Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2014	2014_188168_0015	H000738-14	Resident Quality Inspection

Licensee/Titulaire de permis

LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION
44 HUGHSON STREET SOUTH, HAMILTON, ON, L8N-2A7

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

QUEEN'S GARDEN
80 Queen Street North, HAMILTON, ON, L8R-3P6

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

LISA VINK (168), ASHA SEHGAL (159), CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582), LEAH CURLE (585), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 16, 17, 18, 19, 20, 23, 24, 25, and 26, 2014.

This Inspection Report includes findings of non compliance which were identified during inspections which were conducted during this Resident Quality Inspection (RQI), concurrent Complaint Inspections include: H-000393-14, H-000406-14, and H-000586-14, and concurrent Critical Incident Inspection H-000946-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (ADOC), corporate Nursing Consultant, Business Office Manager, Food Services Supervisor (FSS), Environmental Supervisor (ES), Resident Support Services, Resident Assessment Instrument (RAI) Coordinator, Social Worker (SW), Registered Dietitian (RD), registered nursing staff, Personal Care Providers (PCP's), unregulated staff, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to: relevant policies and procedures, meeting minutes and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The home was not a safe and secure environment for its residents.

On June 16 and 25, 2014, a stove in the basement activity kitchen, was found unsecured and fully functional with the turn of a knob. A sign was posted on the kitchen door directing it to be kept locked. The Administrator confirmed residents had access to the area and that the door was to be locked. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The written plan of care did not set out the planned care for the resident.

A. The plan of care for resident #21 did not include their planned care related to bowel functioning. The plan included statements related to level of assistance to toilet, supplies required, and bladder functioning, however did not include bowel functioning, which was confirmed during an interview with the registered staff. (168)
B. Two interventions were observed and confirmed with staff and resident #21 as current. The equipment was implemented over a year ago, following incidents involving co-residents, where the resident identified safety concerns. A review of the plan of care did not include the use of these interventions as part of the planned care for the resident, which was confirmed during an interview with the registered staff. (168)
C. On May 6, 2014, the heat risk assessment for resident #12, indicated moderate risk for hot weather ill effects. Review of the plan of care did not include resident specific interventions to minimize the risk for hot weather related illness. Interview with the ADOC confirmed that the planned care related to heat risk was not included in the plan of care. (528)
D. On May 2, 2014, the heat risk assessment for resident #21 indicated high risk for hot weather ill effects. Review of the plan of care did not include resident specific interventions to minimize the risk for hot weather related illness. Interview with the ADOC confirmed that the planned care related to heat risk was not included in the plan of care. (528) [s. 6. (1) (a)]

2. Staff and others involved in different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Resident #21 had a Minimum Data Set (MDS) assessment completed October 11, 2013. This assessment identified under mood persistence that the resident had no mood indicators in the last seven days and identified the behavioural symptom of resistance to care occurring four to six times in the last seven days, not easily altered. A second assessment of January 10, 2014, noted under mood persistence that indicators were present and easily altered, however identified no change in mood when compared to the status on the last assessment and that the resident did not exhibit behavioural symptoms in the last seven days, however did not note the improved change in symptoms. Interview with the back up RAI Coordinator confirmed that the assessments were not consistent and did not complement each other. (168)

B. Resident #60's family stated that during the last week of April and into May 2014, the resident had complaints of pain. Daily PCP Flow Sheets for April and May 2014, indicated that the resident's skin was intact and clear of redness. On May 5, 2014, the family informed the registered staff and physician that the resident had been calling out in pain due to a skin irritation. The registered staff and physician assessed the area and confirmed the altered area of skin integrity. (526) [s. 6. (4) (a)]

3. The care set out in the plan of care was not provided to the resident as specified in the plan.

A. Resident #26 had a plan of care for one bed rail in the raised position when in bed. Registered staff reported the resident was found on a specified date in 2014, sleeping in bed without the rail up. At this time half of the resident's body was on the bed and the other half between the bed and the wall. The mattress shifted partially off the bed away from the wall. On June 18, 2014, the resident was observed sleeping in bed, without a raised bed rail. A sign was on the wall and the kardex instructed the rail to be raised when the resident was in bed, which was confirmed in a staff interview. Staff did not provide care as per the plan related to the use of the rail. (585)
B. Resident #15 had a physician's order on March 17, 2014, for a daily pain diary and reassess pain in one week. A review of the clinical record did not include a pain diary. Progress notes reviewed for seven days beginning March 17, 2014, included one entry of the resident's evaluation of pain. Interview with the full time registered staff, who processed the order could not recall the implementation of a pain diary and confirmed that it was not completed. (168) [s. 6. (7)]

4. The licensee failed to ensure care set out in the plan of care was provided to the resident as specified in the plan.

Resident #26 had a plan of care to have a one bed rail up when in bed. An RPN reported that they found resident #26 on a specified day in 2014, sleeping in bed without their rail up. Half of the resident's body was on their bed and the other half was between their bed and the wall. The resident's mattress was found shifted partially off the bed away from the wall. On June 18, 2014, the resident was observed sleeping in bed, with no bed rail raised. A sign was on the wall in the resident's room and the care kardex instructed the bed rail to be raised when resident was in bed. PSW reported the plan of care was for the bed rail to be up when the resident was in bed, and verified instructions in the resident's room and kardex. RPN confirmed the resident had a plan of care to have one bed rail up when in bed. The resident's care set out in

resident #26's plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

5. The plan of care was not reviewed and revised when the care was not effective.

The plan of care for resident #13 identified a goal for attendance at recreation programs at one to five times a month. A review of Activity Pro Attendance Monitoring Monthly Report identified participation was one program during the month of May 2014. The MDS assessment protocol did not include an evaluation of the recreation interventions in relation to the goals identified on the plan of care. An evaluation of the program attendance and resident engagement in relation to the goal did not occur. Staff interview confirmed the resident was not meeting the goal and that the plan of care was not revised. (159) [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care sets out the planned care for the resident, that staff and others involved in different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to ensure that care is provided as set out in the plan of care, and to ensure that the plan of care is reviewed and revised when it is not effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was not complied with.

1. The home had a policy "Pain, LTCE-CNS-E-4, with an effective date of May 2012", which indicated that "each time a PRN pain medication is given staff are to complete the Pain Flow Sheet prior to the administration of PRN pain medication and then again 30 minutes to 1 hour after medication administration. For cognitively well residents the numeric scale is to be used; for cognitively impaired residents the faces scale is to be used."
i. A review of the clinical record for resident #22 did not include the completion of a Pain Flow Sheet when as needed analgesic medication was administered on over 35 occasions for the months of May and June 2014, which was confirmed during staff interview. (168)
ii. A review of the clinical record for resident #15 did not include the completion of a Pain Flow Sheet when as needed analgesic medication was administered on May 20, 2014, or June 21, 2014. Staff identified in the progress notes the effectiveness of the medication, however did not utilize a Pain Flow Sheet. (168)
B. The home had a "Chartwell Assessment Guide, last revised May 2013", which indicated that if a resident used bed rails, the use of the devices were to be assessed, using the Bed Rail Assessment, with any significant change in status. Interview with the ADOC and Nurse Consultant confirmed that significant change, was as described in MDS.
i. Resident #21 used two bed rails in the raised position on request. The use of the bed rails were last assessed on June 12, 2013, according to the clinical record and staff interview. The resident had a significant change in status on July 12, 2013, and October 11, 2013, according to MDS assessment and did not have a Bed Rail Assessment completed as per policy. (168)
ii. Resident #26 used one bed rail as per their plan of care. The resident had triggered changes in condition November 29, 2013, February 28, 2014, and May 30, 2014. Record review identified that the most recent bed rail assessment was conducted June 13, 2013, which was confirmed during an interview with registered staff. (585)
3. The home had a "Chartwell Assessment Guide, revised May 2013", which noted that a resident was to have a quarterly Pain Assessment completed if they scored "greater than zero" in MDS Section J - Health Conditions, code items "J2a and/or J2b".
i. Resident #15 had MDS assessments completed December 6, 2013, March 7, 2014, and June 6, 2014, which indicated scores greater than zero in section J for items "J2a

and J2b". The last Pain Assessment was completed June 12, 2013, as confirmed in the clinical record and staff interview. (168)
4. The home's "Food and Fluid Intake Policy, LTC-CNS-B-14 dated May 2012", identified "If the resident consistently (3 days or more) has a reduced fluid intake (1000 ml or below) Registered staff are to refer the resident to the Registered Dietitian following the home established process of completing a Dietary Referral Note in the progress note section in PCC unless: (a) The RD has seen the resident for the same reason in the last 30 days and had revised the care plan with appropriate interventions if needed, or (b) The RD has stated that fluid intake 1000 ml or less is resident appropriate".
i. The food and fluid intake record for June 1, to June 20, 2014, identified that resident #13 consumed less than their established fluid target of 1500 ml/day, with an average fluid intake of 850 ml/day. A referral to the RD was not initiated when there was a significant change in the resident's health status, and fluid intake was less than 850 ml/day for several consecutive days, for example: June 2, 2014, intake was 750 mls; June 3, 2014, intake was 750 mls; June 4, 2014, intake was 875 mls; and June 5, 2014, intake was 750 mls. On June 24, 2014, the RD confirmed that a referral did not occur for the resident's fluid intake and that they did not meet their hydration requirement on nine of sixteen days during June 2014. A progress note dated June 3, 2014, identified the family had concerns regarding the resident not drinking well. (159) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is not complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. Not all doors leading to non-residential areas were kept closed and locked when not supervised by staff.

Washrooms identified for staff use, located off main hallways used by staff, residents and visitors on the first, second, and third floors, were considered non-residential areas, as they did not contain a communication and response system.
A. On June 16, and June 20, 2014, two staff washrooms, in non-residential areas were unlocked and unsupervised on the second floor in Westdale and Dundurn areas. Three staff interviewed on the second floor reported that they did not have keys for the staff washrooms and the door was often unlocked.
B. On June 20, 2014, a staff washroom was unlocked and unsupervised on third floor in Mountain Brow. A registered staff present reported they did not have a key to lock the door, but that it should be locked when not in use.
The Administrator confirmed the home's expectation to keep staff washroom doors locked at all times when not in use. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are kept closed and locked when not supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Not all areas of the home, furnishings and equipment were kept clean and sanitary.

A. On June 16, 17, 18, and 19, 2014, the carpet in the hallways on all home areas were noted to be heavily soiled and stained. The carpet in hallway in Jamesville home area, outside of the jacuzzi room was noted very dirty and stained. The ES confirmed that the carpets were soiled and in need of a cleaning.
B. On June 18, 19, and 20, 2014, six resident's rooms were noted to have dirty floors soiled with food and dust particles, used tissues, dirty dishes, and dried liquids. Bedroom floors in six identified rooms, were not cleaned daily as per the procedure in the home, areas under the beds in the identified rooms were left with debris. Flooring surfaces were noted to be stained, sticky and soiled.
C. Wooden shelves in resident #22's room were noted to be dusty. The resident reported staff did not always dust the furniture and the shelves.
D. Wall surfaces in hallways and resident's rooms throughout the home were noted to be stained and soiled with food spills.
E. The ES confirmed that the identified areas were part of the daily cleaning schedule. [s. 15. (2)]

2. Not all furnishings and equipment were maintained in a safe condition and in a good state of repair.

A. The bathroom call bell in resident #25's room was not in a good state of repair when observed on June 17, 18, and 20, 2014. The call bell cord was noted to be short, white and approximately three inches long. The cord did not include a red plastic extender which would promote ease of use. Interview with the registered nursing staff, on June 20, 2014, confirmed that the call bell was not in a good state of repair and that the red extender should be in place. (168)

B. On June 25, 2014, the bathroom fans in three resident rooms, were not in a good state of repair. The fans did not have sufficient air flow to hold a piece of one ply tissue over the grille when turned on. Interview with the ES confirmed that the fans were not working, required replacement, that the motors were ordered however not in the home for use at this time. (528)
C. On June 23, 2014, the exhaust fan was not working in resident #25's bathroom. The ES confirmed the offensive urine odours present in the bathroom. It was confirmed that there was no routine monitoring of the system to determine adequate function and that cleaning was completed according to need and not identified in any existing procedure. (159)
D. A significant number of resident rooms, on the first and third floors, had walls which were damaged with chipped and/or peeling paint. Doors and metal door frames, on the first and third floors, were noted to be heavily scratched and peeled. Paint finishes on doors throughout the home were observed to be worn, leaving metal exposed with rough and uneven surfaces, especially on the bottom portion of the door frames. (159)
E. On the first floor, in the common areas areas, the following was observed:
i. Outside the servery area, a sink basin had rust around the edges and the wall above the hand washing sink was damaged and scratched.
ii. Ceiling tiles in the jacuzzi room were damaged.
iii. The light bulb in shower room was missing in the Durand home area.
iv. Holes were in walls in the Durand dining room.
v. Wall surfaces in the shower room were damaged with paint chipped. (159)
F. On the second floor the following was observed:
i. Walls and ceiling tiles in the mud room were damaged.
ii. Ceiling tiles in activity/lounge room, across from the nurses station, were damaged and stained.
iii. The laminate on the counter top at the nurses station was chipped and damaged exposing a rough absorbent inner layer.
G. Interview and tour with the ES confirmed the areas of disrepair and included plans to address the concerns. (159) [s. 15. (2) (c)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee did not immediately forward any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

Family of resident #60 made a verbal complaint to the Administrator. After a meeting with the Administrator, the family complained to the Administrator in an email. The family confirmed that the email submitted was a written letter of complaint. The home's policy "Complaints, RCA-LTCE-E-09" indicated that if it was unclear whether an email was a complaint, the receiver or Administrator should clarify with the author of the email about whether the email was a complaint. The Administrator verified that they did not clarify with the family if the email correspondence was a complaint, and that it was not forwarded to the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee immediately forward any written complaints concerning the care of a resident or the operation of the home to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. 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 O. Reg. 79/10, s. 26 (4).
(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 plan of care was not based on, at a minimum, an interdisciplinary assessment of sleep patterns and preferences.

Resident #25 was observed on June 20, 2014, to be up and fully dressed with morning care completed at 0530 hours, and sitting in a recliner chair beside their bed. The PCP indicated that the resident liked to wake early. The plan of care did not include the preference for an early wake time or if waking times were discussed. Registered staff interviewed confirmed the sleep preferences for waking times were not assessed or documented in the plan of care. [s. 26. (3) 21.]

2. The Registered Dietitian who was a member of the staff of the home did not assessed the resident's hydration status and any risk related to hydration.

Food and fluid intake monitoring indicated that resident #13's fluid intake was less than their target fluid requirements. According to the plan of care, the fluid requirement was 1500 ml/day. The intake records for June 1 to 20, 2014, were reviewed and identified fluid intake was less than 800 mls most days. The resident did not meet the fluid requirement of 1500 ml on any day recorded from June 1 to the 20, 2014. Progress notes dated June 16, 2014, indicated the RD completed a dietary review in response to a referral received for a symptom. The RD did not assess the resident's hydration status. The resident was identified to be at risk of dehydration. On June 24, 2014, the RD confirmed the resident did not have an interdisciplinary hydration assessment, and interventions and strategies had not been initiated to address hydration concerns. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Registered Dietitian, who is a member of the staff of the home, assess the resident's hydration status and any risk related to hydration, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The resident did not receive fingernail care, including cutting of fingernails.

A. On June 16, 19, and 20, 2014, resident #14 was noted to have long fingernails, at least half a centimeter in length. The plan of care identified fingernail care needs by the registered staff or foot care nurse. PCP's confirmed that they were not trimming the resident's fingernails. The Daily Flow Sheet indicated that the resident's nails had not been cared for during the month of June 2014. Registered staff confirmed that they had not been trimming the fingernails as per the plan of care. (526)
B. Residents #10, #17 and #18 were observed to have long, soiled fingernails on June 16, 18, and 19, 2014. The PCP providing care to the residents stated that the fingernails were supposed to be trimmed and cleaned on bath days. The plans of care also directed the staff to provide fingernail care on bath days. On June 19, 2014, the bathing flow sheets were reviewed for the month of May and June 2014, blank entries indicated the residents did not receive care on scheduled bath days. Staff interviewed confirmed that the nails were not cut and cleaned during the identified time period, despite soiling. (159) [s. 35. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents receive fingernail care, including cutting of fingernails, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. Not every resident of the home received assistance, if required, to use personal aids.

Resident #60 required the use of an aid. The family would remove the aid periodically from the home for repair. Recent assessment indicated that the resident had some memory problems and was moderately impaired in terms of cognitive skills for daily decision making. The plan of care directed staff to care for the aids including removing it nightly and returning every morning. On a specified date in 2014, registered staff gave the resident the aid. At bedtime, the resident was visiting with family when staff went to remove the aid, when staff returned at 2230 hours to retrieve the aid, as per the plan of care, it was not with the resident, who asked the staff if the aid had been returned to the home by their family. The staff searched for the aid, could not locate it, and requested day shift contact the family regarding. Staff did not contact the family until two days later and the aid was not found. The home did not assist the resident to use the device, as they did not ensure that it was secured, according to plan of care. [s. 37. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure each resident of the home receives assistance, if required, to use personal aids, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. When a resident had fallen, they were not assessed, using a clinically appropriate assessment instrument, that was specifically designed for falls, when the condition or circumstances of the resident required it.

The home's policy "Falls, LTCE-CNS-G-10, last revised January 2013", identified the following assessments, including clinically appropriate, were to be completed as part of the post fall assessment: the Morse Fall Risk Assessment, Risk Management, Progress Notes and Post Falls Analysis.
i. Resident #16 was not assessed using a clinically appropriate instrument that was specifically designed for falls, in 2013 and 2014. In 2013, the resident had an unwitnessed fall. In 2014, the resident was found on the floor. A post falls assessment, using a clinically appropriate assessment instrument, specifically designed for falls was not located in the health record and registered staff confirmed that the assessments should have been completed and in the health record. (526)
ii. Resident #60, who was at a high risk for falls, sustained a fall in 2014. No Post Falls Analysis was found in the resident's health records and registered staff confirmed that the analysis had not been completed. (526)
iii. Resident #60 sustained a fall around a specified date in 2014, according to the progress notes. Progress notes for the day of the incident and the following day confirmed the resident was monitored and assessed. No formalized falls assessments were noted during this time period. Registered staff confirmed that the notes indicated a fall had occurred but did not include details of the fall, the use of a clinically appropriate assessment or a post falls analysis. (526)
iv. Resident #23 sustained a fall in 2013. The Post Fall Analysis completed the same day identified the resident at high risk prior to the fall. The resident did not have a Morse Fall Risk Assessment completed post fall. Interview with the registered staff confirmed that the last Morse Assessment was completed March 14, 2013. (168)
v. Resident #19 sustained an unwitnessed fall in 2013. The post-fall documentation in the resident's record included an Occurrence Note, Incident Report and Head Injury Routine, however the Morse Falls Risk Assessment tool was not completed. An interview with registered staff confirmed that according to the policy the Morse tool was to be administered after the fall and was not completed. (582) [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, they are assessed and where the condition or circumstances of the resident requires, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Between June 16, and June 25, 2014 resident #16 was observed to have a skin tear and a lesion. Registered staff indicated that the resident had been referred to a specialist for assessment of the skin condition. The staff confirmed that the resident had not received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. When a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

i. Resident #16's progress notes indicated a skin tear to an extremity on May 15, 2014, and a skin and wound assessment dated May 19, 2014, indicated that the wound had a "moderate amount of fresh blood observed on site". Registered staff confirmed that no further weekly skin assessments were completed regarding this area between May 19, and June 25, 2014.
ii. Resident #16's progress notes indicated that on May 28, 2014, staff observed a skin tear to the upper torso that was bleeding and a dressing was applied. Registered staff confirmed that weekly skin assessments were not completed for this area between May 28, 2014, and June 25, 2014. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 and that when a resident exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. When the resident's pain was not relieved by initial interventions, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Interview with resident #22 and a review of the clinical record identified ongoing issues with pain. The Medication Administration Records (MAR) were reviewed for May and June 2014. These records indicated the administration of as needed analgesic on over 20 occasions in May 2014, which were not effective on five occasions, and the administration of as needed medication on over 15 occasions to date in June 2014, which were not effective on six occasions. The resident was not reassessed using a clinically appropriate assessment instrument, which was specifically designed for this purpose when the initial interventions were not effective, on 11 occasions, which was confirmed during an interview with the registered staff. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure 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 #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The actions taken to meet the needs of the resident with responsive behaviours did not consistently include assessments, reassessments, interventions, and documentation of the resident's responses to the interventions.

Interview with the ADOC and Nurse Consultant on June 26, 2014, confirmed the expectation that if a resident experienced an aggressive episode, the priority for staff was to manage the situation and ensure resident safety and security. Following incidents, staff were to complete a Responsive Behaviour Debrief and a Risk Management Report as part of the assessment and reassessment process, in an effort to determine possible causes, follow up actions, any changes to the plan of care and for further analysis. Resident #46 was known to staff and residents to demonstrate responsive behaviours. The clinical record for a six month period of time, included more than 10 episodes of aggressive behaviour, directed towards staff and/or residents. During this period, only one Responsive Behaviour Debrief was completed and four Risk Management Reports for the incidents identified. The record also identified two incidents, involving a co-resident. A review of the co-residents record did not include the incident, interventions or the residents response, which was confirmed by registered staff. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the actions taken to meet the needs of the resident with responsive behaviours includes assessments, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for, (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 O. Reg. 79/10, s. 72 (3).

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, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The food production system did not include the preparation of all menu items according to the planned menu.

A. On June 23, 2014, the planned menu for lunch included three-bean salad. The recipe called for frozen and waxed beans, canned kidney beans, and frozen green peppers. During meal service on first and third floors, the prepared salad contained red peppers, chickpeas and garbanzo beans. The cook stated they prepared a five bean salad.
B. On June 23, 2014, the planned menu for lunch included baked chicken on a wheat ciabatta bun. The recipe called for raw, boneless, skinless chicken and seasonings. During meal production, the cook prepared chicken patties. The cook confirmed they did not follow the recipe as the chicken was already seasoned. [s. 72. (2) (d)]

2. Not all menu substitutions were documented on the production sheets.

A. On June 23, 2014, for the lunch meal, three bean salad was on the menu and listed on the production sheet. Prior to meal service, the salad was observed and contained different beans and ingredients than on the listed recipe. The cook

confirmed they used a different frozen product that contained five beans. On June 24, 2014, the FSS provided the production sheet for the lunch meal and it contained no documentation for menu substitution. [s. 72. (2) (g)]

3. Not all foods were prepared and served using methods to preserve taste, appearance, and food quality.

A. Some residents reported that the food served appeared cheaper than previously served, was presented poorly, and lacked flavour.
B. On June 16, 2014, fresh blueberries were posted on the lunch menu. The blueberries appeared to be sitting in liquid when served. The FSS confirmed frozen berries were served. Resident's Council Meeting Minutes from June 16, 2014, identified that residents found the blueberries to be watery.
C. On June 23, 2014, grilled chicken on a ciabatta bun was on the planned menu. The recipe called for three ounces (90 gram) pieces of boneless, skinless raw chicken breasts and additional seasonings. During lunch meal production, on June 16, 2014, a cook was observed preparing frozen meat products. The cook stated they were chicken breasts, came fully cooked and seasoned, only required reheating and did not require additional seasonings. The box for the chicken was labelled "Chicken Patties", appeared to be pre-formed, and had grill marks on them. The product label stated the patties were each 65 grams in weight, contained ground chicken meat, chicken skin, and hydrolyzed soy and corn proteins. The product included different seasonings than the recipe. A cooked chicken pattie was inspected and had a piece of chicken byproduct inside. The FSS confirmed the product was not a natural chicken breast. The recipe for the chicken sandwich included a garnish of three tomatoes. During meal service, sandwiches were prepared on first and third floor with one tomato slice per sandwich. The cook confirmed the recipe called for three tomatoes per sandwich. [s. 72. (3) (a)]

4. Not all foods in the food production system were prepared, stored, and served using methods to prevent contamination and food borne illness.

A. On June 23, 2014, during lunch meal preparation, a dietary staff was observed to lick their finger tips to flip pages in the recipe book and then return to food production without completing hand hygiene. Interview with FSS confirmed the expectation for hand hygiene during food production was for staff to wash their hands after coming into contact with their mouth.
B. On June 23, 2014, during lunch meal, a dietary aide was observed assembling

chicken sandwiches. The aide was cutting a chicken sandwich with a knife then placed the same knife in a margarine container and took margarine to prepare another sandwich. The employee continued this practice for the remainder of the meal service. The aide confirmed they used the same knife to cut the sandwich and spread margarine and the expectation was to use a different knife. The employee confirmed that the margarine was used for multiple meal services. The FSS confirmed appropriate food handling practice was for the dietary staff to use a separate knife. [s. 72. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all foods in the food production system are prepared, stored, and served using methods to prevent contamination and food borne illness, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Foods were not served at temperatures that were both safe and palatable for the residents.

The Temperature Record Log indicated that cold foods were to be kept below 4.0 degrees Celcius and hot foods above 60.0 degrees Celcius. This standard was confirmed by the FSS.
On June 23, 2014, during lunch meal, the following menu items did not meet the home's temperature expectations.
i. Regular chicken breast was 50.8 degrees Celcius and minced was 42.5 degrees Celcius.
ii. Regular carrots were 46.3 degrees Celcius, minced 50.9 degrees Celcius, and pureed 48.4 degrees Celcius.
iii. Regular bean salad was 12.0 degrees Celcius, minced 16.4 degrees Celcius, and pureed 16.7 degrees Celcius. The minced and pureed bean salad were sitting on the counter outside of the ice bath.
iv. The temperatures recorded on the log for the first choice puree entree, a chicken sandwich, was recorded as 42 degrees Fahrenheit, which is 5.5 degrees Celcius. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that foods are served at temperatures that are both safe and palatable for the residents, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The advice of the Residents' Council was not sought in the development and carrying out the satisfaction survey nor in acting on its results.

A review of the 2013 and 2014 Residents' Council Meeting Minutes and interviews with the President of the Council and the Assistant identified that the Council had not participated in the development and carrying out the satisfaction survey. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the advice of the Residents' Council is sought in the development and carrying out the satisfaction survey and in acting on its results, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Procedures were not developed and implemented for addressing incidents of lingering offensive odours.

A. On June 20, 2014, at approximately 0525 hours, offensive urine odours were emanating from resident #25's room. The PCP suggested that the odour could be coming from the soiled laundry in a hamper in resident's bathroom. Lingering odours were present during each day of the inspection outside of the resident's room and bathroom. Interview with staff confirmed awareness of the offensive odours, and its presence for an extended period of time.
B. On June 19, 2014, lingering offensive odours were detected in a specified room and common shower room.
C. Telephone interview with the Administrator confirmed that the home did not have a policy or procedure for the management of odours. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that a documented record was kept in the home that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution; every date on which any response was provided to the complainant and a description of the response; and any response made by the complainant.

A. On April 29, 2014, the family of resident #60 was informed of a misplaced item and consequently the family logged a complaint to the Administrator. The complaint log was reviewed and did not include an entry for the complaint. The Administrator confirmed that the complaint was not documented using the home's Investigation Report Form, that contained information including the date the complaint was received, steps taken to investigate, action taken, final resolution, and other significant information.
B. Resident #60's family reported they complained to the Administrator during the week of June 10, 2014. On June 18, 2014, the Administrator confirmed the complaint and a that he had not documented the conversation in the home's Complaint Log, in the Investigation Form, nor provided a response to the family at the time of the interview.
C. Resident #21 reported that on June 16, 2014, some product was taken from their room. They also reported that this was the third occasion within the past two months that the product had gone missing. The resident notified the Administrator and had not heard back nor had the items been located as of June 23, 2014. Review of the Complaint Log, did not include an entry for the verbal complaint, nor of previous complaints of the lost product. The Administrator confirmed that he had not documented the complaint in the home's Complaint Log or in the Investigation Form. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes: the nature of each verbal or written complaint; the date the complaint is received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution; every date on which any response is provided to the complainant and a description of the response; and any response made by the complainant, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Not every was afforded privacy in treatment and in caring for his or her personal needs.

On June 20, 2014, at approximately 1130 hours, the SW was observed having a conversation with resident #64 in the hallway adjacent to a recreation room, on the second floor. The resident and SW were overheard discussing personal financial information for approximately 10 minutes. The SW confirmed that the conversation should have been conducted in private, to respect the resident's right to privacy. [s. 3. (1) 8.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The resident did not received oral care to maintain the integrity of the oral tissue, including mouth care in the morning, evening and/or cleaning of dentures.

On June 19, 20, and 23, 2014, resident #14 was noted to have halitosis. The plan of care indicated to provide assistance with personal hygiene including oral care, directing staff to cue the resident and to stay to ensure that personal hygiene tasks had been completed. According to the Flow Sheets, the resident did not receive oral care during the identified time period, nor was there a refusal of the care recorded. PCP's identified that the resident would at times refuse oral care and that care was not consistently completed twice a day as required. [s. 34. (1) (a)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the license was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system. This required each resident's care and services needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the Assessment Reference Date (ARD) of the previous assessment, and any significant change in resident's condition, be reassessed along with Resident Assessment Protocol (RAPs) by the team using the MDS Full Assessment by the 14th day following the determination that a significant change had occurred.
For all other assessments:
a) The care plan must be reviewed by the team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of the VB2.
b) RAPs must be generated and reviewed and RAP assessment summaries must be completed for triggered RAPs and non-triggered clinical conditions within seven days maximum of the ARD.

Resident #22 had a MDS assessment completed with an ARD of March 21, 2014. The information recorded in "Section J" of the assessment indicated that the resident experienced moderate pain, less than daily. A Pain Assessment tool was completed, as per the home's policy, on March 28, 2014. The resident did not have a "non-triggered clinical problem" assessment summary completed, for pain, for the March 21, 2014 assessment. Interview with the Resident Assessment Instrument (RAI) Coordinators and a charge nurse confirmed that the "non-triggered clinical problem" assessment, or RAP should have been completed as the resident was coded as experiencing pain. The last "non-triggered clinical problem" assessment completed related to pain was dated December 23, 2013. [s. 101. (4)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
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. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Not all staff were screened for tuberculosis (TB) in accordance with evidence-based practices and if there were none, in accordance with prevailing practices.

Four staff health records were reviewed, and identified that an employee with a start date in 2012 was last screened for TB in September 2010, and a second staff with a start date in 2012 was last screened for TB in September 2010. The Business Office Manager confirmed that the two staff were not adequately screened for TB. [s. 229. (10) 4.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The written record for the resident was not maintained at all times.

Resident #22 had a diagnosis of arthritis and used as need medication for pain management. Behaviour Supports Ontario (BSO) assessed the resident in 2014, and requested a pain scale completed twice a day for five days. A review of the clinical record, did not include a pain assessment record during the identified time period, however progress notes indicated that the pain level was assessed on three occasions. Interview with full time registered staff confirmed that a hard copy assessment was completed and should be included in the clinical record. The staff were unable to locate the document despite a search of records and other areas of the unit when requested. [s. 231. (b)]

Issued on this 11th day of July, 2014

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