Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 28, 2015	2015_377502_0012	T-1704-15	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - ROCKCLIFFE
3015 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 2V7

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

JULIENNE NGONLOGA (502), JULIET MANDERSON-GRAY (607), SOFIA DASILVA (567)

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 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, and 18, 2015.

During the course of the inspection, the inspector(s) spoke with the Administator, director of care (DOC), assistant director of care (ADOC), resident assessment instrument (RAI)- Coordinator, nurse manager (NM), registered nursing staff, personal support workers (PSWs), director of dietary services, registered dietitian (RD), dietary aides, cooks, director of resident programs, recreation activation aide, physiotherapist (PT), resident care relation coordinator, environmental service manager (ESM), housekeeping staff, residents, substitute decision makers (SDMs) and family members of residents.

The inspectors also conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following intakes were conducted concurrently with the Resident Quality Inspection: T-1039-14, T-1915-15, and T-2007-15.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
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

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

- **19 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Record review of the written plan of care revealed that an identified resident's advanced directive was a specified level. A review of the advanced directive signed by the resident upon return from hospital indicated that the resident was a specified level.

Interview with an identified staff confirmed that the resident's advanced directive was a specified level. Interview with the DOC confirmed that the resident’s written plan of care did not provide clear directions to staff. [s. 6. (1) (c)]

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

On two occasions during an identified meal service the inspector observed identified residents were being offered an honey thickened fluid consistency.

Record review of the above mentioned residents' diet order revealed that some identified residents required pudding fluid consistency, and other identified residents required nectar thickened fluid consistency.

Interview with identified staff members confirmed that all residents requiring fluid modified consistency are served only honey thickened fluid. Interview with the Director of Dietary Services confirmed that the residents should be served fluid consistency according to each resident's diet order. [s. 6. (7)]

3. Record review of the home's investigation document indicated that on a specific date, staff inappropriately transferred an identified resident using two person transfer rather than a ceiling lift, as specified in the plan of care.

Interview with an identified staff, who performed the inappropriate transfer revealed that the resident’s SDM had called staff to immediately transfer the resident back to bed after meal service. The identified staff confirmed that he/she and his/her co-worker performed a two person transfer, because they believed that the request was urgent and the resident was at risk. The identified staff further stated that he/she knew they should use the ceiling lift, but did not do so, as the situation was believed to be urgent.

Interview with an identified staff and the administrator confirmed that the resident was not transferred using the correct transfer technique, as identified in the resident’s plan of care. Following the home’s investigation of the incident, the two staff involved were disciplined. [s. 6. (7)]

4. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary. .

A review of the minimum data set (MDS) annual assessment conducted on a specific date, revealed an identified resident was coded as having a specified condition.

Record review of the resident assessment protocol (RAP) notes on a specific date, revealed an identified resident specified medical condition will be addressed in the care plan. Record review of the written plan of care revealed that the above identified interventions were not included in the plan.

Interview with an identified resident revealed that he/she had the above identified

medical condition. Interview with identified staff confirmed that the resident's plan of care did not include interventions for the above mentioned medical condition. Interview with the DOC confirmed the interventions for the medical condition should be care planned for the resident. [s. 6. (10) (b)]

5. Record review of the current written plan of care revealed that the resident was incontinent, used incontinent products, and required two staff for extensive assistance with toileting.

Interview with an identified resident indicated and interviews with identified staff members confirmed that the resident needed two staff extensive assistance during the day for toileting, but he/she required one staff assistance to change his/her incontinence product during the night.

Review of the current written plan of care revealed and the ADOC confirmed that the resident's written plan of care had not been revised to include the change in continence care. [s. 6. (10) (b)]

6. Record review of the current written plan of care revealed that the resident was incontinent, used incontinent products on a daily basis, and required two staff for extensive assistance with toileting.

Interview with an identified resident and identified staff confirmed that the resident was continent during the day, and required one staff assistance during the night to change his/her incontinent product.

Review of the current written plan of care revealed and interview with the ADOC confirmed that the plan of care had not been revised to reflect the resident's current need related to incontinence. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
- the care set out in the plan of care is provided to the resident as specified in the plan, and
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

On a specific date, at 3:45 p.m., the inspector observed a window in a specified room opened more than 30 centimetres (cm) wide there was no resident present in the room at the time. This was confirmed with inspector #502 who notified the administrator.

Interview with the ESM confirmed that the window was opened greater than 15 cm wide. On the next day at 8:30 a.m., the inspector observed that a chain stoppers was installed and the window opened to a maximum of 15 cm wide. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 cm, to be implemented voluntarily.

WN #3: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On a specific date, during an identified meal service the inspector observed identified residents being served their entrée, while they were still eating their soup.

Interview with the director of dietary services who was present in the dining room confirmed the above mentioned residents were not served course by course. [s. 73. (1) 8.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum appropriate furnishings, including appropriate seating for staff who are assisting residents to eat.

On specific dates during identified meal services the inspector observed that staff were standing while assisting residents to eat.

Interviews with identified staff members confirmed that there was not enough appropriate seating in the dining room during meal services. Staff have to stand to assist the residents, or wait for another staff to finish assisting in order to start assisting the next resident. Interview with the DOC indicated that staff should inform the management if the feeding stools are not enough during meal service to assist residents. [s. 73. (1) 11.]

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
- meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs, and
-there are appropriate furnishings in resident dining areas, including appropriate seating for staff that are assisting residents to eat, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the an identified resident's written plan of care revealed that the resident had an specified medical condition.

Review of the progress notes revealed that the identified medical condition resulted in the resident exhibiting an identified responsive behaviour. On a specific date staff documented on the progress notes that the resident stated "he/she exhibit the above identified medical condition because the medication administered at the home were not effective", "he/she exhibit another responsive behaviour during the night because he/she was not able to sleep".

Review of the medication administration record (MAR) revealed that the resident had a drug regimen that included specific medication given three times daily as needed.

Record review of the daily observation sheet (DOS) revealed that the resident exhibited a specified responsive behaviour frequently at night on specific dates. Review of the medication administration record (MAR) from specified date indicated the resident did not receive his/her medication as needed for his/her medical condition

Interview with the DOC confirmed that the prescribed medication was not administered to the resident as needed. [s. 131. (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 drugs are administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the program

On a specific date, the inspector observed an identified staff scratching his/her head and body and continued to serve food without performing hand hygiene.

Interview with identified staff confirmed that he/she did not wash his/her hands after scratching and indicated that he/she should wash his/her hands after touching the menu book and scratching his/her face. [s. 229. (4)]

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

Record review of the resident’s written plan of care revealed that identified resident experienced and was treated for respiratory infection between specified dates.

Record review of the home’s surveillance documentation revealed that resident’s symptoms of infection were not included in the home’s surveillance list.

Interview with an identified staff confirmed that the symptoms indicating the presence of infection were not recorded on the home’s surveillance list during the above-mentioned period.

Interview with the DOC confirmed that the identified resident symptoms should have been monitored and recorded on the sheets mentioned above by staff on every shift. [s. 229. (5) (b)]

3. The licensee has failed to ensure that there was a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

Record review of the Public Health Ontario’s "Best Practices for Hand Hygiene in all Health Care Settings", revised April 2014, recommends that alcohol-based hand rub dispensers (ABHR) dispensers be located at point-of-care.

On specific dates the inspector observed there were no ABHR dispensers or sinks available in the following shared resident rooms: G-11, 329, 331, 332 315, 316, 304, 301 and 302.

Interviews with identified staff revealed that residents and staff leave the washroom to perform hand hygiene. Staff stated that after assisting residents with toileting and care, they must exit the washroom to use the sink located in the resident room.

Interview with the DOC confirmed that above mentioned washrooms did not have point of care products accessible to staff and residents and they will have to install these. [s. 229. (9)]

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
- staff participate in the implementation of the infection prevention and control program, and
- staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity is fully respected and promoted.

Interview with an identified resident revealed that staff do not treat him/her well. Interview with the administrator revealed that an incident involving the above identified resident

was brought forward and it was investigated.

Record review of the home's investigation notes with a specific date, revealed at approximately 4:45 p.m., the resident's family member had complained about an identified staff being rude and rough to his/her family member. The unidentified PSW reported the concern to the administrator who contacted and placed the above identified staff on leave with pay. The home's investigation notes also revealed that the identified resident requested to use the toilet but was forced to use a urinal by the identified staff.

Interview with the identified staff confirmed that he/she spoke with the resident roughly, that he/she forced him/er to use the urinal and he/she did not respect the resident's wishes.

Interview with the administrator confirmed that identified staff did not respect the resident wishes. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the rights of residents to be told who is responsible for and who is providing the resident's direct care is fully respected and promoted.

On multiple occasions on a specific date, between 7:00 a.m., to 1:44 p.m., the inspector observed identified staff not wearing their name tags.

Interview with both identified staff revealed they took their name tags off to provide care to residents and put their name tags on immediately. Interview with the DOC confirmed that the expectation was that all staff should be wearing a name tag at all times. [s. 3. (1) 7.]

3. The licensee has failed to ensure that the rights of residents to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act is fully respected and promoted.

On a specific date at 1:15p.m., the inspector observed the electronic medication administration record (e-MAR) screen on top of the medication cart displaying an identified resident's personal health information with no staff present in the area.

Interview with an identified staff confirmed that the screen should have been locked prior

to leaving the area. [s. 3. (1) 11. iv.]

4. On a specific date, at 9:45 a.m., the inspector observed the point of care (POC) screen unlocked on the main floor with an identified resident's personal information visible on the screen.

Interview with an identified staff confirmed that the POC screened was unlocked and locked the screen. Interview with the DOC confirmed that the POC screen should be locked when staff are not using it, as this was a breach of confidentiality. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy put in place was complied with.

Record review of the home's a specified policy revised July 2010 revealed the following:
- If a resident has been colonized for more than one month, follow-up screening should be done more frequently than every three months.
- Additional precautions may be discontinued when a minimum of three sets of negative specimens taken at least one week apart are achieved, and in consultation with the home's Infection Control Designate. If additional precautions have been discontinued, monthly screening for six months is recommended since re-colonization can occur.

Record review of the home's clinical records with a specific date revealed an identified resident tested positive for MRSA. Record record review of the resident's laboratory results dated on a specific date, revealed that MRSA was isolated to an identified area. No additional testing for MRSA was conducted between a specified period of time.

A review of the home's clinical record dated on specific date for an identified resident revealed that he/she was positive for MRSA. A review of the lab results for the identified resident revealed that he/she was not screened for MRSA again until an identified date, which was longer than 3 months as per the home's policy.

Interview with an identified staff revealed that identified residents were not screened for MRSA until the above mentioned dates.

Interview with the DOC confirmed that residents who are positive for MRSA are to be screened every three months until they have reached three consecutive negative results, and that the home did not meet the screening guidelines for MRSA in relation to the above identified residents. [s. 8. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

On a specific date at 15:32 p.m. the inspector observed a part of an identified resident's privacy curtain missing and the other part of the privacy curtain was not equipped with velcro strips.

Interview with an identified staff confirmed that one part of the identified resident’s privacy curtain was missing as well as the velcro strips. Interview with the ESM confirmed all residents should have sufficient privacy curtains to provide privacy. [s. 13.]

WN #9: 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:
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. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any potential behavioural triggers and variations in resident functioning at different times of the day.

Record review of the MDS assessment dated on a specific date, revealed that an identified resident exhibited a medical condition. Review of an identified assessment completed on a specific date, revealed that the resident exhibited responsive behaviours. The resident exhibits his/her behaviour at meal time.

Interview with an identified staff indicated that when the resident was seated in the wheelchair for extended periods, he/she exhibit a medical condition. Interview with identified staff indicated that when staff attempt to get the resident out of the bed, he/she exhibit the above mentioned condition.

Record review of the current written plan of care and interview with the DOC confirmed that the above mentioned triggers were not care planned. [s. 26. (3) 5.]

2. Record review of the MDS assessment completed on a specific date and an identified assessment tool with a specific date revealed an identified resident was exhibiting an identified condition. Record review of the progress notes revealed on a specific date the identified resident started a fire in his/her room and on another specific date staff found a pack of cigarettes and a lighter in the resident’s room.

Interview with the DOC revealed that the resident’s family member informed the home that the identified resident had an identified addiction and certain triggers cause the resident to exhibit the above mentioned behaviours.

Record review of the current written plan of care and interview with the DOC confirmed the above mentioned triggers were not care planned. [s. 26. (3) 5.]

3. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Continence, including bladder and bowel elimination.

Record review of the progress notes, revealed that on specific date and identified resident had an identified treatment. Review of the physician’s orders with a specific date directed nursing staff to monitor the above identified treatment every two weeks and to ensure the specified treatment was in place at all times. On specific date nursing staff

documented in the progress notes their observation related to the above identified treatment.

Interview with an identified staff confirmed that the resident had the identified devise. Interviews with identified staff confirmed that interventions related to the identified devise were not care planned. The inspector confirmed the interventions were immediately added. [s. 26. (3) 8.]

4. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: health conditions including allergies, pain, risk of falls and other special needs.

Record review of the resident MDS assessment with a specific date, revealed that an identified resident had an identified treatment. Review of the progress notes revealed on specific dates an identified staff documented that the resident's identified treatment was leaking and he/she complained of pain. Record review of the resident's written care plan with a specific date, revealed that interventions related to identified treatment care were not care planned. On a specific date the resident was admitted to the hospital with an identified medical condition, and returned to the home without the above identified treatment.

Interview with identified staff and the ADOC confirmed that the resident had the identified treatment prior to being transferred to the hospital on a specific date and interventions related to the identified treatment care were not care planned. [s. 26. (3) 10.]

5. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: sleep patterns and preferences.

Record review of the progress notes and interview with an identified resident's substitute decision maker (SDM) revealed that the SDM requested that after an identified meal, the resident be placed by the nursing station, and then at the next repositioning time be transferred back to bed for a rest.

Interviews with identified staff and the ADOC confirmed they had knowledge of the SDM's preference. Furthermore, the direct care staff confirmed that the resident was placed by or near the nursing station after the identified meal, with the exception of when he/she was agitated or restless. A review of the identified resident's plan of care did not

reflect the SDM's preference related to his/her sleep patterns.

Interview with an identified staff and the DOC confirmed that the SDM's wish was not reflected in the resident's written care of plan. The identified staff indicated that the care plan would be updated to reflect this preference. [s. 26. (3) 21.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

Record review of the home’s census records revealed that an identified resident was admitted to the home on a specific date and there was no documentation to indicate that a care conference took place.

Interview with the resident’s SDM revealed that he/she was not invited to participate in the annual care conference and that an annual care conference did not take place in an identified year.

Interviews with an identified staff, the resident relations coordinator and the DOC confirmed that an annual care conference for the identified resident did not take place during the above identified year. [s. 27. (1)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the use of the PASD has been approved by (i) a physician, (ii) a registered nurse, (iii) a registered practical nurse, (iv) a member of the College of Occupational Therapists of Ontario, (v) a member of the College of Physiotherapists of Ontario, or (vi) any other person provided for in the regulations.

Record review of MDS assessment with a specific date revealed and interview with RAI-coordinator, and identified staff confirmed an identified resident used two full bed rails when he/she was in bed; the use of the bed rails was considered a personal assistive services device (PASD) and was used for safety. Record review of the written plan of care revealed the PASD was used without approval from a specific period of time.

Interview with an identified staff indicated that the resident's SDM had verbally consented to the use of the PASD and confirmed that approval was not obtained prior from any person provided for in the regulation. [s. 33. (4) 3.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

On specific dates and times the inspector observed an identified resident's finger nails to be long and unkept.

Record review of the identified resident's flow sheet revealed staff signed for providing care to the resident during his/her shower on a specific date.

Interview with an identified staff revealed that he/she was aware of the resident's finger nails being long and needed cutting. The identified staff confirmed he/she gave the resident a shower on a specific date and was responsible for cutting his/her finger nails, but did not cut them, because he/she was unable to locate a nail clipper at the time.

Interview with identified registered staff confirmed that the identified resident's finger nails needed cutting. Interview with the DOC confirmed that PSWs are to be providing nail care on residents' shower days. [s. 35. (2)]

2. On specific dates the inspector observed an identified resident with long finger and toe nails.

Record review of the resident's written plan of care revealed the resident's shower days are on identified days of the week.

Interview with the identified resident revealed that his/her finger nails had not been cut in the past two weeks though he/she preferred to have them cut short and filed. The resident also indicated that he/she refused to have the toe nails cut by a foot care nurse as a result of a past experience.

Interview with an identified registered staff indicated that nail care was provided on shower days. Interview an identified staff indicated that the resident's nails are long and he/she did not cut them while giving a bath, he/she only cut the resident's finger nails upon resident requested.

Interview with the DOC confirmed identified resident should have his/her nails cut on the shower days. [s. 35. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident have their personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required.

On two occasions on a specific date the inspector observed an identified resident’s wheelchair to be soiled with food debris.

Record review of the wheelchair cleaning records revealed on a specific date an identified resident’s wheelchair was scheduled to be cleaned and was not signed for as being cleaned.

Interview with an identified staff revealed that the night shift staff cleaned wheelchairs at least once per week, but when a staff noted a soiled wheelchair he/she should clean the wheelchair. Interview with another identified staff and registered staff confirmed that the resident's wheelchair was soiled with food debris and needed cleaning.

Interview with the DOC confirmed that the wheelchairs are cleaned by PSWs as per the cleaning schedule and registered staff are accountable for the cleanness of the wheelchairs. [s. 37. (1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting 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.

On a specific date the inspector observed an altered skin integrity to an identified resident’s body part.

Record review of the resident's written plan of care revealed that no documentation was available to indicate that a skin assessment was completed for the alteration in skin integrity.

Interview with the resident revealed he/she was aware of the alteration in skin integrity and indicated he/she did not know how long he/she had it.

Interviews with an identified staff and identified registered staff revealed that they were not aware of the alteration in skin integrity of the identified resident’s body part.

Interview with the ADOC and DOC confirmed that the PSWs are to conducted skin assessments on resident bath days. [s. 50. (2) (b) (i)]

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

Record review of the resident's written plan care revealed that an identified resident was admitted to hospital during a specific period of time. A skin assessment was conducted upon returning from hospital and no indication of an altered skin integrity was identified in the assessment. A review of the progress notes with a specific date revealed that the identified resident had an identified altered skin integrity to the identified body parts.

Interview with an identified registered staff revealed that the identified resident obtained the identified altered skin integrity in the hospital and that there were no weekly skin assessments completed until a specific date.

Interview with DOC confirmed the identified altered skin integrity were not captured in the skin assessment completed when the resident returned from the hospital on a specific date. [s. 50. (2) (b) (iv)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

On a specific date the inspector noted an identified resident smelled of urine. Interview with the identified resident revealed he/she was changed in the morning, and was usually wet before lunch. The resident also indicated that if he/she did not call for assistance he/she will not get changed.

Record review of the current written plan of care indicated that the identified resident was incontinent, used incontinent products, and required one staff for extensive assistance with toileting.

Interview with an identified staff indicated that he/she told the identified resident to call if he/she was wet, or had a bowel movement (BM); the identified staff indicated that the resident had a rash on his/her identified body parts.

Interview with the ADOC indicated that residents who are incontinent are assessed by the nurse and the Physiotherapist (PT). If they are assessed as being able, they are added to the toileting program, and a toilet routine is developed for them. Staff will then toilet residents according to the schedule, with the exception of those residents who are bedfast.

Interview with the DOC indicated that the identified resident was bedfast, staff assist him/her when he/she was ready to be changed, and confirmed that the resident did not have an individualized plan of care to promote and manage his/her continence. [s. 51. (2) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 58. Every licensee of a long-term care home shall ensure that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion. O. Reg. 79/10, s. 58.

Findings/Faits saillants :

1. The licensee has failed to ensure that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion.

Record review of the home's investigation revealed on a specific date, staff inappropriately transferred an identified resident using two person transfer rather than a ceiling lift, as specified in the plan of care.

Interview with an identified staff, who performed the transfer revealed that the resident's SDM had called staff to immediately transfer the resident back to bed after an identified meal. The identified staff confirmed he/she and his/her partner performed a two person transfer, because they believed that the request was urgent and the resident was at risk. The identified staff further stated that they knew that the ceiling lift should be used, but did not due to their belief that the situation was urgent.

Interview with the identified staff and the administrator confirmed that the transfer was not performed using the correct transfer technique, as identified in the resident's plan of care. The two staff involved were disciplined as a result. [s. 58.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal.

On two occasions, the inspector observed the following were not available or offered to the residents during the lunch service:
-on June 3, 2015, watermelon, coleslaw, regular and pureed vegetable soup, and corn
-on June 17, 2015, pureed salad sandwich, pureed cauliflower, roast red pepper soup, and pureed

Record review of the spring/summer menu, week 2 and 3 as well as the production sheets revealed that the above identified menu items were planned for lunch but were not produced.

Interview with an identified staff confirmed that the above mentioned items were not prepared and interview with another identified staff confirmed that those items were not available during meal service. [s. 71. (4)]

WN #18: 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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system must, at a minimum, provide for documentation on the production sheet of any menu substitutions.

Review of the spring/summer menu cycle and observation on June 3, 2015, revealed the following:
-that watermelon was substituted with tropical fruits
-coleslaw was substituted with oriental vegetables
-vegetable soup was substituted with broth

In addition, on June 17, 2015,
-pureed chicken salad sandwich was substituted with cooked pureed chicken, hot gravy and hot pureed bread
-pureed cauliflower was substituted with carrot
-roasted red pepper soup was substituted with broth

Record review revealed and interview with an identified staff and the director of dietary services confirmed that the above identified substitutions were not documented on production sheets. [s. 72. (2) (g)]

2. The licensee has failed to ensure that all foods prepared using methods which preserve taste, nutritive value, appearance and food quality.

Record review of the standardized recipes book revealed that the recipe for the Cheese and Fruit Plate directs staff that to use the following ingredients to prepare the cheese and fruit plate: lettuce leaf, #16 scoop cottage cheese, 30 grams (g) cheddar cheese, 30g Swiss cheese, 60 ml pears, and 60 ml peaches. The recipe for Muffin Corn Frozen Batter directs staff to thaw frozen batter in the refrigerator below four degree Celsius for 12 hours; then place #10 scoop prepared batter in muffin pans, and follow manufacturer's instructions for baking.

Observations during the lunch service on June 3, 2015, revealed and interview with an identified staff #102 confirmed Swiss cheese was missing on the cheese fruit plate. Interview with an identified cook confirmed that the standardized recipe was not followed to prepare the Muffin Corn Frozen Batter. [s. 72. (3) (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 129 (1).
(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. Every licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart that is secure and locked.

The inspector observed on the second floor the medication carts were unlocked and unsupervised on the following occasions:
-On June 11, 2015 at 12:13 p.m.,
-On June 16, 2015 at 11:03 a.m.

On each occasion, an identified registered staff confirmed the carts should be locked when not attended and immediately proceeded to lock the cart. [s. 129. (1) (a)]

Issued on this 22nd day of September, 2015

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

Original report signed by the inspector.