1. The Licensee has not ensured that staff comply with policies and procedures for the cleaning of equipment related to the food production system, related to the following: [s. 72(7)(b)]
a) The checklist in the kitchen for daily cleaning of dietary areas was being signed by staff but the tour of the kitchen revealed that despite the signatures, areas in the kitchen were not being consistently cleaned as per the schedule. Staff interviewed at the time of the tour also confirmed that despite the checks on the Dietary Cleaning Checkoff List, it did not appear that some of the areas checked off had actually been cleaned.
b) Discussions with dietary staff revealed that since there was a staffing cut in the dietary department in January 2011, that the thorough cleaning schedule of equipment scheduled for Fridays was not being completed. The tour of the kitchen confirmed that there was a build up of dirt on many pieces of equipment in the kitchen and that the thorough cleaning that was scheduled for every Friday was not being followed.
2. The Licensee has not ensured that the food production system must, at a minimum, provide for, the preparation of all menu items according to the planned menu in relation to the following: [s. 72(2)(d)]
The planned menu for Week 2 Tuesday, September 7, 2011 indicated cheese and fruit plate and the standardized recipe directs staff to use pears and peaches however, resident's requiring a puree meal received puree pears and strawberries. There was no puree bread or puree brussel sprouts prepared for the lunch meal September 16, 2011. The cook confirmed that the homemade potato leek soup was not prepared for the lunch meal September 16, 2011 and a canned cream of asparagus soup was prepared in it's place as a result of staff shortage.
Blueberries mixed with fieldberries were served for the lunch meal September 19, 2011 as the home did not have a sufficient amount of blueberries.The home did not have all the ingredients required to prepare the homemade beef vegetable soup for the lunch meal September 22, 2011. The cook confirmed that the home did not have the beef, tomatoes and carrots required to follow the recipe and prepared canned beef vegetable soup in it's place. The home did not have rice krispies for the breakfast meal and no cream of celery soup for the lunch meal Friday September 23, 2011.
3. The Licensee has not ensured that all food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality with respect to the following: [s.72(3)(a)
i) Perogies served during the lunch meal September 7, 2011 were overcooked and hard. Two residents stated the perogies were hard and difficult to chew and resident plate waste with the perogies was high. Perogies were tasted and the shell of the perogies was hard and crunchy.
ii) The texture of the thickened soup was very thick and lumpy(oatmeal consistency). The food service supervisor on duty confirmed it was not appropriate texture.
iii) The cook confirmed that the preparation of toast for the breakfast meal September 9, 2011 began between 7:30 and 7:45 however, toast did not start being served until 9:00 resulting in the toast sitting in the steam table for at least 1 hour and 15 minutes prior to service. Residents indicated that the toast was soggy and previous food committee minutes indicated residents raised the concern of toast being soggy.
iv) An identified resident complained the food is always overcooked and does not taste good. During the noon meal on August 30, 2011 the beef macaroni being served to residents was sampled and it was noted to be very mushy with a glue-like texture and was just barely warm.(129)
v) The minced cucumber salad served during the lunch meal September 16, 2011 was very runny and contained chunks of peelings.(165)
vi) An identified resident complained that the food is very bland tasting. It was noted while sampling the beef macaroni that the taste was bland.(129)

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 with sections 72(7)(b), 72(2)(d) and 72 (3)(a) of the Regulations,, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

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
(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 has not ensured that the home has a dining and snack service that includes appropriate furnishings and equipment in the resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents with respect to the following: [s. 73(1)11]
Appropriate furnishings were not provided for an identified resident. On September 14, 2011 at the breakfast meal service it was noted that the resident's feet did not touch the ground when she was seated at the table. The resident stated she would prefer that she had something to rest her feet on while seated in the dining room. Registered staff indicated they were unaware of this resident's concern.
2. The Licensee did not ensure that residents who require assistance with eating or drinking are not served a meal until someone is available to provide the assistance required by the resident, with respect to the following: [s.73(2)(b)]
An identified resident was served oatmeal during the breakfast meal September 9, 2011 however, the resident sat with his food in front of him for eighteen minutes prior to a staff member providing assistance to the resident. The resident's plan of care indicated he required total dependence for eating however, staff served his meal prior to someone being available to provide assistance.
3. The Licensee did not ensure that residents are provided with eating aids and assistive devices with respect to the following: [s.73(1)9]
An identified resident was not provided with assistive devices required to safely eat and drink as comfortably and independently as possible. The resident received a breakfast tray in her room September 9, 2011 however, the resident did not have an overbed table and her bowl of oatmeal was placed on her stomach. The Personal Support Worker was unable to locate the resident's overbed table when identified by the inspector and the resident continued to eat with her oatmeal on her stomach.
4. The Licensee did not ensure that the seven-day and daily menus were communicated to the residents with respect to the following: [s.73(1)1]

a) On September 14, 2011 at 0900 the menus posted outside the Country dining room showed meals from September 13, 2011. Two residents commented that they did not know what was for breakfast as they were coming into the dining room because the wrong menu was posted.(171)
b) On August 30, 2011 at lunch meal service it was observed that the weekly menus were not available for residents in the Country Dining Room and were not accessible to residents in the Gardenview Dining room. The menus in the Gardenview dining room were tacked to a board near the steamtable and were not turned to the appropriate week.(171)
c)It was noted that the daily menu posted outside of the large dining room was posted very high on the wall and would be difficult for residents to view and read.(167)
d) On August 30, 2011 at 1145hrs it was noted that the daily menu was posted outside the large dining room approximately five and a half feet from the ground and the weekly menu was posed inside the dining room at the same height from the floor with a dining table placed against the wall. Approximately 90% of the residents using this dining room use wheelchairs for mobility, posted height as well as the font size made these menus unreadable for most of the residents.(129)

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 with sections 73(2)(b) and 73(1)9 of the Regulations,, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee did not ensure that when a resident is taking a drug or a combination of drugs that there is monitoring and documentation of the resident's response and the effectiveness of the drug.[s.134(a)]

a) During the period of September 5, 2011 to September 21, 2011, an identified resident received Ativan as needed in accordance with physician's order, 28 times. There was no documentation of the effectiveness of this medication for 10 of those occasions when the drug was administered and there is no documentation of the resident's response to the drug. (129)
b) An identified resident had a physician's order for Lorazepam to be given three times a day. The plan of care for this resident directed staff to conduct ongoing assessments of the signs and symptoms of depression and the effect of this antidepressant. It was confirmed by the Registered Practical Nurse (RPN) that she is unaware of how this assessment would be conducted and that she has not conducted such a review. It was noted that Personal Support Worker (PSW) documented on the "Mood and Behavior" flow sheet for the period of time of June/July/August and up to the 20th of September 2011, 180 episodes of responsive behaviours. Staff in the home have not monitored the effectiveness of the drug in relation to the resident continuing presentation of a number of mood changes and behaviours.

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 when a resident is taking a drug or combination of drugs that there is monitoring and documentation of the resident's response and the effectiveness of the drug,, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity and foot conditions with respect to the following:[s. 26(3)15]

Despite documentation in the clinical record for an identified resident and confirmation by PSW staff related to the presence of open skin areas, this skin condition was not included in the plan of care.
2. The licensee did not ensure that the registered dietitian completed a nutritional assessment for all residents on admission and whenever there is a significant change in the residents health condition with respect to: [s. 26(4)(a)]

a) The registered dietitian did not assess the hydration status for an identified resident. The June 2011 RAP assessment completed by the Food Services Manager indicated the resident's daily fluid intake was 750-950 mls. There was no assessment in the documentation regarding the actual requirements for this resident and whether the intake met requirements. The resident was being tracked by the registered staff in their hydration book as she was taking less than 1000 mls/ day which was considered a risk. The last annual assessment in December 2010 by the Registered Dietitian indicated sub-optimal fluid intake, however there was no assessment as to the requirements of the resident compared to current intake. This missing documentation was confirmed by registered staff.(171)
b) A complete nutrition assessment including risks related to nutrition care and hydration had not been completed for an identified resident.
- In April and July 2011 the resident's MDS RAP assessment for nutrition indicated she had no chewing or swallowing problems, however she was receiving a minced diet texture. There was no assessment regarding the need for this texture modified diet. A progress note from January 13, 2011 indicated a review of the resident eating a minced diet after a change from a regular texture, however there was no information regarding what the specific issue was with the regular texture or why she was changed to a minced diet texture. In interviews, the Registered Dietitian, registered staff and PSWs were unsure why this texture modification was required.
- The RAP assessment indicated her fluid intake was 1150-1350 mls however, there was no assessment regarding what her personal fluid needs were and if this intake was adequate.
- A complete nutrition assessment was not completed for an identified resident following a significant change in hydration. There was no RAP nutrition assessment completed on the July 2011 quarterly regarding nutrition or hydration. The resident had a significant decrease in fluid intake in June 2011 to a range of 725-1200 ml, however this decrease in intake was not assessed. The registered dietitian and registered staff indicated it would be the expectation that if there was a significant change in the resident's nutrition or hydration status noted by the food services manager or other staff then a dietitian referral should be completed. There were no dietitian referrals noted for this resident.

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 Registered Dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents on admission and whenever there is a significant change in the resident's health condition., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has not ensured any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions were documented with respect to the following:[s.30(2)]

a) Not all interventions have been documented for an identified resident with respect to the Skin and Wound program required under section 48(1)2 of the Act. The resident was to be monitored hourly and repositioned every two hours as an intervention to prevent skin breakdown, however documentation indicating these interventions were provided is incomplete. Documentation on the Resident Turning and Positioning Monitoring Record used by the home to record the position of the resident while in bed and in the chair indicates that the resident was not turned or repositioned on September 1 and 11, 2011 for the entire day and evening shifts hours (0700-2300h), on September 3,4 and 7, 2011 for the entire night shifts hours (2300-0600h) and on September 10, 15 and 19, 2011 the entire evening shift hours (1500-2300h). Registered staff confirmed it is the expectation that the PSWs document positioning hourly.(171)
b) Not all reassessments, interventions and responses to interventions have been documented for an identified resident with respect to the Hydration program required in section 9(1) of the Act. The resident had an annual assessment in December 2010 which indicated sub-optimal fluid intake and the addition of an intervention to offer milk and coffee at snacks. The subsequent RAP assessments in March 2011 and June 2011 did not reassess the hydration status of the resident with regards to whether her intake met her requirements, or responses to the interventions as documented in the care plan section fluids. The interventions in the plan of care have not been updated since December 2010 and were last signed off in April 2011. Staff indicated the intervention regarding fluids at snacks is outdated and not appropriate for this resident. This missing documentation was confirmed by registered staff.(171)
c) Not all interventions and resident's responses to interventions were documented for an identified resident with respect to the Restorative Care program required under section 9(1) of the Act. The resident had an intervention in her plan of care to complete 5-15 minutes of active range of motion (ROM) exercises daily. The Active ROM flowsheets had not been completed each shift as per instructions to indicate the number of minutes the resident participated in active ROM exercises. June 2011 has ten shifts with no documentation, July 2011 has twenty shifts with no documentation, September 2011 has nine shifts with no documentation between September 1-19, 2011. The flow sheet indicated staff are to enter a "0" if no minutes were delivered and an "R" if the resident refused. The flow sheets indicated that a blank in the documentation could mean the exercises were not done or it could mean the staff person did not have time to complete documentation.
2. The Licensee did not keep a written record of an annual evaluation of the Restorative Care program required under section 9(1) of the Act.[30(1)4]

The Home had a program for Nursing Rehabilitation dated January 2011, however the following items: date of the evaluation, the names of persons who participated in the evaluation, a summary of the changes made and the date that the changes were made were not documented with respect to this program when it was reviewed on September 22, 2011. This missing documentation was confirmed by the restorative care lead.

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 any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented,, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following subsections:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a continence care and bowel management program was implemented in the home with in relation to the following:[s. 48(1)3]
The home's Policy and Procedure related to Continence Management, Bowel and Bladder dated August 2011 (Resident Care V3-239) that reflects current legislation has not yet been implemented within the home. Staff at the home are not following any consistent policies or protocols related to bowel and bladder management. The Director of Resident Care confirmed that this program has not been implemented in the home.
2. The licensee did not ensure that an interdisciplinary pain management program was implemented.[s. 48(1)4]
a)The home provided a copy of the pain management program dated April 2011 [revised], which is clearly marked as a draft document. The Director of Care confirmed that this program has not been implemented in the home. This was also confirmed when the care provided for two of two residents experiencing pain was not consistent with the directions in the pain management program document provided by the home.

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 with sections 48(1)3 and 48(1)1 of the Regulations,, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

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

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The Licensee did not ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument, specifically designed for falls. [r. 49(2)]
-A post-fall assessment had not been conducted for an identified resident using a clinically appropriate instrument for a number of falls. The progress notes indicated the resident had multiple falls over the period of a week. The Post Fall assessment sheet in the post-fall binder only had an assessment documented for one of these falls. Registered staff indicated that it was the role of registered staff to fill in the assessment form and it was the expectation that an assessment for each fall was documented.(171)
- Care required when a resident has fallen was not provided to an identified resident subsequent to a fall from her wheelchair. The fall resulted in the resident sustaining a head injury, a laceration and multiple bruises and the required assessment was not conducted by nursing with respect to these injuries. This was confirmed by the Nursing Supervisor. (129)
2. The Licensee has not ensured that supplies , devices and aids for the falls prevention and management program are available at the home.[s. 49(3)]
a) The homes Falls Prevention and Management program indicates that a falls prevention kit should be accessible to staff and include such things as non-slip socks, chair and bed alarms, night lights, hip protectors, reachers, crash mats and helmets. It was confirmed by 4 Registered nursing staff members that the kit that is suppose to contain these items is not available in the home.

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls., to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment in relation to the following:[s. 50(2)(b)(ii)
Progress notes contained in an identified resident's clinical record indicated the resident had areas of skin breakdown, which was also confirmed by PSWs providing care to the resident. Interviews with the resident and PSW confirmed that the resident's brief was not always applied correctly causing the brief to be too tight around the thigh areas, which has resulted in open areas. A skin assessment completed by a RPN indicated the resident had reddened groins however, did not identify the resident's open areas. The resident's plan of care did not identify the open areas and there was not immediate treatment or interventions to reduce or relieve pain, promote healing and prevent infection as required for the open areas and causative factors.
2. The licensee did not ensure that residents who exhibit altered skin integrity are reassessed at least weekly in relation to the following:[O. Reg. 79/10 s. 50(2)(b)(iv)]
An identified resident was assessed as having a Stage 3 ulcer and the resident's skin had not been reassessed weekly by a member of the registered nursing staff. The last documented reassessment happened on July 21, 2011. The resident had continued to have a skin ulcer since that time. The last note regarding the ulcer on September 9, 2011 indicated it was measured at 2.0 x 0.5 cm. Registered staff and the Director of Care confirmed that the expectation was to complete full reassessments weekly and it was confirmed that this information for this resident had not been completed since July 21, 2011.

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 with sections 50(2)(b)ii and 50(2)(b)iv of the Regulations,, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure that when a resident's pain is not relieved by initial interventions the resident is assessed in relation to the following:[s. 52(2)]
a) An identified resident did not receive the required care, when she continued to experience pain. The resident indicated she has constant pain. The resident received a narcotic analgesic and/or Tylenol ordered to be used as necessary by her physician for pain management, eighteen times in June 2011, twenty times in July 2011 and fifteen times in August 2011. The Nursing Supervisor confirmed that this use of as necessary medication to manage pain would indicate that the resident's pain was not being managed, however the required assessment was not completed for this resident who continued to experience pain.(129)
b) The physician ordered a narcotic analgesic for an identified resident to be administered every three to four hours as needed(PRN). Staff did not consider a regular dose of analgesic despite utilizing the PRN narcotic analgesic eighteen times during the evening and night shifts over the last fourteen days. On September 14, 2011 at 1045hrs the resident was calling out and appeared to be in pain. A PSW confirmed that the resident had been experiencing pain throughout the morning. The resident was taken to the RPN at 1100hrs on September 14, 2011, who also confirmed that the resident was in pain however, the RPN stated the resident could not receive pain medication at this time because the resident received pain medication in the morning and not enough time had elapsed to administer another dose of PRN medication. The Physician's order indicates the resident can receive the narcotic analgesic every three to four hours as needed (PRN) and the resident's Medication Administration Record (MAR) indicated the resident's last dose of narcotic analgesic was provided at 0500hrs, on September 14, 2011. The resident could have received another dose as early as 0800hrs however, she did not receive another dose of narcotic analgesic until 2205hrs despite the resident exhibiting pain as early as 1100hrs.(165)

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose., to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has not ensured that written approaches to care including screening protocols, assessments, reassessments, identification of behavioural triggers, written strategies to prevent/minimize/respond to responsive behaviours, monitoring and internal reporting protocols and protocols for referral to specialized services in accordance with section 53(1) of the Regulations were implemented with respect to the Behaviour Management program. [s. 53(3)(a)]
While reviewing the care provided to an identified resident the Director of Care provided a copy of the home's Responsive Behaviour Management program dated August 2000 and although the document includes definitions of responsive behaviours, prevention/reduction/management strategies, evaluation strategies, identification of behavioral triggers, prevention strategies and strategies for the utilization of internal and external resources the Director of Care confirmed that program it is currently in draft form, not implemented in the home and not part of the care for this resident.

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 matters referred to in subsection (1)are developed and implemented in accordance with evidence-based practices and where there are none, in accordance with prevailing practices,, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following subsections:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).

Findings/Faits saillants :

1. The Licensee did not ensure that staff who provide direct care to residents received annual training in accordance with section 221(2)1 of the Regulations with respect to minimizing restraining of residents in accordance with section 76(7)4 of the Act.[s.221(2)1
The last documented inservice on restraining happened in March 2010 and was attended by 32 out of approximately 120 staff working in the home. There were no provisions to ensure that staff who did not attend the inservice received the information. Restorative care staff indicated that staff would receive some information regarding restraining on a regular basis during the course of their work, however this was not formalized or tracked. Five staff were unable to remember the last time they had any training on restraint use, applying restraints or potential dangers of restraints.
2. The licensee did not ensure that annual training in accordance with section 221(2)1 of the Regulations was provided to staff who provide direct care to residents with respect to the area of mental health issues including dementia in accordance with section 76(7)2 and that this training included techniques and approaches related to responsive behaviours.[s. 221(3)]
Information provided by the home with respect to the education provided to staff indicated that the last training provided to staff for the management of behaviours was on March 31, 2010.
The Nursing supervisor and a PSW confirmed that they recall having training and they believed it was last year some time but were unable to recall when this training occurred.

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 with section 221(2)1 and section 221 (3) of the Regulations., to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training

Specifically failed to comply with the following subsections:

s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

Findings/Faits saillants :

1. The licensee did not ensure that staff who work pursuant to a contract between the licensee and an employment agency in accordance with section 2(1)(c) of the Act were provided information on the Resident's Bill of Rights, policy to promote zero tolerance of abuse and neglect, duty to make mandatory reports, whistleblowing protection, fire prevention and safety, emergency and evacuation procedures and infection control before providing their services in accordance with section 79(2) of the Act.[s.222(2)]
A review of the homes staffing schedules and billing invoices from a staffing agency use by the home confirms that between August 3, 2011 and August 13, 2011 the home used 20 agency Registered Nurses(RN) as the in-charge person on evenings and night shifts and between August 17, 2011 and August 26, 2011 the home used 22 agency Registered Nurses on the evening and night shifts as the in-charge person in the home. The homes staffing schedules confirmed that one RN is scheduled to work in the home as the in-charge person on the evening and night shift.
- The Administrator was unable to provide verification that agency staff working in the home were provided with the above noted information.
- An agency RN working the day shift on October 3, 2011
confirmed that she did not receive information related to the Resident's Bill of Rights, policy to promote zero tolerance for abuse, duty to make mandatory reports, whistle-blowing protection, fire prevention and safety, emergency evacuation procedures and infection prevention and control prior to providing service in the home.
- A complaint received at the time of this inspection from a resident indicated that the home is always short staffed and the home lays staff off and brings in agency staff who do not know what they are doing.

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 staff who work pursuant to a contract between the licensee and an employment agency in accordance with section 2(1)(c)of the Act are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8, and 9 of the Act before providing their services, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary in relation to the following: [s. 15(2)(a)]
a) It was noted during a tour of the kitchen on September 13, 2011 that the floors in the kitchen area had a build up of dirt and grime in the seams of tiles as well as a substantial amount of dirt build up in the corners and under pieces of equipment.
b) Surfaces on the large white table beside the oven that is being used as a desk in the production area are heavily soiled with dirt, including the lower shelves and wheels.
c) Two fans in the kitchen were heavily soiled with dirt.
d) The stove was soiled with grease, dirt and dust. The oven exterior surfaces held a build up of dirt.
e) The carts in the kitchen that hold the clean dishes were noted to have unclean surfaces.
f) The maintenance manager indicated that the floors in the common areas, such as the tub areas are to be cleaned by housekeeping every day. It was noted that the same debris and dirty floors were present in the tub area on F and G area for four days (from August 30, 31, September 1 and 2, 2011).
g) A review of the medication rooms on A,B,C,D wings took place on September 7, 2011. It was noted that the floor was heavily soiled and did not appear to have been cleaned for some time. There was waste debris on the floor as well as boxes and other items littering the floor so that it was difficult to even see the floor. The surfaces of shelves in the medication room and the treatment administration carts were sticky and unclean. The top of the medication fridge was sticky and dirty.
h) A review of the medication room for the F and G wings also revealed that the floor did not appear to have been cleaned for several days. There was debris on the floor and it was soiled. The garbage can was full and the sink did not appear to have been cleaned for some time.

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 home, furnishings and equipment are kept clean and sanitary,, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The Licensee did not develop and implement a quality improvement and utilization review system in the home. [s. 84] The homes administrator confirmed that the home does not have a formalized quality improvement and utilization review system implemented that analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents. The Administrator confirmed that members of the management team complete audits, however they do not collaborate to analyze or evaluate the results of those audits.

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 home shall develop and implement a quality improvement and utilization review system that monitors analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to the residents of the long-term care home,, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following subsections:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks;
(b) the distribution and service of resident meals;
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that there were sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for, the preparation of resident meals and snacks, the distribution and services of resident meals and the daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation with respect to the following: [s. 77(1)]
The dietary staffing hours indicated on the homes dietary staffing schedule from September 15-September 21, 2011 was 331.50 hours for the week however, based on the census provided by the home of 112 residents the home was required to have 352.80 hours of scheduled dietary staff. On September 16 and September 20, 2011 the dietary staff did not have sufficient staffing hours for the preparation of resident meals and snack distribution and services of resident meals. The cook simultaneously worked the cook and food service worker position. Homemade soup was not prepared and canned soup was served in it's place related to insufficient time to prepare the soup. It was confirmed that the cleaning of the kitchen was not being completed due to insufficient staffing.

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 there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection(2)., to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The Licensee has not ensured that drugs stored in an area or a medication cart is secured and locked. [s.129(1)(a)(ii)] On September 16, 2011 at 1217hrs the medication cart was sitting outside the main dining room unlocked, for a few minutes, with no registered staff present. The inspector waited for the registered staff to return from inside the dining room. The registered staff person immediately locked the medication cart and confirmed that the expectation was that the medication cart be locked when unattended.

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 drugs are stored in an area or a medication cart that is secure and locked., to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure the resident-staff communication and response system can be easily seen, accessed and used by the resident, staff and visitors at all times in relation to the following: [s.17(1)(a)]
a) An identified resident was sleeping in bed September 22, 2011 0630hr and her call bell was not accessible. The call bell was on the floor laying beside her night stand. The PSW had to move the night stand away from the wall in order to pull the cord out far enough to reach the resident in bed. The PSW confirmed that the resident required the call bell to communicate to staff otherwise she would begin to call out. On September 21, 2011 0955hr this resident was sitting in her wheel chair at the end of bed however, her call bell was not within reach. The resident stated that if she required assistance she would have to call out verbally for staff.
b)An identified resident was sleeping in bed September 22, 2011 0630hr and her call bell was not accessible. The call bell was on top of the resident's night stand wrapped around her radio. The PSW had to unwind the call bell for it to reach the resident in bed. The resident was trying to get out of bed when the inspector brought the PSW into the room. The PSW confirmed that the resident activates the call bell to communicate with staff.

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 home is equipped with a resident-staff communication system that can be easily seen, accessed and used by residents, staff and visitors at all times,, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee did not ensure that care set out in the 24 hour admission care plan sets out clear direction to staff with respect to: [O. Reg. s.24(3)(b)]
a) An identified resident admitted to the home did not have a 24 hour care plan developed that set out clear direction to staff and others who provided direct care to the resident. The care plan did not include the resident's specialized feed order and directions for safe positioning while being fed. A PSW and a registered staff member confirmed that the resident had not been safely positioned by staff while receiving feeding and indicated that there was no direction provided for staff in relation to positioning the resident during feedings. Signage above the resident's bed that provided direction to staff did not appear until after the inspector spoke with staff.
b) An identified resident admitted to the home did not have a 24 hour care plan developed that set out clear direction to staff and others who provide direct care to the resident. The resident's diet order was for puree texture however, there was no order for thickened fluids (as of September 20, 2011). The residents care plan indicated puree texture, thickened fluids and the diet serving list indicated honey thickened fluids. The resident received nectar thickened fluids during the breakfast meal September 9, 2011.

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 care set out in the 24 hour admission care plan sets out clear direction to staff,, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee did not ensure that every resident receives end of life care when required in a manner that meets their needs with respect to the following:[O. Reg. s. 42]
An identified resident's physician documented an order on June 28, 2011 for the resident to receive palliative care.
- The resident was sleeping in her bed during the breakfast meal September 9, 2011 however, staff did not offer the resident a breakfast meal. Registered staff interviewed confirmed that the resident was not offered a breakfast meal September 9, 2011 and if the resident is sleeping they do not wake her for a meal and there is no formalized provisions in place to offer food replacements when she awakes. Personal Support staff interviewed September 19, 2011 indicated they wake the resident up for meals to ensure she is offered meals. The resident's plan of care did not include provisions for staff in relation to end of life care and offering meals/meal replacements in a manner that meets the resident's needs.
- The Registered Dietitian ordered a nutritional supplement September 8, 2011 for 125ml fruit beverage supplement 6 times per day (to receive at meals and snacks) however, the dietary lists for meals was not updated until September 14, 2011 to reflect the intervention and the resident was not offered the supplement. The revised snack lists was not implemented until September 16, 2011 and staff confirmed the resident had not had the fruit beverage supplement offered prior to this date.
- The resident's oral intake is poor and has fluid consumption of 175ml-575ml per day from September 10 to September 15, 2011. On September 19, 2011 1030hrs the resident had a can of chocolate ensure on her beside table from a.m. nourishment pass instead of the ordered fruit beverage supplement. The resident had consumed less than 25% of the chocolate ensure and staff did not take any action to increase her fluid consumption by providing the ordered supplement.

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 every resident receives end of life care when required in a manner that meets their needs,, to be implemented voluntarily.

WN #27: 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 subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :