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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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, 2016;	2016_302600_0006 (A1)	010388-16	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

Rockcliffe Care Community
3015 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 2V7

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

GORDANA KRSTEVSKA (600) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

Extension to the compliance date upon request by licensee and revision to the ground of the order related to the compliance history.

Issued on this 7 day of November 2016 (A1)

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

Original report signed by the inspector.

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GORDANA KRSTEVSKA (600) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): April 14, 15, 18, 19, 20, 21, 22, 25, 27, 28, 29, May 2, 3, 4, 5, 6, 9, 10, 2016.

The following complaint intakes were inspected concurrently with the resident quality inspection: #030979-15 related to skin and wound, dining and snack service, continence care, Resident’s Rights, #013716-15 related to recreation and social activity and food quality, #003745-15 related to falls prevention, #000846-15 related to housekeeping concerns, and #009723-14 related to falls prevention, pain and reporting.

The following critical incident reports intakes were concurrently inspected with the resident quality inspection: #031304-15 and #013355-15 were related to responsive behaviour, # 026545-15 related to abuse and reporting, #024813-15 related to transferring and positioning technique and reporting, #021260-15 related to abuse, #000604-14 related to abuse and responsive behaviour, #009723-14 related to fall prevention, pain and reporting, and #008036-14 related to responsive behaviour and safe and secure home.

During the course of the inspection, the inspector(s) spoke with executive director (ED), director of care (DOC), assistant director(s) of care (ADOCs), director of nutrition and food services (DNFS), registered dietitian (RD), director of environmental services (DES), director of resident programs (DRP), physiotherapist (PT), physiotherapy assistant (PA), physiotherapy student, pharmacy consultant (PC), activation aide (AA), registered practical nurse (RPN),

registered nurse (RN), personal support worker(s) (PSWs), minimum data set-resident assessment instrument (MDS-RAI) co-ordinator, dietary aides (DA), cooks, housekeeping aide (HA), Family Council president, residents, Residents' Council president, and substitute decision makers (SDM's).

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents’ Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Snack Observation

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

15 WN(s)
6 VPC(s)
1 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 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:
7. Sufficient time for every resident to eat at his or her own pace. 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. 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 :

(A1)
1. The licensee has failed to ensure that sufficient time was provided for residents to eat at their own pace.

On an identified date, during lunch service the inspector observed resident #038 in the dining room. The resident was being fed by PSW #118. The PSW was standing approximately a head and half above the resident's eye level. PSW #118 was giving the resident a spoonful of his/her meal one after another at a fast pace. The PSW completed feeding the resident within 10 minutes and then moved the resident to the activity room.

Interview with PSW #118 revealed he/she had fed resident #038 in a fast pace. He/she indicated the room was crowded and needed space.

Interview with RPN #122 confirmed resident #038 had not eaten at his/her own

pace. [s. 73. (1) 7.]

2. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

1) On an identified date the Ministry of Health and Long-Term Care (MOHLTC) Action Line received a complaint. The complainant voiced concerns related to dietary services at the home.

On multiple occasions the inspector observed resident #001 in an unsafe feeding position while being fed in the ground floor dining room. Resident #001 was observed in a reclined wheelchair, lying in a resting position. Resident #001's face was directed towards the ceiling with open eyes. Resident #001 was heard experiencing an ongoing wet cough while being fed.

- On an identified date at 1425 hours, during the afternoon snack service PSW #130 was observed standing over resident #001 while spoon feeding him/her milk. When the inspector entered the dining room PSW #130 stopped feeding the resident. PSW #130 then used a napkin to clean food debris from resident #001's mouth. Interview with PSW #130 revealed that placing resident #001 in upright position would have put him/her at risk for injury.

Director of Nutrition and Food Services (DNFS) #157 had been notified by the inspector to assess resident #001's position for feeding. The DNFS stated that resident #001 was reclined close to a 45 degree angle and it was not a safe position for feeding. DNFS #157 left the dining room without repositioning the resident.

- On an identified date during the lunch service, resident #001 was spoon fed by PSW #146. The inspector approached PSW #146 and inquired about the proper feeding position for resident #001.The PSW was not able to identify the safe position for feeding and continued to feed resident #001.

The inspector brought the concern to RPN #122's attention. RPN #122 revealed resident #001 always demonstrated identified behaviour. Despite RPN #122 acknowledging that resident #001's feeding position was not safe the resident was not repositioned. RD #127 was notified by the inspector to assess resident #001's position for feeding. The RD revealed that resident #001 was at high risk of

choking as he/she was on a modified texture diet. RD #127 confirmed resident #001 was seated at a 60 degree angle and that this was an unsafe feeding position. RD #127 revealed that resident #001 should be seated upright; close to a 90 degree angle however he/she did not adjust the resident's feeding position.

- On an identified date, at 1220 hours, resident #001 was spoon fed by PSW #146. RPN #122 was notified by the inspector to assess resident #001's position for feeding. He/she stated resident #001 was seated close to a 70 degree angle and stated the resident's feeding position was fine.

Record review of resident #001's most recent written plan of care revealed no directions to staff to ensure the resident was seated at a safe feeding position during meals.

2) On an identified date during breakfast service, the inspector observed resident #034 in the dining room. The resident was observed at a 60 degree angle, while being fed by RPN #160. The inspector approached RPN #160 and inquired about the proper feeding position for resident #034. The RPN #160 stated resident #034 was not properly positioned for feeding. RPN #160 also indicated the resident was demonstrating an identified behaviour, and then proceeded to reposition the resident.

Review of the home policy titled, "Pleasurable Dining" revised a specific date, and the home's education package, "Swallowing Disorders, Aspiration & Choking", used during a mandatory staff in-service on an identified date outlined the home's expectation on the correct position of residents and staff during meals. The information included the following: resident must be well positioned, upright at 90 degrees with head and body at midline. Chin should be slightly downward to protect the airway. The staff must sit to feed residents and be at eye level, and they must feed parallel to the mouth.

Interview with PSWs# 130, #146, RPNs #122 and #160 revealed they had not received training on safe feeding techniques since 2011.

Interview with ADOC #128 indicated the described feeding position was not safe for feeding. He/she confirmed the home's expectation was to have all residents, without exception, seated upright as close to a 90 degree angle as possible prior to being assisted with feeding.

Interview with ED #105 confirmed the above described feeding position was not safe for feeding. He/she revealed it was a multidisciplinary responsibility to ensure all residents who required assistance are positioned safely for feeding.

On an identified date the inspector observed resident #001 during lunch service. The resident was observed in an upright position; the inspector did not hear any wet coughing from the resident.

The severity of this finding was potential harm related to a resident at high risk of choking being fed in an unsafe feeding position. The scope of this finding was isolated. [r. 73. (1) 10.]

3. The licensee has failed to ensure that there were appropriate furnishings and equipment in resident dining areas, including appropriate seating for staff that are assisting residents to eat.

On an identified date during lunch service the inspector observed resident #038 in the dining room being fed by PSW #118 standing approximately a head and half above the resident's eye level.

Interview with PSW #118 revealed that he/she should be seated at eye level when feeding resident.
Interview with RPN #122 confirmed PSW #118 standing position was not proper for feeding a resident.

Both staff members revealed that there were not enough feeding stools available in the dining room.

Interview with ED #105 confirmed there has been a shortage of feeding stools and indicated additional stools have been ordered. [s. 73. (1) 11.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 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 licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

On an identified date the inspector observed resident #051 in his/her room

demonstrating a responsive behaviour.

Interview with RN #103 revealed that resident #051 had a history of responsive behaviour and the resident's need for the provision of an identified type of personal care had been identified as a trigger.

Review of resident #051's most recent written plan of care revealed he/she needed one staff extensive assistance to provide this personal care. However the written plan of care failed to reveal when and how often the resident was to be assisted.

Interview with PSW #148 indicated that he/she had not assisted the resident during the shift at almost 1100 o'clock when he/she spoke with the inspector. The PSW indicated he/she was not sure when to assist to resident #051. The PSW revealed he/she was not sure what the written plan of care guidelines were and what they required them to do because it was not specific about when to assist to the resident. PSW #118 also revealed that he/she assisted resident #051 whenever he/she had available time.

Interview with the RN #103 indicated he/she updated resident #051's written plan of care however he/she confirmed the directions given to the PSWs regarding when to assist with the provision of care was not clear. Also he/she confirmed there were no specific instructions to guide the PSWs that the timely provision of this personal care for resident #051 was part of the intervention to prevent or minimize resident #051's responsive behaviour.

Interview with the BSO Lead confirmed that the direction given to the staff who provide care for the resident #051 who demonstrated responsive behaviour were not clear. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On an identified date, at 0930 hours and at 1110 hours the inspector observed resident #031 was in a non residential area. He/she was walking unsupervised and unaccompanied.

Interview with resident #031 revealed he/she enjoyed walking in the identified area multiple times daily to keep him/herself active.

Interview with PT #140 confirmed that resident #035 was not part of the physiotherapy (PT) program and had not been assessed to use the area unsupervised.

Interview with ADOC #128, and ED #105 revealed prior to using the area independently, residents are required to be part of the PT program or assessed by PT to walk unsupervised. The ADOC #128 and ED #105 further revealed being aware of resident #035 using the area unsupervised, and confirmed that the needs and preferences of resident #035 were not included in the written plan of care. [s. 6. (2)]

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

On an identified date the Ministry of Health and Long-Term care Action Line received a complaint with concerns related to a health care professional in the home.

Review of resident #030's written plan of care with specified date revealed on two identified dates the physician assessed resident #030 and had ordered diagnostic procedure two incidents which had occurred 11 and 15 days prior.
Review of the diagnostic report was suggestive of an identified injury.

On another identified date, a review of resident #030's progress notes revealed RN #165 received a phone call from the diagnostic service provider related to the resident #030's result. Further review of the progress notes revealed the physician was not informed of the result until his/her next visit, which was two days after RN #165 had been notified of the results.

Interview with RPN #160 and RN #165 revealed they had been aware of the resident #030's result. Both confirmed they had not informed the resident's primary physician or the physician on call.

Interview with ADOC #128 revealed it is the home's expectation that registered staff are to contact the physician with any changes in a resident's condition and to follow physician orders. ADOC #128 confirmed RPN # 160 and RN #165 had not

collaborated with the physician. [s. 6. (4) (a)]

4. 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 identified dates in April, 2016, at lunch and breakfast service respectively on one of the floors the inspector observed resident #017 eating independently. The resident needed assistance for the meal. Staff members were assisting other residents in the dining room and not available to assist resident #017. Resident #035 who was seated with resident #017 assisted the resident.

Review of resident #017's written plan of care revealed the resident required extensive assistance.

Interview with RPN #145 revealed after a hospital stay in 2015, resident #017 revealed a change in his/her health condition and asked to be assisted with meals.

Interviews with RD #127 and RPN #145 confirmed resident #017 had change in health a condition and required total assistance.

Interview with RN #133 confirmed that the resident was not assisted during meal services as specified in the written plan of care. [s. 6. (7)]

5. On an identified date, at 1230 hours the inspector observed resident #037 in an identified dining room drinking water of a modified consistency.

Review of resident #037's most recent written plan of care revealed the resident was to be provided a modified textured diet and modified texture fluid consistency. Interviews with DNFS #157, RN #103, and RD #127, confirmed resident #037 had not been served the appropriate fluid consistency as specified in the written plan of care. [s. 6. (7)]

6. On an identified date during lunch service, the inspector observed resident #036 in an identified dining room being fed by a family member fluids of a modified consistency not consistent with the fluid consistency identified in the written plan of care. .

Interviews with DNFS #157, RN #103, and RD #127, confirmed resident #036 had not been served the appropriate fluid consistency as specified in the written plan of

care. [s. 6. (7)]

7. The licensee had failed to ensure that the resident was 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 .

Record review of critical incident system report (CIS) submitted on an identified date revealed that resident #021 sustained an injury to his/her body part after having been provided care by personal support worker (PSW).

Record review of the most recent written plan of care and kardex and a review of the MDS-RAI quarterly assessment from an identified date revealed resident #021 required two person extensive assistance with two identified activities of daily living.

On an identified date the inspector observed PSW # 146 providing limited assistance to resident #021.

Interview with PSW #146 and #151 revealed that resident #021 required one person limited assistance for over a year.

Interview with the physiotherapist (PT) #140 revealed that resident #021 had been assessed with one staff assistance prior to being discharged from the physiotherapy program on an identified date.

Interviews with registered staff #150 and #122 revealed that resident #021 required one staff assistance for two identified activities of daily living.

Interview with ED #105 and ADOC #128 confirmed that resident #021's written plan of care had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

8. On a specified date the MOHLTC Action Line received a complaint related to a health care professional in the home.

Review of the complaint report revealed that resident #030 was transferred to the hospital on an identified date. Resident #030 informed hospital staff that he/she had an incident on an identified date and had been complaining of discomfort since

the incident. The resident also informed hospital staff he/she had been sent out for two diagnostic procedures, on two identified dates but had not seen a home's physician until the day after the second procedure, when he/she was sent to the hospital, which was three weeks after the initial incident even though he/she was in discomfort.

Review of resident #030's written plan of care from an identified date revealed on two identified dates the physician assessed resident #030 and ordered diagnostic procedure following two incidents which had occurred previously. Further review of the progress notes revealed resident #030 had ongoing discomfort on his/her identified body part and had been ordered a diagnostic procedure following the second incident. The resident was given pain medication as needed on three identified dates.

Review of the diagnostic report from an identified date, was suggestive of an injury of the identified body part.

Review of resident #030's assessment record revealed pain assessment had not been completed for three consecutive weeks.

Interview with RPN #160, RN #165 and ADOC #128 confirmed resident #030 had not been assessed for pain during the above identified period and the plan of care had not been revised to reflect resident #030's change in condition. [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 the plan of care set out clear directions to staff and others who provide direct care to the resident
to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident
to ensure staff and others involved in the 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 the care set out in the plan of care was provided to the resident as specified in the plan
to ensure that the resident was reassessed and the plan of care reviewed and revised 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 #3: The Licensee has failed to comply with LTCHA, 2007, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was provided with fluids that are safe.

On an identified date, at 1230 hours the inspector observed resident #034 in an identified dining room. The resident was being fed milk of one fluid consistency and water of another fluid consistency by Activation Aid (AA) #156.

Review of the resident #034's most recent written plan of care revealed the resident had an identified diet with identified modified fluid consistency.

Interview with AA #156 revealed he/she was not aware of the difference between the types of fluid consistencies. The AA indicated that he/she fed the resident whatever was provided by the nursing staff.

Interview with FSM #157, RN# 103 and RD #127 present in the dining room confirmed that serving resident #034 inconsistent modified fluids consistencies put the resident at risk of choking and was not safe. [s. 11. (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 the resident was provided with fluids that are safe, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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. The licensee has failed to ensure that the home, its furnishings and equipment were maintained in a safe condition and in a good state of repair.

On two identified dates the inspector observed the walk-in refrigerator panel rusted and the paint on the inside door was scratched exposing the metal.

Interview with ESM # 125 revealed he/she had been aware of the rust and confirmed the panels inside the walk in refrigerator were rusted. He/she indicated that the age of the refrigerator and the humidity had resulted in mold and rust developing and had informed the head office two months ago.

Interview with ED #105 confirmed the above observations and revealed that the walk in refrigerator had been scheduled for repair eight days from now. [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 the home, its furnishings and equipment was maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care was based on an interdisciplinary assessment of special treatments and interventions.

On an identified date the Ministry of Health and Long-Term care Action Line received a complaint. The complainant voiced concerns related to a health care professional in the home.

Review of resident #030’s written plan of care completed on an identified date revealed on an identified date the physician assessed resident #030 and ordered a diagnostic procedure following an incident on a specified date. On another identified date resident #030 had another incident. Further review of the progress notes revealed resident #030 had ongoing discomfort on an identified body part after the first incident on the identified date. Resident #030 had received pain medication on three identified dates as needed.

On an identified date, the physician ordered a second diagnostic procedure for resident #030's identified body part and for the PT to apply a therapeutic device.

Review of resident #030’s written plan of care from an identified date, and MDS-RAI quarterly review assessment, revealed the therapeutic device had not been implemented as per physician order.

Interview with PT #140 confirmed he/she had not implement the physician order to place a therapeutic device on resident #030’s body part.

Interview with the ADOC #128 confirmed PT #140 should have implemented the physician's order. [s. 26. (3) 18.]

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 is based on an interdisciplinary assessment of special treatments and interventions, to be implemented voluntarily.

WN #6: 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 licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include:
   * assessment
   * reassessments
   * interventions, and
   * documentation of the resident's responses to the interventions.

On an identified date the inspector observed resident #051 in his/her room demonstrating a responsive behaviour.

Interview with PSW #144 revealed one of the interventions for resident #051 was to place resident in his/her room when demonstrating a responsive behaviour that affected other residents. Further the PSW revealed he/she placed the resident in the room, but the resident had not calmed down, and continued to exhibit the responsive behaviour.

Interview with RN #103 revealed that resident #051 had history of a responsive behaviour and had been followed up by an external program in 2014.

Review of the resident #051's health record revealed he/she had been assessed on two identified dates in 2014. Resident #051 had been discharged from the external program as the interventions in place had been deemed effective and the written plan of care had been revised to reflect resident #051's care needs. Review of the resident #051's health and assessment records had failed to reveal any reassessment of resident #051's responsive behaviours since being discharged from the program.

Interview with the program lead in the home revealed the staff used the assessment or reassessment tool only when a residents' behaviours worsened and needed to be referred to the external program. He/she confirmed resident #051's behaviour had worsened after the last external visit on an identified date and the staff had not reassessed resident #051. [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 include:
**** assessment***
**** reassessments***
**** interventions, and***
**** documentation of the resident's responses to the interventions, to be implemented voluntarily.***

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participated in the implementation of the infection prevention and control program.

On an identified date the inspector observed an unlabelled urinal placed in a labelled bedpan that did not belong to the residents of this room stored on top of the toilet tank. Further observation of a shared resident room revealed two unlabelled toothbrushes and an unlabelled toothpaste tube stored by the sink of a shared room.

Interviews with PSW #108 and RPN #102 revealed that any resident's personal items in a shared bathroom are to be labelled.

On an identified date the inspector observed an unlabelled cream stored on the toilet tank and an unlabelled deodorant stored by the sink of a shared room.

Interview with RN #103 revealed that any resident's personal items in shared rooms are to be labelled.

Interview with ADOC #128 who is also the infection control and prevention lead confirmed that any resident personal care items in shared rooms are to be labelled. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly fed in a manner consistent with his or her needs was fully respected and promoted.

On an identified date the Ministry of Health and Long-Term care ActionLine received a complaint. The complainant voiced concerns related to dining and snack services in the home.

On a specified date, during lunch service the inspector observed resident #031 in an identified dining room. The resident was being fed with an identified food by a family member that was inconsistent with the resident's diet order. Observation of the steam table in the servery revealed the specified meal for this resident had not been available.

Review of resident #031's most recent written plan of care revealed the resident's diet included two dietary restrictions. RD #127 present in the dining room confirmed the resident had been eating a food item inconsistent with the resident's diet order.

Interview with the family member revealed not being aware of what he/she was feeding the resident. The family member revealed resident #031 had maintained the two dietary restrictions for the past 20 years.

Interview with DA #163 revealed he/she was not aware the identified food served was inconsistent with the resident's diet order. Interview with Cook #164 and FSM #157 confirmed the resident was served food inconsistent with his/her diet order. The FSM confirmed serving the resident food inconsistent with the resident's diet order was contrary to the resident's personal preference.

Interview with ADOC #128 confirmed that serving the resident food inconsistent with the resident's diet was not respecting the resident's right. [s. 3. (1) 4.]

WN #9: 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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

On an identified date the inspector observed a topical cream stored in an open box on resident #045's bedside table. Interview with resident #045 revealed he/she had kept the topical cream in the open box and used it whenever he/she felt the need on his/her identified body part.

Review of the pharmacy's policy titled Resident Self Administration, last reviewed and updated on a specified date and number, indicated if the resident self-medicates, the nurse and/or consultant pharmacist will perform a self-medication audit to assess the resident's ability to self-medicate as per facility policy. The assessment should ensure that the resident understands the use of drug, the need for drug, the potential side effects of the drug, and the importance of keeping the drug safe and secure (if the resident is permitted to retain the drug in their possession). This assessment will be repeated every twelve months as per facility policy. The assessment result is to be documented in the resident's chart. The physician, nurse and/or pharmacist will monitor the resident's compliance to the medication schedule.

Interview with RPN # 122 revealed resident #046 preferred to self-administer the topical drug to his/her body parts and the physician had ordered the drug to be self-administered. The RPN confirmed they have not assessed the resident #045's capability to self-administer and had not audited the his/her compliance to the

medication schedule. Further RPN #122 confirmed they had not completed a reassessment since resident #045 had begun self-administration.

Interview with the pharmacy consultant revealed the pharmacy had provided the home with the tool to audit the resident's capability for self-administration of drug, and had expected the registered staff to have completed an assessment of resident #045's ability to self-medicate.

Review of the resident #045's health record revealed an initial assessment had not been completed nor a re-assessment to determine resident #045's ability to self-medicate.

Interview with RN #104 confirmed the home used a form titled Medication-Self-Administration Agreement for initial resident self-administration, but had not completed an assessment, re-assessment or audit for resident #045. RN #104 further revealed the home had an audit tool titled: Self-Medication Assessment Record from policy # XXI-D-40.50 (a) which indicated staff are to assess a resident's cognitive, physical, and visual ability to administer his/her own medications every four months. RN #104 confirmed they had not reassessed resident #045. [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations

Review of the CIS revealed on an identified date at 0930 hour resident #052's POA reported to RPN #152 that resident #052 had complained about PSW #153 being physically abuse while providing care to the resident that morning.

Review of the progress notes on an identified date indicated RPN #152 had received a complaint from resident #052's POA and he/she became aware of the alleged abuse, however no action had been taken to respond to the incident and no investigation had been initiated.

Interview with RPN #152 revealed he/she had talked to resident #052 who confirmed the allegations of abuse. RPN #152 confirmed he/she had not taken any further action regarding the incident, had not assessed resident #052, and had not documented the verbal interaction with resident #052. RPN #152 further confirmed he/she had not initiated the investigation and had left it for DOC #135 to initiate two days later upon his/her return to work.

Interview with DOC #135 confirmed staff are expected to investigate any suspected, witnessed or unwitnessed abuse immediately and that RPN #152 had not taken appropriate action after the incident was reported to him/her. [s. 23. (1) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Review of an identified CIS revealed on an identified date at 0930 hour resident #052’s POA reported to RPN #152 that resident #052 had complained about PSW #153 being physically abuse while providing care to the resident that morning.

Review of the progress notes of an identified date indicated RPN #152 had received a complaint from resident #052's POA regarding an alleged abuse and had not immediately reported the alleged abuse incident to the Director.

Interview with RPN #152 revealed after receiving a phone call from resident #052’s POA, he/she had left a message to DOC #135 expecting the DOC to report the incident when he/she came back to work two days later. RPN #152 further confirmed he/she was aware of mandatory reporting requirements, but had left it to the DOC to report.

Interview with DOC #135 confirmed all staff are aware and are expected to immediately inform the manager on duty who is responsible to report any suspected, witnessed or unwitnessed abuse immediately to the Director. [s. 24. (1)]

WN #12: 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 when resident had exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

During stage one of the resident quality inspection (RQI) on an identified date inspector #502 observed an area of altered skin integrity on resident #008.

On three identified dates the inspector observed a two areas of altered skin integrity on the same body part.

Review of the assessment records under point click care (PCC), the home's documentation system revealed there had not been a skin assessment completed for the above impaired skin integrity.

Interview with resident #008 revealed he/she was not aware how the impaired skin integrity had occurred.

Interviews with personal support workers (PSWs) #137 and #139 revealed that

during care over the past week they had not observed any areas of impaired skin integrity.

Interview with registered staff #133 revealed that skin assessment had not been completed for the identified areas #008.

Interview with ADOC #128 confirmed that the staff failed to ensure that when resident #008 had exhibited altered skin integrity, he/she had received the skin assessment [s. 50. (2) (b) (i)]

2. On an identified date, the Ministry of Health and Long-Term care ActionLine received a complaint. The complainant voiced concerns related to safety of residents in the home.

Record review of resident #033’s progress notes revealed on an identified date at about 1100 hours, PSW #149 observed resident #033 sitting in the hallway with a an alteration in skin integrity to an identified part of the body. The skin healed four days later.

Record review of resident #033’s assessment records revealed a skin and wound assessment assessment was not completed for the identified body part.

Interviews with RNs #104 and #115 confirmed the resident had impaired skin integrity for four days. Both RNs and ADOC #128 confirmed that the skin and wound assessment had not been completed for the above mentioned period of time. [s. 50. (2) (b) (i)]

WN #13: 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 the planned menu items are offered and available at each meal.

On an identified date the inspector observed resident #001 being offered identified food items.

Review of the diet list revealed resident #001 was on a therapeutic diet. Review of the therapeutic menu on this date revealed food items different from what resident #001 was offered.

Interviews with Dietary Aid (DA) #100 and PSW #101 revealed thetherapeutic menu items were not offered and not available to the resident. Interview with cook # 158 confirmed the above mentioned food items had not been offered and had not been prepared as per plan.

Interview with FSM #157 confirmed the above mentioned items were not available during lunch service. [s. 71. (4)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of elopement incidents for resident #022 who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

Review of critical incident system (CIS) submitted to the Ministry of Health and Long Term Care on an identified date revealed that resident #021 had sustained an injury of undetermined cause to an identified body area after being assisted with care.

Record review of the progress notes in point click care (PCC) documentation system for a four month period revealed resident #022 demonstrated seven incidents of elopement.

Record review of the home's 2014 CIS binder revealed that six of these incidents were not reported to the Director. Resident #022 had elpedfor less than three hours for each of the identified incidents.

Interview with ED #105 revealed that it had been the home's practise to only report incident that were greater than three hours and he/she confirmed that the Director was not informed no later than one business day of the above mentioned incidents. [s. 107. (3)]

WN #15: 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. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, and in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber.

On an identified date resident #045 was observed to keep a topical drug in his/her room. Interview with the resident indicated he/she kept the topical drug in his/her room and used whenever he/she felt he/she needed on his/her body parts.

Interview with registered staff #122 indicated resident #046 self-administered the topical drug - applied to his/her identified body parts.

Review of the doctor's order record revealed resident #045 had an order to self-administer the topical drug. However the record failed to reveal the resident had been permitted to keep the topical drug in his/her room.

Interview with registered staff #122 confirmed there was no order for resident #046 who self-administers a topical drug to keep the drug in her room.

Interview with the DOC confirmed the resident who self-administer topical drug is expected to have a doctor's order for self-administering and an order to keep the drug in his/her room. [s. 131. (7)]

Issued on this 7 day of November 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GORDANA KRSTEVSKA (600) - (A1)
Inspection No. / No de l'inspection :	2016_302600_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	010388-16 (A1)
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 30, 2016;(A1)
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Rockcliffe Care Community 3015 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1P-2V7

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JANE SMITH

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg 79/10, s. 73. (1) to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The plan must include but not limited to:

(1) the development of a sustainable system for ongoing monitoring of the safe positioning of residents during meal and snack services;
(2) the plan must identify who will be responsible for monitoring the safe positioning of residents during meal and snack services;
(3) develop and provide training to all staff who participate in the home's feeding program to be able to identify and implement safe positioning of residents, and to recognize the signs of dysphagia while eating and how to apply appropriate interventions when necessary;
(4) to ensure the plan of care identifies the proper feeding position of residents identified at high risk for choking.

The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to juliene.ngonloga@ontario.ca by July 15, 2016.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date the Ministry of Health and Long-Term Care (MOHLTC) Action Line received a complaint. The complainant voiced concerns related to dietary services at the home.

On multiple occasions the inspector observed resident #001 in an unsafe feeding position while being fed in the ground floor dining room. Resident #001 was observed in a reclined wheelchair, lying in a resting position. Resident #001's face was directed towards the ceiling with open eyes. Resident #001 was heard experiencing

an ongoing wet cough while being fed.

- On an identified date at 1425 hours, during the afternoon snack service PSW #130 was observed standing over resident #001 while spoon feeding him/her milk. When the inspector entered the dining room PSW #130 stopped feeding the resident. PSW #130 then used a napkin to clean food debris from resident #001’s mouth. Interview with PSW #130 revealed that placing resident #001 in an upright position would have put him/her at risk for fall.

Director of Nutrition and Food Services (DNFS) #157 had been notified by the inspector to assess resident #001’s position for feeding. The DNFS stated that resident #001 was reclined close to a 45 degree angle and it was not a safe position for feeding. DNFS #157 left the dining room without repositioning the resident.

- On an identified date during the lunch service, resident #001 was spoon fed by PSW #146. The inspector approached PSW #146 and inquired about the proper feeding position for resident #001.The PSW was not able to identify the safe position for feeding and continued to feed resident #001.

The inspector brought the concern to RPN #122’s attention. RPN #122 revealed resident #001 always slides down from his/her chair. Despite RPN #122 acknowledging that resident #001’s feeding position was not safe the resident was not repositioned. RD #127 was notified by the inspector to assess resident #001’s position for feeding. The RD revealed that resident #001 was at high risk of choking as he/she was on a modified texture diet. RD #127 confirmed resident #001 was seated at a 60 degree angle and that this was an unsafe feeding position. RD #127 revealed that resident #001 should be seated upright; close to a 90 degree angle however he/she did not adjust the resident's feeding position.

- On an identified date at 1220 hours, resident #001 was spoon fed by PSW #146. RPN #122 was notified by the inspector to assess resident #001’s position for feeding. He/she stated resident #001 was seated close to a 70 degree angle and stated the resident’s feeding position was fine.

Record review of resident #001's most recent written plan of care revealed no directions to staff to ensure resident was seated at a safe feeding position during meals.

2) On an identified date during breakfast service, the inspector observed resident #034 in the first floor dining room. The resident was observed at a 60 degree angle, while being fed by RPN #160. The inspector approached RPN #160 and inquired about the proper feeding position for resident #034. The RPN #160 stated resident #034 was not properly positioned for feeding. RPN #160 also indicated the resident was sliding down his/her wheelchair, and then proceeded to reposition the resident.

Review of the home’s policy titled, “Pleasurable Dining” revised a specific date and the home's education package, "Swallowing Disorders, Aspiration & Choking", used during a mandatory staff in-service on an identified date outlined the home's expectation on the correct position of residents and staff during meals. The information included the following: resident must be well positioned, upright at 90 degrees with head and body at midline. Chin should be slightly downward to protect the airway. The staff must sit to feed residents and be at eye level, and they must feed parallel to the mouth.

Interview with PSWs #130, #146, RPNs #122 and #160 revealed they had not received training on safe feeding techniques since 2011.

Interview with ADOC #128 indicated the described feeding position was not safe for feeding. He/she confirmed the home’s expectation was to have all residents, without exception, seated upright as close to a 90 degree angle as possible, prior to being assisted with feeding.

Interview with ED #105 confirmed the above described feeding position was not safe for feeding. He/she revealed it was a multidisciplinary responsibility to ensure all residents who required assistance are positioned safely for feeding.

On an identified date the inspector observed resident #001 during lunch service. The resident was observed in an upright position; the inspector did not hear any wet coughing from the resident.

The severity of this finding was potential harm related to a resident at high risk of choking being fed in an unsafe feeding position. The scope of this finding was isolated.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, 2007, O. Reg. 79/10, s. 73 (1): A voluntary plan of

correction (VPC) was previously issued for s. 73. (1) during a Resident Quality Inspection (RQI) on June 3, 2015, under inspection #2015_377502_0012 and during a RQI on August 6, 2014, under inspection #2014_251512_0012.
(502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 05, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7 day of November 2016 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : GORDANA KRSTEVSKA - (A1)

Service Area Office / Bureau régional de services : Toronto