Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 30, 31, Sep 1, 6, 7, 8, 9, 13, 14, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, Oct 3, 4, 5, 6, 7, 11, 14, 17, Nov 21, 22, 23, 24, 25, 28, Dec 7, 8, 16, 2011; Jan 10, 11, 12, 13, 18, 19, 20, 23, 30, 31, Feb 1, Mar 27, 2012	2011_061129_0006	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 - BRANTFORD
389 WEST STREET, BRANTFORD, ON, N3R-3V9

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

PHYLLIS HILTZ-BONTJE (129), ELISA WILSON (171), MARILYN TONE (167), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Business Coordinator,Environmental Coordinator, Social Worker, Resident Assessment Instrument Coordinator, Physiotherapist, Occupational Therapist, Registered Dietitian, Food Service Manager, Resident Relations Coordinator, registered and unregulated nursing staff, cooks, dietary staff, housekeeping staff, residents, family members and Resident Council President with respect to the Resident Quality Inspection [#H-001740-11] and complaint [#H-001602-11] and [#H-001355-11].

NOTE:This is a revised report to reflect changes in compliance dates for orders.

During the course of the inspection, the inspector(s) observed the provision of care to residents, meal service, medication administration, reviewed clinical records, policies/procedures and program documents, Resident's Council minutes, staffing schedules and cleaning schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
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.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident's right to be treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity was respected and promoted in relation to the following: [s. 3(1)1]
a) An identified resident was noted to be in his room lying in bed on October 4, 2011 at 1050hrs with the lower half of his body fully exposed to residents, staff and visitors walking in the main hallway of the home. Staff did not attempt to maintain dignity for this resident by ensuring he was not exposed to public view until the inspector suggested the resident might require some assistance.(129)
b) An identified resident transferred himself onto the toilet on September 7, 2011 at 1300hrs, however, his wheelchair was blocking the door and he was unable to close the door. Staff passed the open door, however did not assist the resident in maintaining dignity and preventing the resident from being exposed to public view until the inspector approached staff.(165)
c) The following were observed during the course of this inspection:
- A resident was noted to be sitting in a wheelchair outside the dining room on August 31, 2011. This resident was not fully dressed and the resident's buttocks could be seen by other residents going into the dining room as well as staff and visitors walking in the hall. The Registered Practical Nurse (RPN) who was administering medication to residents entering the dining room did not take action to address the dignity issue for this resident until the inspector suggested that the resident may need some assistance related to dressing.
- A second resident was noted to be using a small washroom that was designated for use by residents on September 7, 2011 at 1300hrs. The resident used a wheelchair for mobility and independently transferred onto the toilet, but was unable to close the door to the washroom because the washroom was not large enough to accommodate the wheelchair. This resulted in the resident being fully exposed to other residents, staff and visitors walking in the hall, because the washroom opened onto a main hallway in the home. Staff walking in the hall did not attempt to maintain dignity for this resident by ensuring that the resident was not able to be viewed by others while using the washroom.
- A third resident was noted to be sitting on the toilet in washroom #7-D wing on August 30, 2011 at 1130hrs. This resident was in full view of other residents, staff and visitors who were walking in the hall. Personal Support Workers (PSW's) were noted to walk past this washroom, which opened onto the hall and did not attempt to ensure the dignity of the resident was maintained by ensuring the resident was not exposed to the view of others while using the washroom.
- A fourth resident was noted to be using washroom #3-C wing on August 30, 2011 at 1015hrs. The door to the washroom was partially open and the resident was visible to other residents, staff and visitors who were walking in the hall. Staff did not attempt to maintain dignity for this resident by providing assistance which would have prevented the resident from being viewed by others while using the washroom.
2. The licensee did not ensure that every resident's right to be afforded privacy in treatment and in caring for their personal needs was respected and promoted in relation to the following: [s.3(1)8]
a) Personal care was being provided to an identified resident while in bed at 0930hrs on September 6, 2011. The privacy curtains around the resident's bed were not completely closed resulting in the resident's exposed lower body being visible through a reflection in a mirror to other residents, staff and visitors walking in the hall.(129)
b) During the 0800hr medication pass for C and D wings on September 9, 2011 many residents were noted to be sitting in the main hallway waiting to receive their medications before moving into the dining room for breakfast. Staff were observed to provide an eye treatment to one resident and a treatment related to diabetic monitoring for resident while these two residents were visible to other residents, staff and visitors who were also in the hallway.(129)
c) The following were observed during the course of this inspection:
- A treatment was being provided to a resident by the foot care specialist on September 1, 2011 at 1010hrs. This treatment was being provided in a resident lounge while other individuals were in the lounge. The foot care specialist confirmed she did not have a private place in the home to provide this care.
- A resident was being assisted by a PSW to the toilet in washroom #5 on August 30, 2011 at 1000hrs. The door to the washroom opened onto a public hallway and was left open while the PSW removed the resident's pants, transferred the resident to the toilet and during the course of the resident using the washroom. The resident was visible to residents, staff and visitors walking in the hallway.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 by ensuring that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records
Specifically failed to comply with the following subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has not ensured that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that those plans, policies, protocols, procedures, strategies or systems are complied with in relation to the following: [s. 8(1)(b)]

a) Staff were not following the home's policy related to lost or missing clothing which is in accordance with O. Reg. 79/10 s. 89(1)(9)(iv). The policy [Lost/Missing Clothing - V8-300] provides direction to staff when a resident or family member is unable to locate an article of resident's clothes or other item and indicates that the following steps are to be taken:
- The reporting individual is to complete Section A of the Lost/Missing Item Report
- The Nursing Staff in the home area complete Section B of the Lost/Missing Item Report.
- The Nursing Staff responsible for the home area is to complete Section C of the Lost/Missing Item Report.

When the report is completed, the report is to be returned to the Environmental Services manager.
During an interview with the Environmental Services Manager, it was noted that the home was not currently using a formal process related to lost items or articles of clothing. The Environmental Services Manager said that when an item of clothing is missing that a search of the home area and the laundry area takes place. He indicated that there was no form to use for missing clothing.(167)
b) Staff in the home were not complying with the policies and procedures included in the home's falls prevention and management program as required in accordance with O. Reg. 79/10 s. 48(1)1.
- The homes policy included in the Falls Prevention Program dated January 2011, directs staff to complete a [Post Falls Huddle] and an assessment form whenever a resident falls. An identified resident sustained two falls, following both of these falls a post falls huddle and a post falls assessment form were not completed.(167)
- The Falls Prevention Policy directs that after a resident falls the registered staff will document a head to toe physical assessment. A head to toe assessment was not documented for an identified resident, following 3 documented falls. (171)
- The Falls Prevention Policy directs that after a fall the resident is to have a head to toe assessment at least every shift for three days following a fall. Registered staff indicated the expectation is to conduct a head to toe assessments and document this in the progress notes in the computer or in the paper chart. There were no head to toe assessments documented for three days post fall by registered staff on every shift for two of the above noted falls for this resident. (171)
- The Falls Prevention Policy directs that a logo is to be placed at the door frame of the resident's room to alert staff of falls risk. Staff indicated a shoe logo was used to identify residents at risk of falls. The identified resident was assessed as being a high risk for falls, however there were no logos on the door frame of his room or above his bed as noted on September 21, 2011. These missing logos were confirmed by PSWs.(171)
- The home's Falls Prevention Program/Stand F.I.R.M./Falls Injury Reduction Management program directs that all residents will be assessed by nursing and/or Physiotherapy for risk of falls on a quarterly basis and post falls and that the physician will be notified immediately post fall. Another identified resident fell in 2010 and the most recent falls risk assessment was conducted on January 13, 2011 which identified the resident a moderate falls risk. There was not a falls risk assessment conducted quarterly or post fall.(129)

c) Staff in the home did not comply with the homes polices included in the orientation program required under O. Reg. 79/10 s. 216(1). The homes orientation policy [V4-240]directs that a detailed orientation checklist developed by Human Resources is available for each supervisor's use to ensure that the orientation is appropriate and comprehensive. Upon completion of the employee's orientation, the supervisor and/or facilitator and the employee will complete the orientation checklist. A copy of the checklist will be inserted in the employee's file. The home did not have completed orientation checklists in employee files for two RPNs, one RN, one Dietary Aide and one Cook. (165)
d) Staff in the home did not comply with the homes Enteral Feeding procedure [V3-660] included in the homes nutritional care program required under section 11(1)(a) of the Act.
- The enteral feeding procedure[V3-600]directs that the registered staff member elevate the head of the resident's bed 30-45 degrees during the feeding and one hour after the feeding is completed. The head of an identified resident's bed was not elevated to 30-45 degrees on September 21 and 22, 2011 during his feeding and one hour after the feeding was completed.(165)
e)Staff in the home did not comply with the homes policy and procedure Diabetic Protocol-Hypoglycemia [V3-453] included in the homes nutritional care program required under section 11(1)(a) of the Act, for two of two residents reviewed.
-The home's diabetic protocol-hypoglycemia policy [V3-453]directs that when a residents blood glucose drops below 4mmol/L or demonstrates symptoms of hypoglycemia, the following steps will be taken by registered staff provided the

resident can swallow: provide a source of 15grams of carbohydrate, which can include:
Step A 175ml juice or soft drink, 3tsp or 3 packets of white sugar.
Step B retest the blood sugar every 15 minutes and repeat step A until blood sugar level reaches equal or greater than 4.0mmol/L. Once the blood glucose has returned to above or equal 4.0mmol/L, the resident should have the usual meal or snack that is due at that time of day. If the time of the next meal/snack is greater than one hour away, give the resident one of the following snacks listed,notify physician of the hypoglycemic reaction, provide the resident and or the substitute decision maker with a status update and document all assessments, interventions and outcomes as appropriate in the clinical record.
-The glucose tracking sheet indicated that an identified resident had a blood glucose of 3.8mmol/L on June 13, 2011 08:00. Registered staff held the residents insulin with no further interventions taken or recorded. On June 22, 2011 the resident's blood glucose was 2.4mmol/L. The resident's clinical record indicated orange juice with sugar was given but no further interventions were taken or recorded. There was no indication that the physician was notified of the hypoglycemic reaction and there was no documentation of assessment, interventions and outcomes in the clinical record on June 13 and 22, 2011 as indicated in the home's hypoglycemia policy. (165)
-Prior to breakfast on September 9, 2011 staff monitored the blood glucose of an identified resident, documented a reading of 3.6mmOl/L and sent the resident into the dining room for breakfast. Staff did not follow step A or step B of the policy when they did not provide the required 15 grams of carbohydrate and they did not retest the residents blood sugar every 15 minutes until the resident's blood sugar reached 4.0 mmo1/L. This resident was directed into the dining room to eat breakfast when the policy directs that once the residents blood glucose has returned to 4.0 mmol/L the resident should have the usual meal or snack that is due at that time of day.(129)
f) Staff in the home did not comply with the Dietary Intake and Hydration Management program required under section 11(1)(b) of the Act.
- The homes policy for Dietary Intake V9-040 and Hydration Management Program V9-251 directs that the Personal Support Worker will record the amount of food and fluid taken after each meal, nourishment pass and supplement pass, for each resident in the home, as per the Nutrition/Hydration Intake Record form. The procedure indicated that if the resident has not consumed a minimum of 1500ml of fluid per 24 hours for 3 consecutive days the actual fluid intake will be reported to the registered nursing staff member for follow up. The registered nursing staff will initiate an interdisciplinary hydration program. The July 2011 nutritional intake record for an identified resident indicated that the amount of food and fluid taken after each meal, nourishment pass and supplement pass, was not recorded by the Personal Support Worker on 41 occasions. The resident has not consumed greater than 1500ml per day for the entire month of July 2011 however, the Registered Nursing staff did not initiate an interdisciplinary hydration program for the resident as indicated in the policy.(165)
g)Staff in the home did not comply with the home's Medication Administration policy required under sections 114(1) and 114(3)(a)of the Regulations with respect to:
- The home's policy, Medication Administration #V3-890, revised September 2008 directs staff to administer oral medications and remain with the resident to ensure that the medication is taken. During the morning medication pass for C and D wings on September 9, 2011, the RPN poured the resident's medications into a cup, gave the cup to the resident who took the cup into the dining room. The RPN did not remain with the resident nor keep the resident within eye sight to ensure that the medications were taken by the correct resident(129)
h)Staff in the home did not comply with the home's Assessment-Pain policy included in the organized program of nursing services as required under LTCHA, 2007,S.O., c. 8, s. 8(1)(a) of the Act with respect to:
Staff in the home have not followed the directions in the home's Assessment-Pain (V3-170) policy dated September 2008, which directs staff to complete the pain assessment tool weekly until effective pain management is achieved. The Nursing Supervisor confirmed that an identified resident's pain was not effectively managed due to significant use of as necessary medication to relieve pain and the weekly pain assessment was not completed for a period in excess of one month.(129)
i)Staff in the home did not comply with the homes policy included in the organized program of nursing services as required under LTCHA, 2007, S.O., c.8, s.8(1)(a)of the Act with respect to:
The home's palliative care policy V3-1190.1. directs that an individualized palliative care plan will be developed to assist the interdisciplinary team in meeting the individual and unique needs of the resident and their caregiver however, an identified resident did not have an individualized palliative care plan developed despite being deemed palliative.(165)

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following subsections:

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 did not ensure that each resident was bathed, at minimum, twice a week by the method of his/her choice with respect to the following: [O. Reg. s. 33(1)]
a) PSW documentation records were reviewed for 49 residents for the month of August 2011 and the records indicated that all 49 residents did not consistently receive 2 baths/week.
-An identified resident's records indicated the resident did not receive one bath for the month of August 2011.
-Two identified resident's records indicated that both residents only received 1 bath for the month of August 2011. One of these residents did not receive a bath from August 1-29, 2011. The resident's plan of care did not indicate frequency of bathing. The second resident did not receive a bath from August 1-7, 2011 and August 10-31, 2011. The resident's plan of care indicated that she is bathed once per week and it directs staff to provide a tub bath however, the resident received a shower.
-An identified resident did not receive a bath from August 11-31, 2011 and only received 1 bath/week from August 1-7 and August 8-14, 2011. The resident's plan of care indicated she is to receive a bath Saturday PM and Thursday AM.
-An identified resident did not receive a bath from August 1-20, 2011 and only received 1 bath/week from August 15-21 and August 22-28, 2011. The resident's plan of care indicated a shower was to be provided on Wednesday PM and Saturday AM. The resident's bathing choice record indicated a preference for a tub bath however, the resident received showers.
-An identified resident did not receive a bath from August 1-7, 2011 and only received one bath/week August 8-14, August 15-21 and August 22-28, 2011. The resident's plan of care did not indicate frequency of baths. The resident's bathing choice record dated August 17, 2011 indicated the resident prefers a tub bath however, the resident received a shower on all 3 occasions.
-An identified resident did not receive a bath from August 6-29, 2011. The resident's plan of care indicated a bath is to be provided once/week. The resident stated she prefers 2 baths/week and confirmed that some weeks she only receives 1 bath/week. The resident's bathing choice record indicated the resident prefers a tub bath however, the resident received showers.
-An identified resident did not receive a bath from August 3-25, 2011 and received 1 bath/week August 1-7 and August 22-28, 2011. The resident's plan of care indicated he was to receive a bath Monday and Thursday AM.
-An identified resident did not receive a bath from August 1-15, 2011 and received 1 bath/week August 15-21 and August 22-28, 2011. The resident's plan of care indicated she was to receive a shower Monday PM and Thursday PM. The plan of care indicated to shower the resident however, the resident received tub baths for 2 of the 3 bathings.
-An identified resident did not receive a bath from August 1-14, 2011 and received 1 bath/week August 8-14, August 15-21 and August 22-28, 2011. The resident's plan of care indicated he was to receive a shower Tuesday and Saturday PM. The resident's bathing choice record dated March 2, 2011 indicated the resident prefers a shower however, the resident received tub baths.
-An identified resident's record for August and September 2011 indicated that the resident went from August 4-August 16, 2011 without being bathed. The resident did not receive one bath the week of August 7-13, 2011 and only received one bath the week of Aug 14-21, 2011. September 2011 documentation record indicated the resident only received one bath the week of Sept 18-Sept 24, 2011. The resident confirmed that when she does not receive 2 baths a week staff tell her it is because they are short staffed.
b) Personal Support Workers confirmed that if they worked with a shortage of staff residents do not always get bathed twice a week. The PSW confirmed that the bathing list does not indicate the resident's bathing method of choice.
c) A family member interviewed on September 6, 2011 1420hr indicated that their family member is not getting two baths per week because the home is always short staffed.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that drugs where administered to residents in accordance with the directions for use specified by the prescriber in relation to the following:[s.131(2)]

a) An identified resident had a Physician's order for canesten 1% HC cream twice a day for ten days however, the home only administered the cream twice a day for five days.(165)
b) An identified resident had a Physician's order for Tylenol #2 (1) tablet four times a day. The resident did not receive Tylenol #2 (1) tablet four times a day on September 16,17 and 18 2011.(129)
c) On September 9, 2011 the RPN crushed an identified resident's medication in the pouch provided and then mixed the crushed medications in a medication cup with applesauce. The resident did not receive the dose of medication ordered by the physician because crushed medications were left both in the medication pouch and in the medication cup after the staff person administered the medication to the resident.(129)
d) An identified resident had a physician order for Pariet which directs staff not to crush this medication. On September 9, 2011, the RPN was observed to crush this medication and then administer the medication to the resident.(129)
2. The licensee did not ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident with respect to the following:[s.131(1)]

An identified resident had a Physician's order for Hyderm cream 1% GM and Uremol-10 cream 10% GM however, this order was discontinued on the August 1, 2011 physician's Medication Review. The resident's Medication/Treatment Administration Record dated September 1 to September 30, 2011 indicates that Uremol-10 cream 10% and Hyderm-10 cream 1% was applied on twenty occasions since September 1 to September 27, 2011 despite not being prescribed for the resident.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(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. (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
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, in relation to:[s.6(1)c]

a) An identified resident's plan of care directed staff to shower him Tuesday and Saturday PM, however it also indicated that staff are to provide a tub bath.(165)
b) An identified resident's plan of care regarding bladder continence indicated on the most recent Continence Assessment in the chart dated July 4, 2011 that the resident was on a retraining program with a toileting schedule in place. It also indicated the resident used liners. The care plan section "Bladder Continence" signed off in August 2011 indicated the resident refused to wear a disposable product and she was to be encouraged to go to the toilet when she feels the urge. The PSW's and registered staff working with the resident indicated she wears a pad and will use the toilet when she wants as she is ambulatory. The staff indicated they were unaware of a retraining program or toileting schedule in place for this resident. According to the PSW Flow Sheets, she has had two or fewer episodes of bladder incontinence per month for the last three months.(171)
c) The comfort section of the care plan for an identified resident dated August 2011 indicated "if resident cognitive, educate about nursing techniques to alleviate pain, i.e., relaxation, exercise, massage, etc.". Registered staff indicated the intervention for pain for the resident was to provide analgesics and that the relaxation, exercise and massage are sessions offered to resident's of the home in general but were not specific to this resident. The resident stated he does not choose to attend any of the relaxation, exercise or massage sessions offered by the home. The Physiotherapist indicated she will use a specific treatment for pain, however PSW's and registered staff were unaware of these potential interventions for pain.(171)
d) An identified resident's plan of care related to Physiotherapy and Nursing restorative programs following surgery in 2011 contained conflicting information.
- The plan of care dated June 17, 2011 regarding range of motion and exercises for this resident was different in the flow sheet binder and the plan of care. The Nursing Rehabilitation flowsheet, dated July-September 2011, indicated the resident requires 5-15 minutes of ROM (range of motion) exercises daily, however the plan of care for the restorative program indicated active ROM for 15 minutes or more, seven days per week.
- The Nursing Rehabilitation flowsheet indicated that specific instructions for each exercise are kept with the flowsheets, however there were no specific instructions in the binder. This missing information was confirmed by registered staff and PSWs.
- The Nursing Rehabilitation flowsheet indicated joint ROM to upper and lower extremities, with an exception to an injury, however plan of care did not have a restriction and the instructions indicated to do bends and rotations. Staff indicated the resident is able to exercise the injured area most days but they would assess each time for pain.
- The plan of care indicated the resident was to do sit-to-stands x5 and heel lifts x5 each foot however these instructions were not provided in the Nursing Rehabilitation flowsheet.
- The plan of care dated June 17, 2011 indicated that the resident was to receive ice massage x 15 minutes however the physiotherapist indicated that this treatment had not been used since March 2011.(171)
e) An identified resident's plan of care does not provide clear directions related to the following:
- On September 14, 2011 1100hrs the resident was transferred from bed to her wheelchair with one staff person providing physical assistance. A PSW confirmed on September 19, 2011 that the resident is a one person physical assist and staff do not use a mechanical lift for transfers. The resident's plan of care indicates that the resident is a two+ person physical assist and is lifted mechanically.
- A Physician's order indicated that an identified resident's medical device was discontinued June 26, 2011 and the resident currently does not have this device in place. A PSW confirmed that the resident is toileted when she gets up in the morning and before and after meals however, the resident's plan of care indicated the resident has the medical device and does not indicate the resident's toileting plan.
- An identified resident does not have a trunk restraint in place. Registered staff interviewed indicated that the resident does not have a restraint and documentation in the resident's health record does not indicate that a trunk restraint is in place however, the care plan indicated the resident has a trunk restraint.
- The physiotherapy assistant confirmed September 19, 2011 that an identified resident did not currently receive physiotherapy treatments and has not received treatments for the last two and a half weeks due to a decline in health however, the resident's plan of care indicated that she is participating in physiotherapy three times per week.(165)
f) An identified resident's plan of care related to falls did not provide clear directions with respect to the following:
- The resident's risk for falling was changed from medium to high, however the plan of care does not identify the factors that caused the residents risk of falling to change from medium to high risk for falls nor does the plan set out clear

directions for staff in relation to care required to prevent falls now that the risk for falls has increased. The PSW providing care to the resident confirmed that she is unsure of the care to be provided in order to prevent further falls for this resident.(129)
g)An identified resident stated that when some PSW's change her they do not put the new brief on properly. The resident stated that they do not always pull the brief all the way up, it is too tight and it causes redness because it is so low and rubs against her thighs. The resident stated that it is uncomfortable and she is unable to stretch out her legs. The RPN confirmed that the resident has shared her discomfort with her brief and that for this resident, staff have to move the resident' skin on her legs and pull the brief all the way up so that the brief does not sit on the creases of her skin. The residents' plan of care does not include this direction for staff and the resident currently has an area of open skin.
2. The licensee did not ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident related to the following:[s.6(4)a]
a) Staff did not collaborate regarding limitations that affect range of motion for an identified resident. The Resident Assessment Protocol (RAP) quarterly assessment in the March 2011 and June 2011 RAP included one statement in the Activities of Daily Living Section that the resident had some pain and had been referred to physiotherapy as a result. The assessments done by the physiotherapist between these dates had been completed and documented in the physiotherapy department, however this information was not included in the RAP quarterly assessment.(171)
b) Staff did not collaborate in the assessment of an identified resident regarding range of motion exercises and ambulation related to:
- The PSWs had flow sheets to record the number of minutes the resident participated in range of motion exercises per shift. There was a section for the PSWs to fill in comments regarding the resident progression, however the June and July 2011 sheets had no comments included. PSW's indicated they would verbally inform the nurse on duty only if there was a concern with following the plan of care. The physiotherapist was unaware this information was being collected and therefore did not use this information in assessments.
- The RAP assessment, completed by nursing staff regarding activities of daily living (ADL's) dated July 2011 indicated that the resident was no longer able to walk with a walker but used a wheelchair and that she was attending physiotherapy for a walking program. The flow sheet binder included a walking flow sheet, completed by PSWs for June 2011 indicating the resident had been walking on a daily basis with the PSWs as well as with physiotherapy. The resident was observed walking with a walker independently throughout the inspection.(171)
c) An identified resident fell in 2011, following which the Physiotherapist completed a post falls assessment that was kept in the Physiotherapy office. The Physiotherapist confirmed that the assessment data with resulting care recommendations were not communicated to nursing staff and nursing staff confirm that this information was not integrated into a nursing assessment for this resident. Nursing determined that the resident was experiencing pain and did not communicate their assessment that the resident was having increased pain to the physiotherapy staff and as a result the nursing and physiotherapy assessments did not complement each other. (129)
d)Staff did not collaborate with each other in the assessment of pain for an identified resident.
- Nursing staff confirmed they did not collaborate, and were not aware of the assessment and resulting recommendations for ice packs and frequent repositioning when in the chair completed by Physiotherapy staff.
- Physiotherapy staff confirmed that they did not collaborate, and were not aware of the pain assessment completed by nursing staff indicating the resident was experiencing increased pain.(129)
3. The licensee did not ensure that the resident is reassessed and the plan of care revised when the residents care needs change or care set out in the plan is no longer necessary.[s.6(10)b]

a) An identified resident's plan of care had not been revised regarding skin and wound care when her care needs changed. On July 4, 2011 the physician's orders indicated that a specialized dressing was to be discontinued. The care plan summary for skin integrity that was last signed off August 31, 2011 still included this intervention and did not include the dressing interventions that were last ordered on August 15, 2011. The nutrition section of the care plan also indicated that specialized dressings were being used to improve skin integrity.(171)
b) The Nutritional Intake record for an identified resident indicated that her fluid intake had been decreasing over the past three months. The Hydration Management Policy indicated residents are to be followed if intake is less than 1500ml/day for three days. The actual form staff used to track low fluid intake indicated they were to track residents getting less than 1000ml/day. According to the Nutrition Intake Record the resident's fluid intake in June 2011 was less than 1500ml/day every day and less than 1000ml on nine days that month. In July 2011, the resident consumed less than 1000ml on fourteen days, in the month of August 2011 less than 1000 ml on 11 days. There was no documented reassessment of

hydration status and the plan of care had not been revised to include interventions to address poor fluid intake. There has not been a nutrition assessment or reassessment documented since April 2011 for this resident. The Registered Dietitian and registered staff indicated the expectation was to reassess each resident's nutrition and hydration status quarterly and they were unsure why this resident was missed in July 2011.(171)
c) An identified resident had not been reassessed and her plan of care reviewed and revised when the resident's care needs changed. The resident confirmed that she gets constipated at times. The PSW documentation records indicated that the resident did not have a bowel movement from June 6, 2011 - June 16, 2011 and July 25- August 1, 2011, however, there was no reassessment of the resident's bowels and the plan of care had not been based on this information.(165)
d) An identified resident's plan of care contained a physician's order for a tilt wheelchair on August 17, 2011 which included instructions to reposition the resident every two hours while in the chair. This information was not included in the plan of care summary last dated August 31, 2011 or the PSW flowsheet binder for August or September 2011, which were the two primary sources of information regarding resident care to which PSW's had access. The Director of Care confirmed this information should have been updated at the time of the change in August 2011.
4. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan in relation to the following:[s. 6(7)]

a) A Physician's order for an identified resident dated August 15, 2011 specified that a wound dressing was to be changed every three days and as necessary. This information was part of Medication Administration record, however this treatment was only signed off as being completed on August 23, 30, September 2, 6, 9 and 23, 2011. The registered staff and Director of Care indicated that the expectation would be that the nurse who performs the treatment would sign off that it was completed and if it was not signed it was likely not completed.(171)
b) A Physician's order for an identified resident indicated she was to be repositioned while in her tilt wheelchair every two hours. The PSW staff indicated this intervention was not implemented on a routine basis and this care was not being recorded as being provided. This was confirmed by two PSWs and a registered staff.(171)
c) An identified resident had a Physician's order for beneprotein 1 scoop in cereal at breakfast daily. This was ordered to respond to the increased protein needs of the resident, however, the resident does not receive it as specified in her plan. The resident's Medication Administration Record indicated that the beneprotein was signed as given on only 8 of the 31 days in July 2011. It was observed that resident was not provided beneprotein 1 scoop in her cereal at breakfast September 9, 2011 and the Registered Practical Nurse confirmed that the beneprotein was not administered as ordered. The resident's laboratory values indicate that her albumin levels remain below the normal range at 25. The plan of care indicates dietary servers are to follow a special marked menu related to the resident's likes/dislikes for entrees provided to ensure adequate protein intake, however, there is no special marked menu developed and available for staff. The plan of care indicated the resident is to receive 1 banana daily at breakfast related to low potassium however, the resident did not receive a banana at the breakfast meal September 9, 2011.(165)
d)Care set out in the plan of care was not provided to an identified resident with respect to the following:
- Care set out in the plan of care based on an assessment completed by Physiotherapy for the management of pain was to frequently reposition the resident while sitting in the wheelchair. PSW's confirmed that they were unaware of this care direction, it was not included in the document the direct care staff use to identify care required and this care was not being provided to the resident.
- Care set out in the plan of care based on an assessment completed by nursing staff for the management of pain was to apply topical heat rub when the resident complained of pain. PSW's confirmed that not all direct care staff are aware of this intervention, it is not included in the document direct care staff use to identify care to be provided to the resident and this care was not consistently being provided to the resident.
-The resident confirmed that she continues to have pain, reports this pain to the staff, however no action is taken to relieve her pain.(129)
5. The Licensee did not 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 the resident with respect to the following:[s.6(2)]

a) The plan of care was not based on the resident's needs and preferences for an identified resident with regards to hydration. The resident prefers to not take any fluids at snacks as indicated by the food/fluid tracking sheets and PSWs, however the plan of care for fluids indicated only one intervention to increase fluids and that was to offer milk and coffee at snacks.(171)
b) On September 14, 2011 during the breakfast meal service it was noted that an identified resident was not served

prune juice. Dietary and PSW staff confirmed that this resident does not like prune juice so they stopped giving it to her. The resident stated that she does not want the prune juice. The plan of care for constipation still indicated that the resident is to receive prune juice even though the resident indicated that she does not want it.
6. The Licensee did not ensure that staff and others involved in different aspects of care of the resident collaborate in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent and complement each other, with respect to the following:[s.6(4)b]

a) The resident was observed at the breakfast meal service on September 14, 2011 requiring full assistance to eat hot cereal and guidance to eat toast. The Occupational Therapist documented an assessment on June 7, 2011 regarding the resident's ability to feed herself and indicated the resident was able to feed herself finger foods and was dependent on help for other foods and beverages. The resident has medical conditions that factor into her abilities. There was no complementary documentation from the Dietitian or Food Services Manager regarding developing a nutritional plan of care or individualized menu that would address the Occupational Therapist's evaluation regarding finger foods.

Additional Required Actions:

CO # - 005, 006, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 with sections 6(2), 6(4)(a) and 6(4)(b) of the Act,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee did not ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. [s.8(3)]
According to the staffing schedules and the payroll records the home did not have a registered nurse on duty in the home on Saturday August 6, 2011, 1500hrs-2300hrs; Sunday August 7, 2011 1500hrs-2300hrs; Saturday August 27, 2011 1900hrs-2300hrs and Monday August 29, 2011 2300hrs-0700hrs. The home confirmed that on August 6, 2011 there was only a Registered Practical Nurse in the home and the Director of Resident Care was on call.
According to the staffing schedule the home did not ensure there was a registered nurse working in the home on Wednesday September 7,2011 15:00-16:30; Friday September 9, 2011 15:00-23:00; and Friday September 23, 2011 15:00-23:00. The home was unable to confirm that agency staff were used for these dates in September at the time of this inspection.

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The Licensee did not ensure that the package of information provided to residents and substitute decision makers of residents included a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee. [s. 78(2)(m)]
On September 8, 2011 a review of the admission package was conducted. The package did not include a statement that residents are not required to purchase care, services, programs or goods from the licensee, and may purchase such things from other providers. This missing documentation was confirmed by the resident relations coordinator.

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 by ensuring that the package of information provided to residents and substitute decision makers of the residents included a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee,, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. 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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;
(b) a cleaning schedule for all the equipment; and
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :