed rail raised. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rails, nor any documented consents or approvals for its use. The DOC and OT confirmed the resident's bed rails were not assessed to determine if the bed rails were being used as a PASD or a restraint nor did they have a documented consent or approval for the bed rails in place. [s. 33. (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 and ensuring that residents are assessed, consent is received and the use of a Personal Assistance Services Device (PASD) are included in the resident's plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents, in relation to the following; [s.36]

A) On an identified date in 2014 while being transferred from the toilet to wheelchair by a Personal Support Workers (PSW), resident #400 fell and sustained a scratch to their leg. Review of the clinical record indicated that the resident's wheelchair brakes were not on at the time of the transfer and the resident was not wearing proper footwear. The PSW did not ensure that safe transferring techniques were used when assisting the resident from toilet to wheelchair and this was confirmed by the Director of Care (DOC). (581)

B) On an identified date in 2014 during the provision of care and the transferring of the resident #304 to wheelchair, the resident sustained a laceration to the identified foot and a skin tear to their identified arm. The PSW reported it the the registered staff. The resident was transferred to hospital for sutures to close the wound to the foot. The PSW's noted that the resident's legs were stiff upon transfer and got caught in the lift. Upon investigation, the home updated the resident's written plan of care to add the use of complete leg support when using the sit/stand lift to transfer the resident. The home did not ensure the staff used safe transferring techniques when transferring the resident resulting in resident injury. (539)

C) On an identified date in 2014 during the provision of care and the transferring of resident #301 to bed, the resident sustained an abrasion to their lower leg. The resident reported the injury to management and xrays were obtained and wound treatment started to the scrape on their identified shin. On an identified date in 2014 the resident was observed during care with both legs lifted, "kneeling on the knee guard on the standing lift". The staff confirmed to the registered staff that they felt this was how the resident obtained the old scratch marks to both shins. The sit to stand lift instruction guide stated that if the resident is not actively participating and required passive lifting another type of lift is recommended. (539) [s. 36.]

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 and ensuring staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #8: 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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person simultaneously assisted more than two residents who required total assistance with eating and drinking.

A) On an identified date in 2014, during lunch meal service, in the identified dining room, one PSW was observed providing full assistance to residents #014, #021, and #200. All three residents sat at table six, and required total assistance with eating.

i) At 1245 hours, the three residents were present at their table. Resident #014 was receiving total assistance with their meal from the PSW. Resident #021 and #200 both had partially consumed thickened fluids in front of them and no one was present to assist them.

ii) At 1300 hours, dessert was provided to all three residents. Resident #014 was still receiving full assistance, and no one was present to assist resident #021 and #200.

iii)At 1307 hours, the PSW moved to another table to encourage and assist a different resident.

iv) At 1310 hours, the PSW returned to table six, and began to assist resident #021. After approximately one minute, the PSW moved to assist resident #200 with their drinks and dessert.

The PSW confirmed they were providing full assistance to the three residents at table six, and encouragement and assistance to another resident at another table. The registered nursing staff confirmed residents #014, #021, and #200 required full assistance. The Registered Dietitian confirmed that staff were to feed a maximum of two residents who required full assistance.

B) The PSW provided a document, "supervising tables in the dining room during meals", with no effective date, that said one PSW was to supervise residents at table five, six, and seven. Resident #014, #021, and #200 all required full assistance, indicating that the PSW was responsible to provide full assistance to more than two residents at meals. [s. 73. (2) (a)]

2. The licensee failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

On multiple occasions, during lunch meal service on the identified dining room, residents who required full assistance with meals were observed with food and beverages in front of them, with no staff present to assist them with eating or drinking.

A) On an identified date in 2014:
i) Resident #014 was observed with their main meal in front of them, untouched, and no staff present to assist them for 10 minutes.
ii) Resident #021 was observed with their main meal in front of them, untouched, and no staff present to assist them for 5 minutes.

B) On an identified date in 2014:
i) Resident #014 was observed with their drinks in front of them, untouched, and no staff present to provide assistance for over 15 minutes.
ii) Resident #021 was observed with their drinks in front of them, untouched, and no staff

present to provide assistance for over fifteen minutes.

C) On an identified date in 2014:
i) Resident #021 was observed with their dessert in front of them, untouched, with no staff available to provide assistance for 7 minutes. During this time, Resident #021 was watching another resident receive full assistance with their meal.
ii) Resident #200 was observed with their dessert in front of them, untouched, with no staff available to provide assistance for 10 minutes.

A PSW confirmed that residents #021, #014, and #200 required full assistance, and residents #021 and #200 should not have received dessert until staff were able to provide full assistance. Registered staff confirmed residents #021, #014, and #200 required full assistance at meals. The residents who did not receive full assistance immediately being served were negatively impacted as they were not provided an optimal dining experience in that they did not receive as much time to complete and enjoy their meal as they were entitled to.(585) [s. 73. (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 and ensuring that no person assists more than two residents who require total assistance with eating and drinking, and residents who require assistance with eating or drinking are served a meal only when someone is available to provide the assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

A) Resident #032 required total assistance of one staff to complete oral care of the resident's teeth. The task list for the completion of oral care from identified dates in 2014, noted that the resident had refused oral care seventeen times during the period. The written plan of care directed staff to follow a four step approach, "offer alternatives when resident refuses care. Be flexible in approach/care giving, allow extra time. Allow resident to wake up on their own. If resident becomes agitated, do not continue to make requests, take a 15 min break and reorient. Staff to be mindful of their body language and keep communication positive". A PSW confirmed that they would try again over time if the resident refused oral care. The home did not ensure the resident received oral care twice daily. (539)

B) Resident #016 was noted to have foul breath when interviewed on an identified date in 2014. The resident's written plan of care, updated on an identified date in 2013, identified that the resident had halitosis. The written plan of care also confirmed that the resident's teeth should be cleaned once per day, and if the resident resisted with activities of daily living to "reassure resident, leave and return 5-10 minutes later and try again". The

resident and PSW confirmed the staff cleaned their teeth once a day. The task list for the completion of oral care for the identified dates in 2014 noted that the resident had refused oral care fourteen times during the period. The home did not ensure the resident's oral care was completed twice daily. (539) [s. 34. (1) (a)]

2. The licensee failed to ensure that each resident received assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care.

On an identified date in 2014, resident #302 was transferred to hospital after becoming unresponsive while in the home. They subsequently died in hospital, having choked on a chicken bone. It was documented during the incident that the resident "does not use any dentures". The family of the resident had noted that the personal support workers were no longer placing the residents dentures in their mouth. Both registered staff and the personal support workers knew that the resident was not wearing their dentures. The written plan of care was not updated to reflect the change. The resident's written plan of care, last updated on an identified date in 2014, stated that the resident's dentures were to be placed in the resident's mouth daily. An ADOC confirmed the written plan of care should have been followed or updated to reflect that the resident was no longer wearing their dentures. [s. 34. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure resident #023 received fingernail care, including the cutting of fingernails.

On an identified date in 2014, resident #023 was observed having long, untrimmed fingernails. On an identified date in 2014, the resident was observed having untrimmed, chipped fingernails. The resident confirmed some of their nails were cracked. Documentation revealed that nail care was not provided on five out of eight shower/bath days in an identified month in 2014. A PSW reported that the resident was to receive nail care with every bath or shower, and confirmed the documentation indicated nail care was not provided on five out of eight shower/bath days. On an identified date in 2014, a PSW confirmed the resident had long, chipped nails that required trimming. (585) [s. 35. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that resident #010's personal items were labelled.

Resident #010's plan of care stated they wore glasses for reading, and staff were to ensure they were properly labelled to prevent accidental loss. On an identified date in 2014, two pairs of glasses were observed in the resident's room, of which the resident confirmed belonged to them, and that they were unlabelled. Registered staff confirmed the glasses were not labelled, that the resident's care plan indicated they were to be labelled, and the home's expectation was for the personal items, including glasses, be labelled. [s. 37. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #018 was dressed appropriately, suitable for the time of day.

On an identified date in 2014, the resident was observed at 1030 hours in their room, fully dressed, with a shirt protector on, with no visible drooling. On an identified date in 2014, the resident was observed at 1620 hours sitting in a common area with a shirt protector on, with no visible drooling. The resident's plan of care was reviewed it did not indicate the resident was to wear a shirt protector between meals. Interview with registered staff stated the resident wore a shirt protector at mealtime as the resident was known to pocket food when eating. The registered staff confirmed that prior to the observation on September 30, 2014, they were aware the resident did not have food pocketed in their mouth. The registered staff confirmed the resident was not appropriately dressed suitable to the time of day. [s. 40.]

WN #13: 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 has failed to ensure that they consulted regularly with the Family Council and in any case at least every three months.

Both the Family Council representative and staff representative confirmed that the licensee did not consult regularly with Family Council. [s. 67.]

WN #14: 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. (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 has failed to ensure that they sought advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Both the Family Council representative and staff representative confirmed that the licensee did not seek advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

WN #15: 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 failed to ensure that the lost and missing clothing policy was implemented for resident #302.

On an identified date in 2014, resident's # 302 family member met with the home to discuss missing clothing that had gone missing in the past. They stated that they had "brought in 12 pairs of pants and 12 shirts (all labeled) and 6 pairs of pants and 2 shirts went missing and were never found". Progress notes dated on identified dates in 2012 and 2013 note that the items went missing; however, there was no documentation that the issue had been followed up with the family by staff. No missing clothing form could be found by the Environmental Manager. The policy, Lost/Missing Clothing, #V8-300, reviewed in an identified month 2012, stated that the home designate will contact the family to advise of the outcome of the investigation and sign the completed form. [s. 89. (1) (a) (iv)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Resident #302 had their hair cut short on three occasions in 2013. A family member conveyed their concern to staff in regards to this on identified dates in 2013. The family member felt the resident looked like they were in "some sort of concentration camp", and did not like that they were able to see scar marks on the resident's head. The home's policy, [Concerns and Complaint Process-Home and Corporate policy, # V2-220], revised January 2011, stated the complaint form was to be completed "immediately by front line staff and is immediately forwarded to the Director of Care or to the Manager In-Charge" if the complaint remains unresolved. The DOC/acting Executive Director confirmed that a complaint log could not be found in regards to the family members concerns noted on the above dates. The home did not ensure that the family members concerns were noted and addressed. [s. 101. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 138. Absences

Specifically failed to comply with the following:

s. 138. (6) A licensee of a long-term care home shall ensure that before a resident of the home leaves for a medical absence or a psychiatric absence,
(b) notice of the resident's medical absence or psychiatric absence is given to the resident's substitute decision-maker, if any, and to such other person as the resident or substitute decision-maker designates,
(i) at least 24 hours before the resident leaves the home, or
(ii) if circumstances do not permit 24 hours notice, as soon as possible. O. Reg. 79/10, s. 138 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that the Substitute Decision Maker (SDM) and other person designated by the resident/SDM were given notice of the medical or psychiatric absence of the resident as soon as possible.

On an identified date in 2014,resident #302 was transferred to hospital after becoming unresponsive while in the home. They subsequently died in hospital. It was documented during the incident that the Power of Attorney and the next of kin were contacted without success. The documentation further stated that the home would continue to attempt to contact the family as the hospital had been unsuccessful in reaching them. There was no further documented attempt by the home to contact the resident's next of kin following their transfer to hospital. When asked, the Power of Attorney confirmed that they were not contacted by the home and received notification the next morning by the hospital. [s. 138. (6) (b)]

WN #18: 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 failed to ensure that the quality improvement and utilization review system complied with the legislative requirements.

On an identified date in 2014, inspector(s)reviewed 23 mandatory and non-mandatory program evaluations provided by the home. During the review of the program evaluations, it was identified that the majority of the evaluations did not include an evaluation of the goals, objectives, policies, procedures and protocols and a process to identify initiatives for review. The evaluations were not ongoing and interdisciplinary. The majority of the evaluations did not include any of the requirements under the Quality Improvement and utilization review system. This was confirmed by the DOC and ADOC. [s. 228. 1.]

WN #19: 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 staff participated in the implementation of the infection prevention and control program.

During breakfast on an identified date in 2014 on Rose Wood home area, a PSW was observed picking a banana peel off the floor and did not wash their hands. The PSW then continued to serve the breakfast meal and handle resident's food items. [s. 229. (4)]

Issued on this 5th day of December, 2014

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

Original report signed by the inspector.