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

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

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

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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
May 9, 2017	2017_527665_0001	003321-17	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

JOY IERACI (665), BABITHA SHANMUGANANDAPALA (673), FAYLYN KERR-STEWART (664), LYNN PARSONS (153), SABRINA GILL (662), SHIHANA RUMZI (604)

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): February 27, 28, March 1, 2, 3, 6, 7, 8, 9 and 10, 2017.

The following Critical Incident Intakes were inspected concurrently:
- Intake #009765-16, #034278-16 and #031542-16 related to transfer to hospital with injury.

The following Follow-Up Log was inspected:
- Log #019773-16.

During the course of the inspection, the inspector(s) spoke with Director of Nursing (DON), Nurse Managers (NM), Director of Food and Nutrition Services (DFNS), Manager of Recreation and Volunteer Programs, Quality and Compliance for Resident Services Manager, Chef/Production Manager (PM), Pharmacist, Physiotherapist (PT), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Dietary Supervisor (DA), Facility Department Supervisor(FDS), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapy Assistant (PTA), Recreation Aide/Residents' Council Assistant (RA), Personal Support Workers (PSW), Dietary Aides (DA), Laundry Aides (LA), Residents' Council Representatives, Family Council Representative, Residents and Families.

The inspectors also conducted a tour of the home including resident home areas, medication administration observations, dining observations, staff and resident interactions, provision of care observations, reviewed clinical health records, minutes for Residents' Council and Family Council meetings, relevant home policies and procedures, staff training records and other pertinent documents.

During the course of the inspection,

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #901	2016_377502_0006	664

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:
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 every resident has the right 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.

On March 7, 2017, on an identified resident home area, the inspector observed a medication cart to be parked outside an identified resident room with the Electronic Medication Administration Record (eMAR) screen left open revealing resident #038's eMAR. The eMAR screen revealed resident #038's 0730 hours (hrs) and 0800 hrs medication administration record. The inspector did not observe a nurse to be in the area. RPN #120 was observed to come out the identified resident room.

Interview with Registered Practical Nurse (RPN) #120 acknowledged the eMAR screen was left open to resident #038's medication record. The RPN indicated it was the home's expectation to lock the eMAR screen when not in use or when not with the cart. RPN #120 indicated when the eMAR screen is left open people can see resident's medication administration record and indicated he/she did not protect the resident #038's Personal Health Information (PHI).

Interview with the Director of Nursing (DON) #137 indicated that the home's expectation for the medication cart and eMAR screen to be locked when not in use in order to protect against a breach of confidentiality of a resident's health information. The DON acknowledged that the above mentioned incident constitutes a breach of confidentiality as the eMAR screen was left open with resident information and RPN #120 did not protect resident #038's personal health information when the RPN was not in attendance. [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 every resident has the right 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Resident #006 was triggered from stage one for falls in the last 30 days through a staff interview.

During the stage one interview with RPN #125, he/she indicated that resident #006 had three falls within the last 30 days. The RPN indicated the resident had a total of three falls without injury in an identified month in 2017.

A review of resident #006's progress notes related to fall incidents and fall prevention interventions revealed resident had several falls between a three month period and specific fall interventions were in place.

A review of the plan of care during the three month period revealed the fall interventions did not reflect documentation in resident #006's progress notes. The fall interventions were implemented but was not included in the written plan of care.

Interviews with Personal Support Worker (PSW) #118, RPNs #145 and #146 stated resident #006 was at risk for falls. They further indicated resident #006's care needs are communicated through the plan of care and the care guides located in the care binder in the nursing station.

Interview with RPN #146 stated that registered staff update both written plan of care and care guides when there is a change in the care provided to the resident. The RPN acknowledged the most recent plan of care located in the care binder dated August 29, 2016, did not reflect resident #006's interventions related to falls prevention and the plan of care was not revised.

Interview with Nurse Manager (NM) #130 indicated the home's expectation is that plans of care and care guides are to be updated by the registered staff upon changes in a resident's care needs once assessed and routinely every three months during the Resident Assessment Instrument Minimum Data Set (RAI-MDS) quarterly assessment. The NM further stated resident #006's plan of care and care guide related to falls prevention were not revised and did not set out the current planned care for this resident. [s. 6. (1) (a)]

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

Resident #003 was triggered in stage one from the most recent RAI-MDS assessment related to continence.

The home has a care plan binder on each unit which includes a written plan of care for each resident. There is also a care guide binder on each unit which provides a condensed version of each resident's care needs. PSWs access the above identified records to become aware of each resident's care needs.

Record review of resident #003's identified assessment related to continence, completed on an identified date, revealed resident is a good candidate for an identified program.

Review of resident #003's written plan of care for an identified period in 2017 and care guide on a specified date in 2017 did not reflect the resident's continence care needs based on the identified assessment completed.

Interviews with PSWs #127 and #156 and RPN #131 revealed conflicting information on resident #003's specific continence care needs.

Interview with NM #130 indicated resident #003's plan of care was to reflect interventions based on the identified assessment completed. The NM reviewed the plan of care and the care guide for resident #003 and acknowledged the two documents did not provide clear directions on resident's continence care needs for staff. [s. 6. (1) (c)]

3. Resident #006 was triggered in stage one from the census record review.

A review of the progress notes indicated resident #006 was transferred to hospital on an identified date in 2016 and was diagnosed with an identified medical condition. Resident #006 returned to the long term home seven days later.

Record review of RAI-MDS assessment records, revealed a RAI-MDS assessment for significant change in health status was not completed upon resident #006's return from hospital.

A review of the care binder in the nursing station on an identified date in March 2017, revealed a printed plan of care with an identified date in 2016, and a care guide with an identified date in 2017, for resident #006.

Interview with RPN #146 and NM #130 revealed that residents' care needs are communicated to PSWs, the front line staff, through the printed plan of care and care guides stored in the care binders located in the nursing station. RPN #146 further revealed that PSWs do not have access to the electronic plan of care or progress notes.

The printed care guide and care plan available in the care binder stated resident #006 was at risk for falls, and included three specific fall interventions. Record review of resident's progress notes from an identified date in 2017, indicated four specific fall

interventions which were different from the printed care guide and care plan in the care binder noted above.

The printed care guide and care plan available in the care binder identified resident #006 to be at a specific nutritional risk. Record review of progress notes on an identified date in 2017, indicated that resident is at a specific nutritional risk which was different from the printed care guide and care plan in the care binder.

Neither documents in the care binder reflected resident #006's current care needs upon his/her return from hospital, related to nutrition and risk of falls.

RPN #146 indicated that interventions related to falls and nutrition for resident #006 were not correctly specified in the printed care plan and care guide as they did not accurately reflect resident #006's current care needs.

NM #130 confirmed that resident #006's care plan and care guide did not contain up to date, relevant and clear information related to nutrition and risk for falls for resident #006. [s. 6. (1) (c)]

4. On an identified date in 2016, the home submitted to the Ministry of Health and Long Term Care (MOHLTC), a Critical Incident System (CIS) report. The CIS report stated on an identified date in 2016, resident #045 was transferred to hospital as a result of a fall with injury, and was diagnosed with an identified fracture.

Within a two month period of resident #045's fall with injury, the home submitted another CIS report indicating resident #045 was transferred to hospital for further assessment with possible fracture.

Record review of resident #045's progress notes revealed the resident had multiple falls between a four month period in 2016, and a majority of the falls occurred in an identified month.

A review of resident #045's progress notes revealed resident sustained injuries and complained of pain with majority of the falls that occurred.

Record review of resident #045's Resident Assessment Protocol (RAP) on an identified date revealed the resident was at a high risk for falls and staff were to anticipate the resident's needs.

Record review of resident #045's written plan of care during an identified three month period in 2016, had conflicting information related to the residents ability to use the call bell. The written plan of care was updated by the registered staff, but continued to have conflicting information related to the call bell.

Interviews with PSW #148, PSW #151, RPN #152 and RPN #149 stated resident care needs are communicated through the written plans of care and care guides. The PSWs and RPNs indicated resident #045 was unable to use the call bell for assistance.

Interview with DON #137 acknowledged resident #045's plan of care did not have clear direction to staff related to the use of the call bell. [s. 6. (1) (c)]

5. 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 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.

Resident #001 was triggered in stage one from census record review.

A review of resident #001's progress notes indicated the resident was admitted to hospital on an identified date in 2016 and diagnosed with an identified fracture. Resident returned to the long term care home five days later.

A review of Physiotherapist (PT) #150's progress notes indicated he/she assessed resident #001 upon resident's return from hospital and recommended eight fall prevention strategies.

The home has a care plan binder on each unit which includes a plan of care for each resident. There is also a care guide binder on each unit which provides a condensed version of each resident's care needs. PSWs access the above identified records to become aware of each resident's care needs.

A review of resident #001's plan of care and care guide failed to identify three of the eight fall prevention strategies that were recommended by the PT.

Interview with NM #130 revealed it is the home's expectation for the nurses to implement the recommendations made by the PT and update the plan of care and the care guide.

The NM acknowledged after reviewing resident #001's care plan and care guide, the recommendations made by the PT had not been implemented into the plan of care and care guide. [s. 6. (4) (b)]

6. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective.

On an identified date in 2016, the home submitted to the Ministry of Health and Long Term Care (MOHLTC), a Critical Incident System (CIS) report. The CIS report on an identified date in 2016, indicated resident #045 was transferred to hospital as a result of a fall with injury, and was diagnosed with an identified fracture.

Within a 2 month period of resident #045's fall with injury, the home submitted another CIS report indicating resident #045 was transferred to hospital for further assessment with possible fracture.

Record review of resident #045's progress notes revealed the resident had multiple falls between a four month period in 2016.

A review of the home's Monthly Fall Report for an identified month revealed resident #045 had multiple falls in an identified month during an identified shift. Resident sustained injuries with some of the falls.

Record review of resident #045's Resident Assessment Protocol (RAP) on an identified date revealed the resident was at a high risk for falls and staff were to anticipate the resident's needs.

Review of the plans of care for resident #045 revealed the following:

- The plan of care during a three month period in 2016, had conflicting information related to the resident's ability to use the call bell.
- The plan of care was updated after the three month period, but continued to have conflicting information related to the resident's ability to use the call bell.

Interview with RPN #149 revealed that resident #045 was at risk for falls, and doesn't know how to use the call bell. RPN #149 further stated that an identified fall intervention was implemented on an identified date after the three month period as a falls prevention

intervention.

Interview with PT #150, stated there were no changes observed after resident #045's multiple falls on an identified month and no new interventions were implemented. PT #150 further stated there were no changes in the physical presentation of resident #045 after his/her multiple falls on an identified month.

NM #130 confirmed that the home's expectation related to reassessment when care strategies are not effective is for staff to identify and implement alternative strategies to address resident's needs. The NM further acknowledged that the call bell was not an effective strategy for resident #045 and his/her plan of care was not reassessed until an identified date in 2016. [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:
-there is a written plan of care for each resident that sets out the planned care for the resident
-there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident
-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 complement each other
-the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

According to O. Reg.79/10, s. 131 (6) (d), Where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand, the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7).

A review of the home's "Self-Administration of Medication", policy number: VII-123, supersedes date of May '11 and October '08 under procedure (3) it stated: medication will be securely stored in a locked drawer or locked box.

On March 7, 2017, while conducting the mandatory medication task, in an interview with RPN #120 the inspector was informed by the RPN that residents #040 and #041 had medications that were self-administered.

On March 7, 2017, the inspector observed two different medications located in resident #041's bathroom cabinet and on top of the resident's bedside table.

On March 7, 2017, the inspector observed two different medications located in an open bottom bathroom cabinet and in the unlocked top drawer of the bedside table in resident #040's room.

Review of resident #040 and #041's current Quarterly Medication Reviews, revealed physician orders for the above mentioned medications for self-administration.

Interview with RPN #101 revealed that residents have lock boxes in their rooms and the home's expectation is that self-administered medications are to be kept locked when stored. RPN #101 further indicated that self-administered medications were not properly stored in resident #040 and #041's rooms as medications were not locked, and the home's expectation is that the medications should be locked.

Interview with DON #137 revealed that the home's expectation is that self-administered medications are to be kept locked in lock boxes in resident rooms. DON #137 further revealed that the home's policy was not followed in the improper storage of self-administered medications in resident #040 and #041's rooms and that the home's expectation is that the medications should be locked. [s. 8. (1) (b)]

2. According to O.Reg.79/10, s. 136 (2) (2), The drug destruction and disposal policy must also provide for the following: (2) That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The home follows Remedy'sRx Pharmacy's Policies and Procedures for Medication Management. Remedy'sRx Policy titled, "Narcotic and Controlled Medication Destruction". Policy No. 8.2 with an effective date of September 1, 2013, and revised March 1, 2016, revealed that any narcotic or controlled substance to be disposed of must be stored separately from any medication available for administration to a resident. Narcotics that are discontinued must be removed from the narcotic lock box in the locked medication cart and transferred to a separate secure storage area for narcotic and controlled substances waiting for destruction.

During the mandatory medication observation for storage of narcotics and controlled substances conducted on the fifth floor's medication cart on March 8, 2017, the following were observed:

- discontinued controlled substances were found in the medication cart's narcotic box. 30 pills of an identified controlled substance belonging to resident #016 was discontinued on an identified date
- 27 identified discontinued narcotics belonging to resident #017 were found in the narcotic box

Interview with Nurse Manager #136 stated discontinued narcotics and controlled substances are to be removed and are to be taken to the DON's office where the DON signs for the medication and stores the medication in a locked box. It is the expectation of the home that discontinued narcotics and controlled substance are brought to the DON right away.

Interview with DON #137 acknowledged that it is his/her expectation that the discontinued narcotics and controlled substances come down a day or two after being discontinued or on physician's day if the physician had discontinued any narcotics and or controlled substances. The DON stated that he/she received the discontinued controlled substances and narcotics on March 9, 2017, after it was brought to the home's attention on March 8, 2017, by the inspector. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the policies and procedures are complied with related to:
-self-administration of medication
-storage of discontinued narcotics and controlled substances, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

During resident interview in stage one, resident #058 reported the following to the inspector:

Resident #058 felt that he/she was being rushed, then pushed onto his/her bed during a transfer from his/her wheelchair to the resident's bed by PSW #161. Resident #058 indicated he/she shared this information with his/her SDM who reported the incident to PT #150.

The home's policy "Zero Tolerance of Abuse and Neglect of Residents", policy number: NURS VI-116, dated January 2017, under part of purpose number 2.02 it stated: all allegations of resident abuse shall be thoroughly investigated and authorities notified where required. In the reference and related statements of policy and procedure number 25. (1) it stated: a person other than a resident, who has reasonable grounds to suspect that a resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect, shall forthwith report the suspicion and the information upon which it is based to the Director.

Interview with NM #136 informed the inspector that it was the home's expectation that when a staff member reports an incident of alleged abuse or neglect, the manger is to start an immediate investigation. The NM indicated he/she was unaware of the above concern and reviewed his/her emails received on an identified date with the inspector. The NM stated he/she found an email sent to him/her by PT #150 on the identified date, and stated that he/she was unable to recall seeing or replying to the email once it was received. The NM acknowledged he/she did receive an email from the PT notifying him/her of an incident, he/she did not notify a nurse manager working on an identified shift or DON, and had not done an investigation.

Interview with the DON stated the home's expectation related to staff complaints was to commence an investigation as soon as the home is aware of the complaint, inform the DON and management of the home. The DON indicated he/she was unaware of the above complaint and verified that the incident was not handled properly and constituted emotional and physical abuse. The DON stated the email to NM#136 should have triggered an immediate investigation on the day the email was received. [s. 20. (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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with related to investigations of all allegations of resident abuse and notification to the Director, to be implemented voluntarily.

WN #5: 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. (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 resident who requires assistance with eating or drinking is served until someone is available to provide the assistance required by the resident.

Inspectors conducted observations of the lunch meal service on specified dates in February 2017, and March 2017 at 1200 hrs, on multiple floors of the home.

The inspectors' observations were as follows:

a) Inspector #662 observed residents #034 and #035 were served soup with no feeding assistance provided by staff. 16 minutes later, the inspector observed PSW #104 start to feed residents #034 and #035. Both residents observed to require total assistance with eating.

b) Inspector #662 observed at 1220 hrs, resident #034 was served his/her main entrée. At 1239 hrs, the inspector observed the main entrée still sitting untouched on the table

and no feeding assistance was provided. 25 minutes later, the inspector observed a PSW provide feeding assistance to resident #034.

c) Inspector #662 observed at 1157 hrs, resident #036 was served soup. At 1210 hrs, the soup was observed to be still sitting on the table and no feeding assistance was yet provided. 17 minutes later the inspector observed PSW #103 assisting resident with feeding his/her soup. Resident #036 was asleep at the table and the PSW attempted to wake the resident but was unsuccessful and PSW #103 left the table.

d) Inspector #664 observed at 1250 hrs, Dietary Aide (DA) #109 placed a bowl of soup in front of resident #024 and RPN #106 offered the resident a few spoonsful of soup then left the dining room. PSW #105 resumed feeding the resident soup at 1310 hrs, 20 minutes later which was followed by the entrée.

Interviews conducted with PSWs #103 and #104 revealed that residents #034, #035 and #036 required total assistance with feeding and the home's expectation was that residents should be served a meal only when a staff member is available to assist with feeding. The PSW's acknowledged the above three residents were served their meal prior to assistance being available.

Interview with PSW #105 indicated resident #24 required total assistance for eating and indicated the home's expectation are for meals to be served only when staff are ready to feed the resident.

Interview with PSW #105 indicated resident #24 required total assistance for eating and indicated the home's expectation are for meals to be served only when staff are ready to feed the resident. The PSW confirmed the resident's soup was on the table for 20 minutes before he/she began feeding the resident.

Interview with RPN #106 stated food should not be left in front of residents requiring assistance until staff was available to assist the resident. RPN #106 further stated that sometimes residents have to wait, as there is not enough staff to provide assistance.

Interview with the DON #137 stated food should not be served to residents requiring assistance until staff was available to provide assistance. The DON further indicated staff did not follow the home's expectation. [s. 73. (2) (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:
-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, to be implemented voluntarily.

WN #6: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a registered nursing staff has permitted a staff member who is not otherwise permitted to administer a drug to a resident, to administer a topical was trained by a member of the registered nursing staff in the administration of topical medications.

During stage one room observations in resident #007's room, the inspector observed two identified prescription topical medications located on top of the cabinet in the resident's washroom. The inspector informed RPN #101 of the above observations and the RPN removed the topical medications from resident #007's bathroom and returned them to the treatment cart.

A review of the home's "Administration of Medicated Creams, Ointments and Shampoos", policy number: VII-126, supersedes date of May '11 and June '09 under policy it stated: medicated creams, ointments and shampoos may be administered by an HCA/PSW under the direct supervision of a registered staff person, providing there is not an open area present; the HCA/PSW must be trained in the application of medicated creams, treatments and shampoos. Under procedure it states: registered staff are to be sure the HCA/PSW understands treatment directions properly.

Interviews with PSWs #100 and #118 acknowledged they administer topical medicated creams to residents.

Interview with PSW #100 indicated that he/she could not recall having received training on the application of topical medicated creams.

Interview with PSW #118 recalled having received training on administration of topical medications on surge learning but he/she could not recall having received training from a registered staff member.

Interview with RPN #101 indicated that PSW staff administer topical medications to residents, however he/she was not able to confirm if PSW #100 received training on the administration of topical medications.

Interview with RPN #120 indicated that PSW staff can only administer barrier creams and that medicated topical creams are only administered by the registered staff.

Interview with DON #137 indicated that PSW's are to be trained by registered staff in the administration of topical medicated creams, and PSW's are to demonstrate their competency in the administration of topical medicated creams to the registered staff. DON indicated there was no process to follow up or monitor that this training has been completed. The DON further indicated that the home's expectation of training unregulated staff to administer topical medicated creams was not followed. [s. 131. (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 where a registered nursing staff has permitted a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical was trained by a member of the registered nursing staff in the administration of topical medications, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure there is at least quarterly, a documented reassessment of each resident's drug regime.

In preparation for the mandatory medication observation for resident #015, a review of the resident's chart found a quarterly drug regime reassessment for an identified three month period. The inspector was unable to locate a documented quarterly drug regime reassessment in resident #015's health record for the current quarter.

Record review conducted by the inspector and RPN #131 of resident #015's medical record failed to locate a documented quarterly reassessment of the resident's drug

regime for the current quarterly period.

Interview with RPN #131 indicated the quarterly medication review is put in the physician's book where it is reviewed and signed by the physician. Review of the physician's book did not include a current quarterly medication review for resident #015. RPN #131 reviewed the resident's chart with the inspectors and acknowledged that the last quarterly medication review for resident #015 was for an identified quarterly period that is no longer current.

Interview with the Consulting Pharmacist #122 stated that the pharmacy sends the home a list of residents who are due for their quarterly drug reassessment for the next month. The list is sent to the nursing staff on each unit and or to the nurse manager. The night before the physician visits, the nurses will print the quarterly drug regime reassessment from Point Click Care (PCC) and provide to the physician for review and authorization.

Interview with NM #136 said that the home receives an email from pharmacy to indicate which residents are due for a quarterly drug regime reassessment for the following month. The night before the physician is to complete his rounds, the night nursing staff will print the quarterly drug regime reassessment from PCC and the day nurse doing rounds with the physician will give the quarterly medication review to the physician.

NM #136 provided the inspector with a copy of an email the home received from Remedy Pharmacy on an identified date in 2017, of the residents who required quarterly drug regime reassessment for the following month. The list of residents that were due for quarterly drug regime reassessment included resident #015. NM #136 acknowledged that the identified quarterly drug regime reassessment for resident #015 was not completed.

The home was unaware the quarterly reassessment of resident #015's drug regime had not been completed until it was brought to the home's attention by the inspector. There were 104 days between the reassessment of resident #015's drug regime which exceeded the minimum quarterly requirement.

NM #136 acknowledged that it is the home's expectation that resident's drug regime be reassessed at a minimum quarterly. [s. 134. (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 at least quarterly, there is a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #8: 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 staff participate in the implementation of the infection prevention and control program.

The inspectors conducted lunch meal service observations on a specified day in February 2017, at 1200 hrs, on identified resident home areas as a mandatory task of the Resident Quality Inspection (RQI) process. Observations were as follows:

a) PSW #105 and two Private Caregivers (PC) #107 and #108 were observed to remove dirty dishes from the table and proceeded to feed residents without completing hand hygiene.

b) PSW #103 cleared the dirty dishes from an identified table, picked up dessert from the servery and served the dessert to the same table without performing hand hygiene.

Interview with PSW #103 indicated the home's expectation is to perform hand hygiene before serving food to residents. PSW #103 stated he/she did not carry out hand hygiene after clearing the dirty dishes from an identified table prior to serving dessert.

During stage one of the inspection the following observations of identified residents' rooms were made by the inspectors:

- An identified resident appliance was stored over a toilet grab bar and was hanging and touching the bathroom floor
- A urine collector hat was found on the floor in a resident bathroom
- Wash basins were found sitting on the floor under the sink in three identified resident rooms
- A call bell cord was touching the floor in a resident's bathroom
- Moisturizing body wash and body lotion were not labelled in a resident's shared bathroom

Interview with NM #130 who is the Infection Prevention and Control (IPAC) lead, indicated that the home has an infection control program and staff are educated on the program once a year.

NM #130 stated the following home's expectation related to the home's infection prevention and control program:

- The identified resident appliance should be disinfected and covered when not in use
- Urine collector hats are to be discarded after each use and not be stored in resident bathrooms
- Wash basins should be labelled with the residents' name and stored in the resident bathroom cabinet
  on the bottom shelf and not on the floor
- Call bell cords are not to be touching the floor in resident bathrooms
- Personal care items such as body lotions and body washes are to be labelled

NM #130 indicated that staff receive training on the hand hygiene program annually. NM #130 further revealed that the home's expectation is that staff should be performing hand hygiene in the dining room between residents, when hands are visibly soiled and after handling dirty dishes prior to handling food.

In closing, the IPAC lead acknowledged that staff did not follow and implement the infection prevention and control program in the above mentioned incidents. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control program related to hand hygiene and storage of personal care equipment, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

On an identified date in February 2017, during stage one resident interviews, resident #007 told the inspector that a staff member working on an identified shift between an identified date range in 2017, was rude to the resident when the resident requested assistance with care in his/her room. As per resident, he/she had reported this incident to NM #136 the following week after the incident.

Interview with the NM #136 indicated the home's expectation when a complaint is brought forward by a resident, is for the complaint to be recorded and an investigation is to begin immediately by the person in receipt of the complaint. The NM indicated resident #007 was competent and oriented and he/she regularly communicated with resident #007 and if resident informed the inspectors of the above incident it would be factual. The NM indicated that he/she could not recall if resident #007 had brought forward a concern as indicated above. The NM in closing stated that he/she did not conduct an investigation related to the above incident.

Interview with NM #142 revealed that he/she recalled a complaint related to the incident above and had a complaint record form for an identified date in 2017. The NM stated the form was completed by NM #136 however he/she did not start an investigation as per the home's expectation. NM #142 indicated that this form was placed in his/her mailbox and he/she had misfiled the form. NM #142 went on to indicate that he/she was prompted to search for this form when he/she received an email from the DON on an identified date in 2017, to investigate an incident involving resident #007. NM #142 further acknowledged that when a concern is brought forward, the home's expectation is for the concern to be investigated immediately by the person in receipt of the complaint and he/she did not follow this process.

Interview with DON #137 indicated the home's expectation when a complaint is brought forward by a resident, is for the complaint to be recorded and an investigation is to begin immediately by the person in receipt of the complaint. The DON indicated that he/she requested NM #142 to investigate another incident involving resident #007 that was brought to the attention of the home by the inspector. The DON further indicated that the identified complaint record form, was started by NM #136 as his/her signature was on the form and an investigation should have been started immediately. DON #137 acknowledged that the incident with resident #007 was never investigated and a CIS report should have been completed. [s. 23. (1) (a)]

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of or that is reported was immediately investigated.

During resident interviews in stage one, resident #058 reported the following to the inspector: being rushed, then pushed onto his/her bed during an identified care procedure by PSW #161. Resident #058 indicated he/she shared this information with his/her family member and this was reported to the Physiotherapist (PT) #150 who reported the concerns by email to NM #136 on an identified date in 2016.

A review of the residents progress notes on the identified date in 2016, by PT #150, indicated a referral note was sent for him/her to assess resident #058. Resident #058 felt that staff is not giving him\her enough time and rushes him/her during the identified care procedure. The resident became emotional while expressing his/her concerns to the PT.

Interview with PT #150 revealed that on the identified date, following a request by staff to reassess the resident, the PT visited the resident who was in his/her room to conduct the assessment. During the assessment, the PT was informed by the Substitute Decision Maker (SDM) that the resident felt staff on an identified shift tended to rush him/her and does not give him/her enough time during the identified care procedure and resident waits for assistance. Resident #058 became emotional when the concern was expressed to the PT. The PT informed the inspector that he/she reported these concerns to NM #136 on the identified date by email. The PT indicated that he/she had not had any follow-up once he/she sent the email to the NM regarding the above allegation, and is unaware of the outcome of the allegation brought to him/her by the resident and SDM. The PT, in closing, stated that the incident would be considered as emotional abuse.

Interview with PSW #134 revealed that resident #058 complained about delays in answering the call bell, care is not provided in the way that he/she expected, and PSWs on the identified shift provides the identified care procedure for the resident quickly.

Interview with the NM #136 stated the home's expectation was once a complaint is brought to the home's attention, the individual receiving the complaint is to commence an investigation as soon as he/she is aware of the complaint, and inform the DON and management of the home. The NM revealed he/she was not aware of the email that was sent by PT#150 on the identified date. After further review of his/her emails, the NM confirmed receipt of an email from the PT on the identified date. The NM indicated he/she did not have any knowledge of this email and was not able to provide documentation to support that the email was reviewed and followed-up with, or was forwarded to the nurse manager on an identified shift for an investigation. The NM indicated nothing was done by the home related to the allegation of abuse stated above.

Interview with the home's DON stated the home's expectation related to a resident's allegation of abuse was to commence an investigation as soon as the home is aware of the allegation, inform the DON/management of the home, and notify the Director of the MOHLTC by completing a CIS report. The DON indicated he/she was not aware of the above allegation of abuse and verified that the incident was not handled properly. The

DON, in closing, stated the email to NM #136 should have triggered an immediate investigation on the day the email was received. [s. 23. (1) (a)]

WN #10: 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, are cleaned as required.

Resident #003 was triggered in stage one as a result of observations of unclean ambulation equipment.

Resident #003's walker was observed to be unclean on three specified dates in March 2017.

Interviews with PSWs #126, #127 and #128 and NM #136 indicated the home has a monthly cleaning schedule for resident wheelchairs and walkers which is done by the night shift PSWs. They all acknowledged that if mobility aides are dirty, it is the home's expectation that staff cleans the
equipment.

Record review of the monthly cleaning schedule found that resident #003's walker was cleaned on a specified date in February 2017, and scheduled for cleaning on a specified date in March 2017.

On March 6, 2017, inspector showed resident's walker to PSW #127. PSW #127 acknowledged that the walker needed to be cleaned and made arrangements for the night staff to provide additional cleaning to the walker.

NM #136 acknowledged the staff did not follow the home's expectation related to cleaning residents' personal items for resident's #003's walker when required. [s. 37. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who is incontinent has an individualized plan of care to promote and manage bladder continence based on the assessment.

Resident #006 was triggered for inspection related to continence care and bowel management from stage one through the most recent MDS quarterly assessment.

Review of the most recent MDS quarterly assessment, with an identified date in 2016, stated that resident #006 is on an identified plan related to continence. Review of the resident's identified assessment with an identified date in 2017, revealed resident #006's continence status and resident was a good candidate for an identified program.

Interviews with PSW #118 and RPNs #145 and #146 stated that care needs are communicated to staff though care plans and care guides kept in care binders in the nursing station. PSW #118 and RPN #145 also stated resident #006's continence status and the care needs of the resident related to continence. PSW #118 further outlined what continence care was provided to resident #006.

RPN #146 stated that registered staff update both care plans and care guides as soon as possible when there is a change in in the care provided. RPN #146 outlined what continence care was provided to resident #006. RPN #146 acknowledged that the care plan and care guide available in the care binder did not specify the individualized plan to promote and manage resident #006's continence.

Interview, NM #130 confirmed that if resident #006 was assessed to require an identified plan, the care plan and care guide should include the plan. [s. 51. (2) (b)]

WN #12: 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,
(f) is reviewed by the Residents' Council for the home; and 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 is reviewed by the Residents' Council.

During the mandatory Residents' Council interview, residents #057, #066 and #067 stated the last time the licensee provided the home's menu cycle for review by the Residents' Council was in 2015.

A review of the minutes for Residents' Council meetings for 2015 and 2016 revealed that on an identified date in 2015, Food and Nutrition staff #139 and #167 attended the meeting and provided the upcoming seasonal menu for review and comments.

During a review of the Residents' Council minutes for an identified date in 2016, inspector noted Dietitian #173's attendance at the meeting where he/she discussed identified information. There were no documentation in the minutes related to sharing the home's menu cycle with Residents' Council members.

Interview with Residents' Council Assistant #176 indicated the home's menu cycle was not reviewed in 2016, with Residents' Council. Residents' Council Assistant reviewed the minutes and failed to find any documentation to support the home's menu cycle was reviewed with Residents' Council in 2016.

Interview with Director of Food and Nutrition Services (DFNS) #166, revealed that twice yearly when the menu cycle changes, the new menu is communicated at Residents' Council meetings. The DFNS #166 stated the purpose of attending the meeting is to

provide an update on key changes in menu items and to share the menus with members for their review and recommendations. The DFNS #166 stated a representative from Nutrition and Food Services last attended the Residents' Council meeting on a specified date in 2017, to review the seasonal menu change for the spring/summer cycle which would be reflected in the Residents' Council minutes. A review of the minutes from Residents' Council meetings that were held in 2016 and an identified month in 2017, failed to locate documentation to support a review of menu items for meal and snack times. [s. 71. (1) (f)]

2. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

During a mandatory lunch dining observation on an identified resident home area on an identified date in February 2017, pureed textured bun was not available from the home's planned lunch menu. The lunch menu was a choice of 1) angus beef burger topped with cheese on a bun and diced beets OR 2) fancy egg salad sandwich and fresh cucumber salad. It was observed that residents #012, #013 and #014 who were on a pureed textured diet, received mashed potatoes instead of a pureed bun.

Interview with the DA #133, informed inspector that the pureed bun was not available and residents on pureed texture received mashed potatoes instead. DA #133 said that he/she makes the pureed bun if the PSWs request it, however DA #133 indicated that there was no bread for him/her to make the pureed bun during the lunch meal service.

Interview with PSW #138 acknowledged that mashed potatoes were always served for residents who are on a pureed texture diet instead of a pureed bun. The bun for the beef burger was not available in a pureed texture for residents who are on a pureed textured diet.

Interview with the Production Manager (PM) #167 indicated the process when the servery runs out of a product such as pureed bread, is for the dietary aide to call the kitchen, so that it can be replenished immediately.

Interview with DFNS #166 indicated the home have all planned menu items available for all diet textures. The DFNS indicated breadcrumbs are available in the kitchen to provide to residents who are on pureed textured diets. The DFNS further indicated that he/she was not aware that mashed potatoes were provided in place of pureed bread on the identified lunch meal service. [s. 71. (4)]

WN #13: 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,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu substitutions are communicated to residents.

During a mandatory lunch dining observation on an identified resident home area on an identified date in February 2017, pureed textured bun was not available from the home's planned lunch menu. The lunch menu on the identified date in February 2017, was a choice of: 1) angus beef burger topped with cheese on a bun and diced beets, or, 2) fancy egg salad sandwich and fresh cucumber salad.

It was observed that residents #012, #013 and #014 who were on a pureed textured diet, received mashed potatoes instead of a pureed bun.

Interview with DA #133, informed inspector #665 the pureed bun was not available and residents on pureed texture received mashed potatoes instead. The DA indicated he/she makes the pureed bun if the PSWs request it, however the DA indicated that there was no bread for him/her to make the pureed bun during the lunch meal service. Interview with PSW #138 acknowledged that mashed potatoes were always served for residents who are on a pureed texture diet instead of the pureed bun. The bun for the beef burger was not available in a pureed texture for residents who are on a pureed textured diet.

Interview with the Production Manager (PM) #167 indicated when the servery runs out of a product such as pureed bread, the dietary aide is to call the kitchen so that it can be replenished immediately.

Interview with the Director of Food and Nutritional Services (DFNS) #166 indicated the home's expectation was to communicate menu changes to residents and this was not done on the identified date in February 2017's, lunch meal service on the identified resident home area. [s. 72. (2) (f)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure there is a process to report and locate residents' lost clothing and personal items.

Interview with residents #058 in stage one revealed he/she was missing an identified piece of clothing for a month and indicated the missing clothing was labeled with his/her name. The resident also indicated the home did his/her laundry and reported the missing clothing to PSW staff on an identified shift.

Observations of residents #058's clothing was carried out by the inspector which found two pieces of clothing not to be labelled.

Interviews with PSW #117 and #134 revealed residents' laundry will be labeled on the day of admission, the next day, or may be up to a month later. The PSW staff indicated they were unaware of the missing clothing of resident #058. The PSWs indicated if a resident brings a complaint of missing clothing they would carry out a search of the resident's room and go down to laundry with the resident in assisting to identify the missing clothing. The staff indicated they were unaware of any form to be completed.

The home's policy, "Lost & Found-Wearing Apparel", policy number L:26, effective date January 2015, under procedure lost items tab number two directs staff to: Health Care Aides (HCA) Personal Support Worker (PSW) will check resident's area and personal clothing cart located on North and South wing of each floor. Under procedure unidentified articles located through laundering process directs staff to: a logbook system of lost and

found items will be kept in the laundry room.

Interview with Laundry Aide (LA) #160 stated unlabeled clothing found in the laundry is returned to the same care unit and the unit staff are to identify who it belongs to and return the item to the appropriate resident. The LA further stated unlabeled clothing that is found mixed in with linen is stored in a separate area in the laundry area marked "Unlabeled Clothing" and residents are able to identify their clothing. The LA indicated that he/she is unaware of a logbook system for lost and found items located in the laundry room.

Interview with the Facility Department Supervisor (FDS) #113 stated on admission to the home, laundry staff take the labeling machine to the resident's room to label all clothing. When additional items are brought into the home after the initial labeling, it is expected that family take any new or unlabeled clothing to the main reception so that labeling can be done. FDS stated once the staff is aware of missing clothing the staff is to complete the "Report Of Lost Or Missing Articles" form and is brought down to the FDS, a search of the resident's room is to be carried out along with a search on both units of the floor is also to be conducted. The FDS indicated he/she was unaware of resident #058's missing clothing and in closing indicated the staff did not follow the home's policy for missing clothing.

Interview with the DON #137, he/she indicated staff practice related to labeling laundry is inconsistent with the home's policy. The expectation related to managing resident's laundry is that staff should be following the policy related to labeling resident's laundry when they are admitted and on obtaining new items. [s. 89. (1) (a) (iv)]

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

Issued on this 19th day of May, 2017

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

Original report signed by the inspector.