Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 30, 2015	2015_377502_0010	T-1731-15	Resident Quality Inspection

Licensee/Titulaire de permis

SHEPHERD VILLAGE INC.
3758/3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

SHEPHERD LODGE
3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

JULIENNE NGONLOGA (502), GORDANA KRSTEVSKA (600), JULIET MANDERSON-GRAY (607), TILDA HUI (512)

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): April 27, 28, 29, 30, May 1, 4, 5, 6, 7, 8 and 11, 2015.

During the course of the inspection, the inspector(s) spoke with Vice President (VP) of client services, director of nursing (DON), Resident Assessment Instrument (RAI)-Coordinator, nurse managers (NMs), registered nursing staff, personal support workers (PSWs), Director of food and nutrition services, registered dietitian (RD), food service managers (FSM), dietary aides, cooks, manager of recreation, director of facilities, facility coordinator, housekeeping staff, residents, substitute decision makers (SDMs) and family members of residents.

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

The following intakes were conducted concurrently with the Resident Quality Inspection: T-1526-14, T-3821-14, and T-4201-14.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **24 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

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

On a specific date and time, the inspector observed resident #021 sitting in a wheelchair in the lounge. The resident was dressed in a night gown that was pulled up high above

the waste, so that the incontinent product and his/her bare legs were exposed to the public. Resident #021's wheelchair was tilted back so resident was moving his/her legs up in the air, lifting the gown even higher and exposing more parts of his/her body. An identified staff was delivering afternoon snack between 2:00 p.m., and 3:00 p.m., in the same area and he/she did not cover the resident during the above mentioned time period.

Interview with an identified staff confirmed that the resident was exposed from the waist down in a common area which was not appropriate and did not fully recognize the resident's dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the rights of residents to live in safe and clean environment was fully respected and promoted.

On a specific date and time, the inspector observed in the common area on an identified unit a pair of scissors on a table, the residents were present and not supervised by staff.

Interviews with identified nursing staff and activation assistant confirmed that the scissors should not be left unsupervised in the resident common area. [s. 3. (1) 5.]

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

Observation on specific dates, during lunch meal service revealed that the residents' name, location, and their associate diets and restrictions were posted on the dining room tables. The dining rooms are located in open areas accessible to the public.

Interview with an identified food service supervisor (FSS) and the Director of the food and nutrition services confirmed that the residents' PHI was posted on the dining room's tables and accessible to anyone. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted:
- to be treated with respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity,
- to live in a safe and clean environment, and
- to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

On a specific date during lunch service, the inspector observed resident #020 sitting at a bedside table in the dining room, isolated from the other residents while eating his/her lunch.

Interview with an identified registered nursing revealed that the resident sits at the bedside table because he/she displays an identified responsive behaviour towards other residents at the table, and that was also the intervention to prevent the occurrence of the identified responsive behaviour.

Record review of the most recent written plan of care revealed that on a specific date, resident #020 was assessed as being at ease interacting with others, did not require assistance with meals, and had an identified behaviour toward other residents sitting at the same table during meals.

Interviews with identified staff revealed that the resident prefers to be seated alone at the bedside table for all meals and it was also a strategy to address the identified resident's responsive behaviour. Both staff confirmed that this information was not care planned to reflect resident #020's needs and preferences. [s. 6. (2)]

2. On a specific date and time, the inspector observed resident #021 sitting in a wheelchair in the common area and dressed in a night gown. Interviews with identified staff revealed that resident #021's SDM preference was to dress resident in a night gown.

Record review of the recent plan of care did not indicate that #021's SDM preference was to wear night gown at all times.

Interview with identified nursing staff confirmed that the resident’s and his/her SDM preferences was to wear a night gown was not included in the written plan of care. [s. 6. (2)]

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

A review of the progress notes indicated that resident #018 had been identified with numerous alterations in skin integrity on specific dates over a specified period of time.

However, a review of the minimum data set (MDS) assessments dated on specific dates over the above mentioned period of time did not include the above mentioned altered skin intergrity for the resident.

Interview with the DOC confirmed that there were discrepancies among the assessments conducted by different registered nursing staff. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Record review of the progress notes indicated that on specific dates, resident #007 was identified as having altered skin integrity on an identified body part on various shifts .

On a specific date resident #007 was seen by the physician related to the above identified altered skin integrity. There was no documentation indicating that the resident's SDM was notified of this above mentioned altered skin integrity.

Interviews with identified registered nursing staff and nurse manager confirmed that resident #007's SDM was not notified of the resident change in status. [s. 6. (5)]

5. Record review of the progress notes indicated that on multiple occasions registered nursing staff identified resident #018 as having change in condition including:
- on a specific date, resident #018 had altered skin integrity on identified body parts,
- on a specific date, the resident was seen by the nurse practitioner (NP) , and was prescribed an identified medication. The resident's SDM was notified three days after the onset of the identified altered skin integrity,
- on a specific date, resident #018 had an identified symptom from a medical condition,
- on a specific date, nursing staff was informed by the DON that resident #018's SDM expressed concern that he/she has not been informed about the above identified symptom from a medical condition,
- on a specific date, resident #018 had swelling on his/her identified body part,
- on a specific date, the MD ordered the X-ray for identified body part,
- on a specific date, the resident's SDM was notified of the result of the X-ray,
- on a specific date, resident #018 had an altered skin integrity on an identified body part, and his/her identified body parts were swollen,
- on a specific date, the resident was seen by the NP,
- on a specific date, an identified resident's body part was slightly swollen and mildly bruised, and
- on a specific date, the resident's SDM was notified about the result of the X-Ray on an

identified resident #018's body part.
On each occasion the SDM was not notified.

Interview with an identified management staff confirmed that on each occasion, resident #018's SDM was not notified when the resident condition had changed and was not provided the opportunity to participate in the development and implementation of the plan of care. [s. 6. (5)]

6. 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.

Record review of the recent written plan of care revealed and interview with an identified staff indicated that resident #018's prefers to have naps after lunch and be involved in the activities for the rest of the day.

On specific dates and times, the inspector observed resident #018 sitting in his/her wheelchair. The resident was bending forward almost touching the knees, his/her feet had dropped between the footrest, and his/her hands were hanging down the side of the wheelchair, it's appeared that the resident was not able to support herself.

Interview with an identified staff confirmed that resident #018 did not have a nap after lunch. Interview with the DOC who also observed the resident confirmed that the resident did not receive care as specified in the plan of care [s. 6. (7)]

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

A review of the progress notes revealed that on a specific date resident #007 was served sliced beets, regular vegetables, and minced meat at dinner. Record review of the resident written plan of care revealed that on a specific date, resident #007 had an identified diet order.

Interview with an identified registered nursing staff confirmed that on a specific date, the resident was served meal that was not in compliance with his/her diet as specified in the care plan. Interview with the DOC confirmed that staff should serve meals as per the plan of care. [s. 6. (7)]

8. Record review of the most recent written plan of care indicated that resident #008 had

an identified medical condition, and requires two person to transfer from bed to chair or bath chair. A review of the most recent written plan of care also indicated that the resident was to receive showers twice per week, and staff were to use the shower chair and transfer the resident with the assistance of two staff.

Interview with the resident's SDM indicated that the resident was getting showers with staff assistance showers prior to his/her deterioration. Presently the resident was just getting bed baths. The resident's family member stated that the resident preferred to have showers instead of bed baths.

Interviews with identified nursing staff confirmed that the resident was getting bed baths instead of showers, as identified resident tended to slide off the bath chair. Interview with an identified nurse manager indicated that he/she thought that the resident was getting showers. The nurse manager stated that the home had a tilted bath-chair which could be used for residents with similar physical limitations. [s. 6. (7)]

9. 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.

Interview with resident #011 revealed that he/she did not receive nail care on bath days. Record review of the recent written plan of care revealed that staff are required to file the resident's nails on bath days. A review of a pedicure receipt with a specific date, and billed to resident #011 revealed that he/she received nail care through a private care giver.

Interview with an identified staff confirmed that nail care was not provided to the resident on shower days. Interview with an identified registered nursing staff indicated that nail care for residents with an identified medical condition was provided by registered nursing staff. Interviews with an identified nurse Manager and the DOC confirmed that resident #011's plan of care did not provide clear directions to staff to provide nail care. [s. 6. (7)]

10. The licensee has failed to ensure that the plan of care was reviewed and revised at any other time when the resident's care set out in the plan was no longer necessary.

Record review of resident #007's written plan of care revealed that the resident had dentures and staff are required to provide denture care. A review of the progress notes with a specific date revealed that resident #007's dentures were cracked and the resident's SDM took them for repair.

Interviews with identified nursing staff confirmed that resident #007 no longer wears dentures. Interview with the DOC confirmed that the care plan should have been updated when resident's needs had changed. [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 written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident,
- the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and compliment each other,
- the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care,
- the care set out in the plan of care is provided to the resident as specified in the plan, and
- the plan of care is reviewed and revised at any other time when the resident's 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.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home and its equipment was maintained in a safe condition and in a good state of repair.

On specific dates the inspector observed that black marks were on the floor in identified resident rooms.

Interview with resident #042 indicated the black marks had been present on the floor in his/her room for the past six years.

Interview with identified housekeeping staff indicated that the floor was mopped and buffed regularly, but the black marks on the floor could only be removed by waxing the floor. Interview with the facility coordinator indicated that the black marks are traffic and accident marks caused by the wheelchairs and urine spill. He/she confirmed that the black marks in the identified rooms can only be removed if the floor was waxed, however he/she stated that waxing the floor will expose the damage on the tiles and the best intervention was to replace the floor tiles. [s. 15. (2) (c)]

2. On specific date and time the inspector observed that the floor inside the walk-in refrigerator was chipped and scratched.

Interview with an identified cook confirmed that the floor inside the walk-in refrigerator was not in a good state of repair. The cook also indicated that the floor was not repaired in the past two years. [s. 15. (2) (c)]

3. On specific date and time, the inspector observed the light fixture above the shower in the north side spa room, and the area around the shower in the south side spa room both located on an identified floor were corroded.

Interviews with the DOC and facility manager confirmed the above identified areas were corroded. [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 and its equipment was maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Record review of the progress notes indicated that on a specific date resident #018 was identified as having an altered skin integrity, a dressing was applied and the resident's SDM was notified.

A review of the skin and wound assessments revealed that an assessment had not been conducted on a specific date, or after the initial identification of the alter skin integrity.

Interview with the DOC confirmed that there was no documentation to support that any skin and wound assessment had been conducted for the resident upon identification of the altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is 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.

Record review of the progress notes indicated that on a specific date resident #018 was identified as having altered skin integrity, a dressing was applied and the resident's SDM was notified.

Record review of the written plan of care revealed there was no documentation to support that the registered dietitian (RD) had assessed the resident on a specific date or after the initial identification of the altered skin integrity.

Interviews with the DOC confirmed that there was no referral made to the RD to assess the resident upon identification of altered skin integrity, and the RD confirmed that he/she did not assess the resident for skin breakdown. [s. 50. (2) (b) (iii)]

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

Record review of the written plan of care indicated that resident #006 was identified as having an altered skin integrity which had deteriorated. Further review of the written plan of care revealed that a weekly wound assessment was to be conducted by using an identified Tool. Review of the above identified tool records revealed that weekly assessments were not conducted from a specific period of time.

Interviews with an identified registered nursing staff and the DOC confirmed there was no evidence that a weekly wound assessments had been conducted for the resident during the above mentioned periods. [s. 50. (2) (b) (iv)]

4. Record review of the written plan of care indicated that resident #012 was identified as having an altered skin integrity on his/her body part. The treatment was every two days with identified medication. A weekly wound assessment was to be conducted using the above identified Tool. Review of the above identified Tool's records revealed that weekly assessments were not conducted for a specific period of time.

Interviews with identified registered nursing staff and the DOC confirmed that weekly wound assessments had not been conducted for the resident during the above mentioned periods. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
1. the resident exhibiting 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,
2. the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and has any changes made to the plan of care related to nutrition and hydration been implemented, and
3. the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

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 home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks.

Record review of the house diets indicated that the following diets have been approved by the home's RD:
- regular diet with regular texture,
- regular diet with minced texture,
- regular diet with pureed texture,
- modified diabetic diet with regular texture,
- modified diabetic with minced texture,
- modified diabetic pureed diet,
- lactose restricted/ lactose free diet with regular texture,
- lactose restricted/ lactose free lactose with minced texture,
- restricted/ lactose free pureed texture, and
- low fat/reducing calorie diet with regular texture.

Record review of the diet spread sheets revealed that residents with the above identified diets are currently residing in the home. A review of week #1 and #2 of the spring/summer menu cycle revealed that the current approved home's menu cycle did not include menus for the modified diabetic and restricted and lactose free diets for minced and pureed texture for meals. Furthermore, the menu cycle did not include

menus for the modified diabetic minced, modified diabetic pureed, lactose restricted/ lactose free regular, minced and pureed texture diets;the snack menu did not include a low fat/reducing calorie diet.

Interviews with the RD, an identified FSS and the Director of food and nutrition services confirmed that the current approved home's menu cycle did not includes menus for the above identified therapeutic and texture modified diets for both meals and snacks. [s. 71. (1) (b)]

2. The licensee has failed to ensure that the home's menu cycle includes alternative choices of vegetables at lunch and dinner.

Observation on identified dates revealed that alternative choices of vegetables were not included in the menu during lunch meal service.

Record review of the spring/summer menu week #1 revealed that alternative choices of vegetables were not offered on the following days: vegetables salad on Sunday, Caesar salad on Monday, balsamic beet salad on Wednesday, Mediterranean four beans salad on Thursday, carrot & raisin salad on Friday, and romaine salad on Saturday at lunch. Italian mixed vegetables on Sunday, mixed vegetables on Wednesday, California mixed vegetables on Friday, and vegetables farm blend on Saturday at dinner. On each identified day alternate choice of vegetables were not included in the menu. Similar observations were made on week #2 of the spring/summer menu.

Interviews with an identified FSS and the Director of food and nutrition services confirmed that alternate choice of vegetables was not included in the menu when salad or mixed vegetables were offered. [s. 71. (1) (c)]

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

On three occasions the inspector observed that the planned menu items were not offered and available during lunch meal:
- on April 27, 2015, regular chocolate pudding,
- on May 4, 2015, pureed bread and ham sandwich, and
- on May 5, 2015, regular vanilla pudding.

Interviews with identified dietary aides confirmed that the above identified menu items

were not offered to the residents during lunch meal. Interview with identified cook confirmed that the identified menu items were not available on the unit during lunch meal service. [s. 71. (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:
1. the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks,
2. the home's menu cycle includes alternative choices of vegetables at lunch and dinner, and
3. the planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system must, at a minimum, provide for standardized recipes for all menus.

A review of the recipes binder revealed that there were no standardized recipes for baked beans and hot dogs, as well as minced and pureed planned menu items. The home had a generic recipe to produce minced and pureed meat and vegetables.

Interview with identified cook confirmed that standardized recipes were not available for the above identified menu items. [s. 72. (2) (c)]

2. The licensee has failed to ensure that all food in the food production system are prepared and served using methods to preserve taste, nutritive value, appearance and food quality.

On specific date during lunch meal service the inspector observed that minced and pureed beef were not available and not offered to the residents requiring texture modified

diets.

Record review of the production sheets revealed that the cooks were directed to produce minced and pureed hot dogs, minced and pureed baked beans, and dietary staff were directed to use #8 scoop or four ounces (oz) to serve each item.

Review of the Cucumber Salad standardized recipe revealed that the following ingredients were required: fresh julienne cut cucumber peeled and seeded, fresh red peppers, pasteurized fresh lime juice, granulated sugar, fresh mint leaves, salt, ground white pepper, green leaf lettuce.

Interview with an identified cook indicated that the baked beans and hot dogs were mixed and blended to the appropriate consistency minced and pureed respectively. Interview with an identified cook indicated that he/she had prepared a tomato and cucumber salad. Both identified staff confirmed that the standardized recipe was not followed. Interview with an identified dietary aide indicated that he/she served four ounces of the mixed hot dogs and beans, four ounces of mixed cucumber and tomato salad. Interview with the production supervisor confirmed that mixing different menu items had altered the taste and did not provide similar nutrition value. [s. 72. (3) (a)]

3. The licensee has failed to ensure that all food in the food production system are stored using methods which prevent adulteration and contamination.

On a specific date the inspector observed that containers with pureed food items were placed inside containers with minced food items.

Interviews with an identified dietary aide and cooks confirmed that containers of pureed food items are placed inside containers with minced food items, due to limited space and shortage of the food containers. Interviews with the Director of food and nutrition services indicated placing the food containers inside food items did not prevent contamination, and indicated that new food containers have been added to the service. [s. 72. (3) (b)]

4. The licensee has failed to ensure that staff of the home comply with a cleaning schedule for all the equipment related to the food production system and dining and snack areas.

On a specific date the inspector observed that the refrigerator located inside the third floor dining room's servery was not clean. Milk, yogurt, fruit, dessert, bread, egg salad

sandwich, and left over food were stored inside the identified dirty refrigerator.

On a specific date the inspector observed the following in the production area:
- the lamp inside "Bakery" walk-in refrigerator was covered with dust and was chipped and scratched;
- the floor inside "Defrost" walk-in refrigerator was not clean, and
- the floor inside the walk-in freezer was covered with accumulated black dust.
Food items including baked goods, milk, dessert, meat, and vegetables were stored inside the identified cold storage areas.

Interview with an identified dietary aide confirmed that the refrigerator in the servery was not clean. Interview with an identified cook confirmed that the above identified areas were not clean. [s. 72. (7) (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 food production system must, at a minimum, provide for standardized recipes for all menus,
- all food in the food production system are prepared and served using methods to preserve taste, nutritive value, appearance and food quality,
- all food in the food production system are stored using methods which prevent adulteration and contamination, and
- staff of the home comply with a cleaning schedule for all the equipment related to the food production system and dining and snack areas, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of the written plan of care revealed that on a specific date resident #019 was prescribed an identified medication with very specific instructions for administration.

A review of the progress notes revealed that on a specific date and time the resident was administered the above mentioned medication by an identified registered nursing staff, who then noticed that the resident did not appear well and notified his/her supervisor The resident was transferred to the hospital for treatment and was returned to the home on a specific date after he/she became stable.

Record review of the home's investigation on the incident indicated that the Director was notified and the outcome of the investigation documented on the Corrective Action Report revealed that the registered nursing staff gave the medication on what was entered on the eMAR and concluded that it was an input error by the pharmacy.

Interviews with an identified nurse manager and the DOC confirmed the medication incident and the above identified medication was not administered to the resident in accordance with the directions for use as specified by the prescriber. The DOC indicated that a follow up action plan was developed and implemented with the pharmacy and the involved registered nursing staff. [s. 131. (2)]

2. Record review of resident #016 indicated that the resident was identified in the clinical specific exam report by an identified specialist with a specific date as having an identified medical condition, and recommended medications to be altered and administered.

The resident's electronic medication administration report (eMAR) for an identified month was reviewed and noted the above mentioned instruction in each prescribed medications

and to be given after meal on a full stomach.

Review of the progress notes revealed an identified registered nursing staff on duty on the specific date did not modified texture of the medications prior to administering them to the resident when the eMAR directed registered nursing staff to do so.

Interview with the DOC confirmed that the RPN should have crushed the medications prior to administering to the resident in accordance to the instructions on eMar. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: 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 policy put in place was complied with.

On specific date the inspector observed an identified staff carrying a load of soiled linen in his/her hands from resident #009's room to the soiled utility room located at the end of the hallway.

Record review of the home’s "Routine Handling of Soiled Linen" policy, #ICM P-15, dated March 2014, revealed that all soiled linen should be bagged or put into a cart at the location where it was used.

Interview with the lead of infection prevention and control program confirmed that the soiled linen should not be carried by hand in the hallway but should be bagged and placed in the hampers prior to be taken to the soiled utility room. [s. 8. (1)]

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

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways are kept closed and locked, and equipped with a door access control system that is kept on at all times. On a specific date during the initial tour of the home, inspectors #600 and #607 observed that the door on the first floor leading to the stairways and the door in the basement across the elevator leading to the stairways were closed but not locked. The inspectors observed staff going through the door without using the lock pad.

Interview with the DON confirmed that the identified doors were unlocked then she proceeded to reset the door code. [s. 9. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 residents are provided with food that is nutritious and varied.

On specific date during lunch service, the inspector observed that resident #008 was served peach/carrot salad and apricot pureed for lunch.

Record review of the recent written plan of care revealed that resident #008’s had an identified diet and fluid consistency; the resident dislikes fish and mashed potatoes.

Record review of spring/summer home' menu cycle revealed that week 2 of the spring/summer menu on identified date did not have planned menu items for identified diets.

Interviews with identified dietary aide and FSM confirmed that resident #008 was served fruit as a main course and also as desert at lunch because suitable menu items for the resident's diet were not available. Interview with the RD, who was present in the dining room, confirmed that the lunch meal provided to resident #008 was not nutritious and varied. [s. 11. (2)]

WN #11: 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 has failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.

On identified date and time, the inspector observed resident #010 sitting in his/her wheelchair beside the window, away from the bed. The call bell was left behind the headboard and was not visible or accessible by the resident.

Interview with nurse manager #126 confirmed that the call bell was not easily seen and not accessible to resident #010. He/she also confirmed that the call bell should be within the resident's reach when the resident was left alone in the room. [s. 17. (1) (a)]

2. On identified dates and times the inspector observed resident #004 and #005 respectively resting in their beds; the call bells were pinned under the pillows behind the residents' heads.

Interview with an identified registered staff confirmed that the call bell were not visible to the residents and not within reach. [s. 17. (1) (a)]

3. The licensee has failed to ensure that the resident-staff communication and response system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff .

Observations on specific dates on times in resident #002's room revealed that the sound was not audible from resident's room or in the hallways when the call bell was activated.

Interviews with identified staff confirmed that the sound of the activated call bell was not audible to staff; he/she indicated that the sound was turned down during the night and was not properly calibrated in the morning so that the level of the sound was audible to the staff. [s. 17. (1) (g)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed by the method of his or her choice, including tub baths, showers, and full body sponge baths, unless contraindicated by a medical condition.

Record review of the recent written plan of care indicated that resident #008 had an identified medical condition on his/her body parts and required two staff assistance to transfer from bed to chair or bath chair. Further review of the written plan of care revealed that the resident was to receive showers twice per week. Staff were to use the shower chair and transfer the resident with two staff assistance, and there was no documented evidence of contradiction by a medical condition to the resident receiving a shower.

Interview with the resident's family member and SDM indicated that the resident was having showers prior to his/her deterioration and becoming immobile. He/she stated that the resident currently receive bed baths on his/her shower days. The resident's family member stated that the resident preferred to have showers instead of bed baths.

Interviews with identified registered nursing staff confirmed that the resident was getting bed baths instead of showers, due to the above mentioned medical condition.

Interview with an identified nurse manager indicated that he/she thought that the resident was getting showers. The nurse manager stated that the home had a tilted bath-chair which could be used for residents with an identified medical condition. The nurse manager indicated that he/she will follow up with direct care staff to shower the resident. [s. 33. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

On specific date and time the inspector observed an unlabelled tooth brush, tooth paste and wash basin sitting on the counter of an identified shared washroom.

Interviews with identified staff and nurse manager confirmed that personal care items in shared washrooms should be labelled. [s. 37. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is dressed appropriately, suitable to the time of day.

On an identified date and time the inspector observed resident #005 sitting in his/her bed wearing his/her night gown.

Interview with an identified staff indicated that resident #005 dislikes staying in bed, was the first resident to receive morning care, and then transfer out of the bed. The identified staff indicated he/she had changed the resident's incontinent product and confirmed that the night gown was not changed.

Interview with an identified nursing manager confirmed that the resident should have been changed. [s. 40.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

Record review of the home's "Standard for Resident Care policy", #NURS-11-42, dated March 2014, revealed that access to available resources is to be provided as needed to assist non-English speaking residents to communicate with others and to assist staff to communicate with these residents.

Review of the recent written plan of care revealed that resident #007 had a language barrier, he/she speaks an identified dialect and staff are to use simple direct questions and speak slowly.

Interviews with an identified PSW revealed that staff communicate with the resident through gestures as resident had language barrier.

Interview with an identified registered nursing staff and the nurse manager confirmed that there was no strategies developed to communicate with the resident who did not speak English. [s. 43.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond to the Family Council in writing within 10 days of receiving the advice.

Record review of the minutes of the Family Council's meetings for February, March and April 2015, revealed that the Family Council did not receive a written response for the following concerns brought forward:
- some fitted sheets were worn and needed replacement,
- water or ice under canopy at the main entrance,
- a request for laundry carts with foot pedals.

Interviews with the Family Council's Assistant and the DOC confirmed that a written response was not provided to the Family Council within 10 days after receiving the above identified concerns. [s. 60. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months

Review of weight monitoring assessment report from a specific period of time revealed that resident #009 had involuntary weight change.

Record review of the written plan of care revealed that the resident had not been assessed by the RD following the above identified weight change.

Interview with the RD confirmed that he/she did not assess the resident because the resident was not referred to him/her for weight change assessment and the resident was not included on his/her list of significant weight changes to address. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #18: 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:
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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On specific date and time the inspector observed resident #048 and #050 respectively during lunch meal service. The residents were seated in their wheelchairs at the dining room table and their wheelchairs were tilted at a 60 degree angle.

Review of the home's "Special Diets-Dysphagia" policy number NURSIX-168 dated March 2014, indicated that the resident should be placed in an upright position during feeding.

Interview with an identified registered nursing staff confirmed that the residents should be positioned close to a 90 degree angle for meals. The registered nursing staff proceeded to reposition the residents. [s. 73. (1) 10.]

2. The licensee has failed to ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking.

On identified dates and times the inspector observed that identified staff were each assisting three residents simultaneously that needed total assistance with eating and drinking:
- identified staff #129 was assisting residents #042, #043 and #044
- identified staff #130 was assisting residents #045, #046 and #047

Interview with the above identified staff confirmed that the residents were assisted with eating at the same time. Interview with the DOC indicated that staff providing assistance with eating and drinking are expected to assist only two residents at the same time who need total assistance. [s. 73. (2) (a)]

3. The licensee has failed to ensure that no resident who requires assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

On specific date and time, the inspector observed resident #048 sitting in his/her wheelchair at the dining room table. The resident was served lunch at a specific time and

staff became available to assist with the feeding 20 minutes later.

Interview with an identified staff indicated that the resident was totally dependent and requires assistance with feeding. The identified PSW confirmed that the resident was served at the same time as other residents on the table, and he/she will be assisted once other resident are fed. [s. 73. (2) (b)]

WN #19: 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 has failed to ensure the persons who have received training under subsection (2) receive retraining in the home's policy to promote zero tolerance of abuse and neglect of residents annually.

Record review of the home's abuse policy training records revealed that 13.8 per cent of staff had not been retrained in 2014.

An interview with the DOC confirmed that not all staff had not been trained on the above identified policy in 2014. [s. 76. (4)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the annual satisfaction survey, and in acting on its results.

Record review of the minutes of the Resident's Council meetings and interview with the Residents' Council president revealed that the home did not seek advise of the council in developing and carrying out the satisfaction survey and acting on its result.

Interview with the administrator confirmed that the Residents' Council was not consulted in the development of the survey in 2014. [s. 85. (3)]

2. Record review of the minutes of the Family Council meetings and interview with the Family Council president revealed that the home did not seek advise of the council in developing and carrying out the satisfaction survey and acting on its result.

Interview with the administrator confirmed that the Family Council was not consulted in the development of the survey in 2014. [s. 85. (3)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents to live in a clean environment is fully respected and promoted.

On identified dates and times the inspector noted an offensive odour in resident #002's bedroom.

Record review of the recent written plan of care revealed that resident #002 was incontinent, used incontinent products and was toileting independently. The plan of care also indicated that staff should check and clean resident room frequently, remove soiled incontinent products and change bed linen as needed.

Interviews with identified staff indicated when the resident was not able to reach the toilet on time he/she soiled his/her incontinent products, bed linen, and footwear. The staff also indicated that resident #002 removed soiled incontinent products and left them on the floor in the bedroom or in the bathroom. Furthermore, the identified staff confirmed that the room had offensive odour because the resident's bed linen and shoes were soiled with urine and were not removed from the room on the identified dated. [s. 87. (2) (d)]

WN #22: 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 has failed to ensure that drugs are stored in an area that was secure and locked.

Observation on an identified date and time revealed a container of medicated cream for resident #017 on a care cart in the shower room.

Review of the container's label revealed that identified medicated creams were stored inside the above mentioned container.

Interview with an identified registered nursing staff confirmed that PSWs are delegated to apply topical medication to residents, however, the container of the prescribed medicated cream should be returned to the locked treatment room after use. [s. 129. (1) (a)]

WN #23: 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 has 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, and the signature of the person acknowledging receipt of the drug on behalf of the home.

Review of the drug record book on an identified floor revealed the following drug deliveries were not signed by registered staff nor deliveries were dated when received:

* March 11, 26, 27, 2015, one entry for each day,
* March 28, 2015, two entries,
* March 31, 2015, two entries,
* April 1, 2015, five entries,
* April 8, 2015, one entry,
* April 11, 2015, two entries.

Interviews with an identified registered nursing staff and the DOC confirmed that the above mentioned drug deliveries were not signed for and the home's expectation is that the person receiving the drugs should date and sign for them. [s. 133.]

WN #24: 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 all staff participate in the implementation of the infection prevention and control program.

On an identified date and time the inspector observed the following on the south side second and fourth floors spa rooms:
- soiled urine hat on the floor, and
- an unlabeled nail clipper.

Interviews with identified staff confirmed that the above identified items were not cleaned. The identified staff indicated that the items should be cleaned after use and not left on the floor.

On an identified date and time the inspector observed an identified staff who was serving dinner in the dining room. The identified staff was observed removing dirty dishes then resuming serving the residents without performing hand hygiene.

Interviews with identified staff and FSS confirmed that PSW #115 should have performed hand hygiene in between clearing soiled dishes and serving residents. [s. 229. (4)]

Issued on this 22nd day of September, 2015

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

Original report signed by the inspector.