Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Oct 1, 2014	2014_237500_0015	T-000137-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

SEVEN OAKS
9 NEILSON ROAD, SCARBOROUGH, ON, M1E-5E1

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

NITAL SHETH (500), JANICE PITTS (587), SLAVICA VUCKO (210), SUSAN SEMEREDY (501), VALERIE PIMENTEL (557)

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): July 28, 29, 31, August 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 2014.

Additional inspections related to the CI Log# T-841-13, and T-595-14 were also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), the acting director of care (ADOC), nurse managers, environmental service supervisor, dietary supervisors, RAI- MDS coordinator, physiotherapist (PT), occupational therapist (OT), registered nursing staff, personal care aides (PCA), house keeping staff, maintenance staff, laundry staff, residents, and families.

During the course of the inspection, the inspector(s) observed residents' care areas, reviewed home policies and procedures and residents' records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 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.

Review of the post fall assessment huddle form for resident #17, indicated the resident to be toileted before bedtime, when needed or when wet, staff to anticipate the resident's needs and meet them. Review of the written plan of care indicated this strategy was not included in the plan of care in order to be communicated to all staff and performed accordingly.

Review of the flow sheets and interview with PCA and registered nursing staff confirmed the resident was not assisted with toileting on any shift (day, evening or night) on six identified days, but he/she was assisted with changing the incontinent product only. [s. 6. (4) (a)]

2. A review of resident #33's plan of care revealed that the resident has highly impaired vision and uses visual appliances at all times.

Interview with the registered nursing staff confirmed that the resident wears visual appliances all the time. A review of MDS assessment completed on two identified months, revealed that the resident has highly impaired vision and no visual appliances.

Interview with the nurse manager confirmed that the MDS assessments completed on above mentioned months are errors made by the registered nursing staff based on previous documentation and not based on the resident's assessment. [s. 6. (4) (a)]

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

Review of the clinical record, quarterly physician medication review for an identified period of time for resident #14 indicated identified blood tests has to be performed once weekly.

Interview with the registered nursing staff indicated the technician is coming to the home to draw blood from residents for an identified blood test on Tuesday and Thursday and the night shift registered staff prepares the list of residents for blood work. The resident was known to be resistive to care sometimes and to refuse blood to be drawn. If the technician was not able to take the blood sample from the resident he/she would write the reason down. The resident refused the blood sample to be taken on three identified days but it was taken once.

Review of the clinical documents and interview with the registered nurse confirmed that on three identified days the resident was not included on the list for blood work, therefore the required blood test was not performed. [s. 6. (7)]

4. The licensee failed to ensure 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.

Review of the written plan of care for resident #11 indicated the resident has impaired vision, he/she sees large print, but not regular print in newspapers or books. The intervention for vision correction was the resident to wear visual appliances.

Review of the clinical record indicated the resident was assessed by an eye specialist

on an identified day, and was diagnosed with identified eye issues, with a plan to monitor and to wash his/her eye lashes daily with diluted baby shampoo.

Interview with registered nursing staff and a PSW indicated the resident does not wear visual appliances for almost two years, because his/her family member took them at home. He/she does not watch TV or read books, but likes listening to music.

Interview with the registered nursing staff confirmed she/he washes the resident eye lashes with baby shampoo and the written plan of care was not updated that the resident does not wear the visual appliances. [s. 6. (10) (b)]

5. The licensee failed to ensure the resident is reassessed and the plan of care reviewed and revised at any time when care set out in the plan has not been effective.

Review of the clinical record for resident #16 indicated the resident blood sugar (BS) to be checked three times a day, identified dose of the medication to be administered three times a day. Review of the clinical blood glucose monitoring record for an identified period of time, indicated blood sugar results measured at bedtime, on at least more than ten occasions to be higher.

Interview with registered nursing staff indicated for out of normal range blood sugar results the physician should be contacted according to standards.

Review of the progress notes, physician orders and interview with registered nursing staff confirmed the physician was not notified about the out of normal range blood sugar results in the period of one month, nor the resident was monitored for increase blood sugar signs and symptoms. [s. 6. (10) (c)]

6. Review of the written plan of care in relation to toileting, last updated May 1, 2014, indicated resident #17 required limited assistance by one staff, he/she toileted him/herself during the day. At night, one staff provided verbal cuing and physical guidance to use the toilet/urinal.

Review of the clinical record indicated during the falls two consistent days, the resident was either wet and needed change of the incontinent product or he/she tried to go to the washroom by him/herself and he/she fell beside the bed.

Interview with PCAs and registered nursing staff indicated on April 2014, the resident

was not able to toilet him/herself and staff assisted him/her with toileting on the toilet only for bowel movement. For bladder incontinence the staff changed the incontinent product. The resident's plan of care has not been reviewed and revised when the care set out in the resident plan of care has not been effective. [s. 6. (10) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the following minimum lighting levels set out in the regulations are maintained:
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux.

On July 29 and 31, 2014, the inspector observed that in two resident rooms the lighting levels were low. On August 5, 2014, the inspector observed the building services manager take lux meter readings in unit one in the hallway and two resident rooms and bathrooms. The following were observed:
- Hallways were inconsistent with lux meter readings from 15 to 340
- At the bed of resident rooms lux meter readings were 182 to 300
- In the bathrooms lux meter readings were 155 to 214.

The building services manager confirmed that these lighting levels did not meet the minimum lighting levels set out in the regulations. [s. 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 that the following minimum lighting levels set out in the regulations are maintained:
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident has occurred, immediately reports the suspicion and the information upon which it was based to the Director.

Interviews with resident #1 revealed that he/she had recently been handled roughly and spoken to rudely.

Record review revealed that rough handling was discussed at his/her care conference on an identified day, and an identified nurse manager was to follow up.

Record review of the nurse managers investigation notes revealed that resident #1 had been spoken to rudely by an identified PCA.

Interview with the identified nurse manager confirmed that even though he/she considered rough handling and speaking rudely to residents as forms of physical and verbal abuse, he/she did not report his/her suspicions or findings to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that abuse of a resident has occurred, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: 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:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care is based on an interdisciplinary assessment of the resident's vision.

Review of the written plan of care in relation to vision for resident #13 indicated the resident had impaired vision, able to see in adequate light and with the visual appliances, if uses; he/she has visual appliances, but does not wear them.

Review of the clinical record indicated the resident was admitted on an identified day, with moderately impaired vision (not able to see newspaper headlines, but can identify objects), and he/she uses visual appliances, he/she has identified eye problems.

Interview with PCAs and registered nursing staff indicated the resident did not wear eye visual appliances in the last year or two, and that his/her family member took them at home.

Interview with nurse manager indicated the eye specialist comes in the home usually twice a year. The responsible person is the nurse clerk who makes posters about the eye specialist visit and post them in the elevator or other communication boards for family to see and if they think the resident needs an eye exam in order put the resident on the list.

Review of the clinical record and interview with PCAs, registered nursing staff and nurse manager indicated since the admission the resident was not assessed by an eye specialist . [s. 26. (3) 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 the plan of care is based on an interdisciplinary assessment of the resident's vision, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A review of resident #31, 33, and 34's nursing and personal care record (NPCR) for food and fluid intake revealed that entries were missing for identified meals and snacks for more than 20-41 days during three identified months. [s. 30. (2)]

Interview with the registered nursing staff confirmed that staff did not record food and fluid intake for above mentioned days for above mentioned residents.

Interview with the nurse manager confirmed that the charge nurse should fill out the food and fluid record for each meal and snacks. [s. 30. (2)]

4. Review of the clinical record for resident #17 indicated on an identified day, he/she was prescribed an identified cream, to be applied twice daily to the affected skin areas.

Interview with registered nursing staff and ADOC indicated whenever staff applies the medicated cream they have to initial in MAR as given. Review of the Medication Administration Record (MAR) for two identified months indicated the application of the medicated cream was not signed as administered on 27 identified days in two identified months. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe techniques when assisting residents.

On an identified day, the inspector observed resident #5 to be lying in bed attached to a mechanical lift with no staff members present. Interview with an identified PCA revealed that she had left the resident alone to get another staff member to help with transferring the resident.

Interview with the identified PCA and the nurse manager confirmed that for safety reasons the resident should not have been left alone and the lift should not have been attached to the resident until both staff members were present and able to perform the transfer. [s. 36.]

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 use safe techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the clinical record for resident #17 indicated the resident had eight falls in three months period. The policy "falls prevention and management" indicates the interdisciplinary care team who is present on the unit at the time of the fall to conduct post fall assessment huddle meeting , to identify the root causes for the fall and preventative strategies for future fall and injury prevention. The meeting to be documented on the post fall assessment huddle form and placed in chronological order in the section of health care record in progress notes.

Interview with acting DOC confirmed that the post fall assessment was not conducted using the post fall assessment huddle form after the two identified falls. [s. 49. (2)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee, within 10 days of receiving the advice, responds to the Residents' Council in writing.

A review of an identified Resident's Council Follow- up form, revealed that the residents raised a concern for the computers not working efficiently on two floors. The form indicates that this form should return with response to the Residents' Council by an identified day.

Interview with the president of the Residents' Council revealed that the home did not provide any written responses to the Residents' Council within 10 days of receiving the concerns.

Interview with the program manager confirmed that before July 2014, the home was addressing any concern raised by the Residents' Council verbally in the following Residents' Council meetings. The home have started a new system of filling out Residents' Council Follow-up form for addressing any concern raised by the Residents' Council since July 2014. Once the concern is raised, the program manager forward initiate this form and forward it to the respective discipline manager to provide the respond for the concern raised. The managers have 10 days to respond this concern. This response is verbally communicated to the Residents' Council in the following meeting where the president of the Residents' Council and the administrator sign the form. [s. 57. (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 if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee, within 10 days of receiving the advice, responds to the Residents' Council in writing, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Nutrition and Hydration program includes, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

A record review revealed that the home did not measure weights for seven residents in three identified months.

Interview with the registered nursing staff confirmed that according to the policy the home should measure all resident's weights on admission and monthly thereafter.

Interview with the nurse manager confirmed that the staff should measure all residents' weight every month, and above mentioned residents' weights were missed out by the staff. [s. 68. (2) (e) (i)]

2. The licensee failed to ensure that the Nutrition and Hydration program includes, a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter.

A record review revealed that the licensee did not measure ten identified resident's heights annually after admission.

Interview with the registered nursing staff confirmed that the home have a policy to measure residents' heights upon admission and annually thereafter. The registered staff confirmed that the above mentioned residents' heights were not measured annually.

Interview with the nurse manager confirmed that the staff should measure all residents' heights upon admission and annually thereafter according to the home's policy. [s. 68. (2) (e) (ii)]

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 Nutrition and Hydration program includes, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The license failed to ensure that the written complaint procedures in place incorporates the requirements set out in section 101 for dealing with complaints.

101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).
(2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).
(3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).
(4) Subsections (2) and (3) do not apply with respect to verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received. O. Reg. 79/10, s. 101 (4).

Review of the "Compliments, concerns and complaints" procedure given to the inspector by the Administrator on August 07, 2014, confirms that it does not incorporate the requirements set out in section 101 for dealing with complaints.

Interview with resident #12 indicated he/she missed a watch in an identified month, from his/her room and reported to the charge nurse. The nurse initiated investigation, notified the family within several days and documented in progress notes.

Interview with a registered nurse indicated that the staff is still searching for the watch and the family is not informed about the outcome within ten business days. The usual procedure for dealing with complaints described by the registered nurse was that if the complaint is not resolved on the unit level (the nurse was not able to identify the time period for non-resolution) it gets escalated to the Nurse Manager, Director of Care and Administrator. Interview with the Nurse Manager indicated the complaint was not reported to him/her.

The Administrator indicated the complaints not resolved in 24 hours should be submitted to the nurse clerk with the 24 hours report. She presented a form to the inspector "Complaint Tracking Form" but stated that she has not seen anyone using it in the last four years.

Interview with the registered nursing staff indicated he/she was not familiar with any official procedure for dealing with complaint or using certain forms for documenting, other than documenting in progress notes and reporting to management by hierarchical order. [s. 100.]

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 written complaint procedures in place incorporates the requirements set out in section 101 for dealing with complaints, to be implemented voluntarily.

WN #11: 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:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's right to have his or her lifestyle and choices are fully respected and promoted.

Interview with resident #35 confirmed that the resident prefers to have a bath instead of a shower, whenever it is communicated with the staff, the staff mentioned that the bath tubs in the home are not in working condition.

Interview with the PCA confirmed that to provide a bath to the resident is "lots of work".

Interview with the registered nursing staff confirmed that the staff member had never seen any resident having bath during last three years.

Interview with the nurse manager confirmed that the home is in a procedure to replace all bath tubs and indicated that currently, the home does not have any resident who prefer to have a bath. He/she was not aware that the resident #35 prefers having a bath. [s. 3. (1) 19.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On July 31, 2014, and August 1, 2014, the inspector found shower room door #526 on the fifth floor to be unlocked on three different occasions. The door had not fully closed and was easily pushed open. The locking system for all tub and shower doors on floors two to five consisted of two separate door handles, one at waist level and the other above the head. In order to open the door from either side, both handles must be pulled down at the same time.

Interview with registered staff confirmed that leaving these doors open and accessible to residents was an unsafe practise because a resident could enter into this room and, if the door became closed, it may not be possible for the resident to get out.

Interview with the building services manager and administrator confirmed that in order to make these doors safer the home would ensure all staff check to make sure the doors are closed and would install actual locks on all the doors and dispense the second handles.

On August 6, 2014, the inspector observed that shower room door #526 was closed, locked and had a new lock installed with no second handle. [s. 5.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the policy for Falls Prevention and Management is complied with.

Review of the policy "falls prevention and management, published August 1, 2013, section c, post fall management, point 8, stated as part of the post fall assessment huddle review fall preventative strategies and modify plan of care when the evaluation of interventions demonstrates that the interventions are ineffective as indicated. Point 11 of the same section states the implementation of the preventative measures identified during the post fall assessment huddle to be monitored.

Review of the clinical record indicated resident #17 fell eight times in an identified year.

Review of the written plan of care, indicated staff to monitor the resident on each shift to ensure the resident has his/her walker close by at all times, staff to remind the resident to remain in TV lounge after each meal, if he/she is weak, to assist him/her back to bed for resting.

Review of the written plan of care, indicated the following interventions to prevent falls: observe resident hourly for safety and need for assistance, encourage the resident to ask for assistance with difficult tasks, place call bell within easy reach and remind the resident to use it.

Review of the post fall assessment huddle form for the incident on an identified day, indicated the following preventative measures (listed as new) for fall and injury prevention/reduction:
the resident to be observed hourly, to be encouraged to use the call bell for help, or to ask for help, bed in low position and mattress beside the bed.

During the fall incident, it was identified that the resident needed assistance with changing the incontinent product and besides the previous interventions a new intervention was added the resident to be toileted before bedtime and when needed, and when the resident is wet, staff to anticipate and meet the resident's needs.

The progress notes indicated the resident was sitting on the floor mat stating he/she went to the washroom by him/herself and no interventions were planned. On an identified day, the resident had another fall and was sent to hospital.

Review of the clinical record confirmed the interventions to prevent to prevent/reduce falls three identified days were not evaluated and monitored for efficacy according to the policy. [s. 8. (1) (b)]

WN #14: 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. (2) Where the Act or this Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the record to be readily produced. O. Reg. 79/10, s. 8 (2)

Findings/Faits saillants :

1. The licensee failed to ensure that the policy "pharmacy policy and procedure manual for LTC homes" is complied with.

Review of the policy "pharmacy policy and procedure manual for LTC homes", section 2, emergency starter box, describes a procedure for taking medications from the emergency box and replacing the emergency medications used as follows:

5. Notify pharmacy that you have used medication from the emergency starter box by writing the resident's name on the medication label and on the peel-off label. Place the peel-off label on the ESB drug record book page and fax immediately to pharmacy.
6. Pharmacy replaces the emergency medication used, with the next delivery.
Note: if pharmacy unaware of ESB supply used, full prescription supply will be dispensed to resident and the ESB will not be restocked.
7. Fax or transmit physician's order to pharmacy together with the ESB drug record book page.

Note: if pharmacy is not notified ESB supply is used-the ESB supply cannot be replaced. Good communication will ensure proper inventory.

Observation of the emergency starter box on August 8, 2014 at 2:00 p.m. indicated a presence of 3x8 tab Cephalexin (Keflex) 250 mg. Review of the "off hours medication supply control sheet", indicated an evaluated supply of 4x8 tab. The "off hours medication supply control sheet" indicated on July 17, 2014, the supply of Cephalexin 250 mg was 2x8 tab, and it was replenished on the same day. The shift count on July 20, 2014 indicated supply of Cephalexin 250 mg 3x8 tab.

Interview with registered nursing staff confirmed that once Cephalexin 1x8 tab was used from the emergency starter box it has never been ordered to be replenished by pharmacy in order to keep the necessary planned supply.

Review of the policy "medication storage" describes a procedure for safe storage of prescribed medications as follows:
Monitor expiry dates ona regular basis (monthly), expecially in the PRN bin, the narcotic bin, treatment areas and extra medication areas.

Observation on August 8, 2014 at 2:00 p.m., of the medication room on 4th floor, top cabinet, indicated a presence of Ectosone cream 0.1% with expiry date April 03, 2014, for a resident who is still present at the home. Interview with registered nursing staff and acting DOC confirmed the expiry date and discarded the cream right away. [s. 8. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that available in every area accessible by residents.

Observation on July 28, 2014, on 5th floor, revealed room #573 (laundry room/centre sprinkle valve) with a washer and a dryer in it. A PCA indicated that the laundry room is used by staff and residents who are capable and is never locked. It was noted there was no communication and response system in the laundry room, as it is used by residents.

Interview with ADOC indicated the laundry room on floors was for family members and residents who are capable of using it, and in further discussion with the Administrator the home decided that the door of the laundry room on the floors would be locked because there is no communication system-call bell installed in these rooms. [s. 17. (1) (e)]

WN #16: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;   O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the resident who is incontinent has received an assessment that:
* includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
* is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Review of the clinical record for resident #17 indicated he/she was continent of urine since admission. The Resident Assessment Instrument (RAI) Minimal Data Set (MDS), indicated the resident was occasionally incontinent of urine and pads/briefs were used. Because of the high risk for falls, on an identified day, the OT recommended that the resident uses a wheelchair as a primary mode of locomotion.

Review of the flow sheets and interview with PCA indicated the resident status deteriorated in an identified month, and he/she was toileted only for bowel movements. On an identified day, he/she has been changed the incontinent product in average two times a shift and he/she was assisted to use the toilet mostly during day and evening shift. During the last week of an identified month, he/she was assisted with toileting only once.

The resident did not receive an assessment for continence status using a clinically appropriate assessment instrument after his/her admission. [s. 51. (2) (a)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received annual retraining relating to the Residents' Bill of Rights.

Record review and interview with the Administrator and assistant Administrator confirmed that 15 per cent of staff did not receive retraining relating to the Residents' Bill of Rights in 2013. The home's education for this training runs from March/April 2013 to March/April 2014. [s. 76. (4)]

WN #18: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

Review of the clinical record and interview with acting DOC indicated resident #17 had a fall on an identified day and was sent to hospital. Upon return to the home the resident health status changed, he was unresponsive and died on an identified day. Review of the hospital discharge report indicated the resident sustained identified diagnosis.

A critical incident report for change in the health status was submitted to the Director on an identified day, but it was not amended til the moment of the inspection that the resident died on an identified day. [s. 107. (4) 3. v.]

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. The licensee failed to ensure that drugs are stored in an area that complies with manufacturer's instructions for the storage of the drugs.

Observation of the medication cart on August 7, 2014, at 11:00 a.m. on 3th floor, and interview with registered nursing staff indicated a presence of Insulin Humulin in a pen that was not labeled when opened.

Review of the manufacturer's instructions on how to store Insulin indicated that vials that are not being used must be stored in the fridge at 2-10 degrees Celsius, in the original package, away from the freezer compartment. Vials that are being used or are about to be used must not be kept in the fridge. You can carry them with you and keep them at room temperature (below 30 degrees Celsius) for up to four weeks. Once the rubber stopper has been punctured the insulin should be discarded after four weeks, even if it is not being used.

The registered nursing staff was not able to confirm when the insulin vial was opened in order to know until when it is good for use. [s. 129. (1) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home: the date the drug is received in the home.

Review of the drug record book on 3th floor for the period of July- August 2014, and interview with registered nursing staff indicated the date when the drugs were received in the home was not written by the registered staff who received the drugs. [s. 133.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before a staff member is hired the criminal reference check was conducted within six months before the staff member is hired.

Record review revealed that an identified staff member's criminal reference check was not conducted within 6 months of the hire date.

Interview with the administrator confirmed that the criminal reference check was not conducted within six months before the staff member was hired. [s. 215. (2)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the direct care staff is provided training in falls prevention and management.

Review of the education record for falls prevention and management indicated 13% of the direct care staff were not provided training in 2013.

Interview with ADOC confirmed that not all direct care staff were trained in falls prevention and management in 2013. [s. 221. (1) 1.]

WN #23: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

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

On July 29, 2014, the inspector observed on the counter of the toilet area in the shower room on the first floor a basket containing unlabelled opened deodorants, lipsticks, a nail brush and jars of petroleum jelly.

Interview with an identified PCA and the ADOC confirmed that these items should be labelled in order to prevent the spread of infection. [s. 229. (4)]

2. Observation on July 28, 2014, at 10:00 a.m., 4th floor, revealed in the shower room #426 three non-labeled deodorant sticks on the counter, in shower room #448 a non-labeled urine collection basin.

Observation on July 31, 2014, at 12:35 p.m., revealed in the shared washroom of two identified rooms a non-labeled urine collection basin on the toilet tank, and a non-labeled opened toothpaste and toothbrushes. In the shared washroom of another identified room there were a non-labeled personal care basin and a urine collection basin.

Interview with the registered nursing staff and a PCA confirmed that the personal care items should be labeled. [s. 229. (4)]

3. The licensee has failed to ensure that each resident is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Record review revealed that resident #6 was not screened for tuberculosis within 14 days of admission. Interview with the acting DON confirmed that the two step mantoux screening was not initiated until after the resident had been in the home for 14 days and the resident had not had prior screening or a chest x-ray. [s. 229. (10) 1.]

Issued on this 27th day of October, 2014

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