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**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 20, 2014 | 2014_282543_0017 | S-000226-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road, SUDBURY, ON, P3E-6L9

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

TIFFANY BOUCHER (543), FRANCA MCMILLAN (544), KELLY-JEAN SCHIENBEIN (158)

**Inspection Summary/Résumé de l'inspection**

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

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

**This inspection was conducted on the following date(s): June 2nd-13th, 2014**

**Ministry of Health and Long-Term Care Critical Incident logs # S-000003-14, 000086-14, 000097-14, 000109-14, 000162-14 and a Complaint log # S-000237-14 were inspected concurrent with the Resident Quality Inspection.**

**During the course of the inspection, the inspector(s) spoke with**
- **Administrator**
- **Director of Care**
- **Assistant Director of Care**
- **Registered Staff (RNs and RPNs)**
- **Personal Support Workers (PSW)**
- **Pharmacist**
- **Environmental Service Manager**
- **Dietician**
- **Food Service Supervisor**
- **Food Service Worker (FSW)**
- **Residents and family members**

**During the course of the inspection, the inspector(s)**
- **Directly observed the delivery of care and services to residents**
- **Conducted resident and family interviews**
- **Conducted daily tour of all resident home areas**
- **Directly observed dining and meal delivery service**
- **Observed fluid and nourishment passes**
- **Reviewed resident health care records**
- **Reviewed staffing patterns for RNs, RPN**
- **Reviewed various home policies and procedures**

**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**
**Food Quality**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. Inspector #543 reviewed several critical incidents, relating to abuse. The following was identified:

-an incident relating to abuse occurred on February 7th, 2014 and was not reported until March 5th, 2014. Inspector spoke with DOC regarding this incident and she confirmed that the progress notes that identified the incident did in fact get missed on shift report. Therefore, the incident did not get reported as required.

-an incident relating to abuse occurred on March 6th, 2014 and was not reported until March 14th, 2014. Inspector #543 spoke with the Site Administrator and she confirmed that anybody who witnesses or suspects any form of abuse must report it immediately.

-an incident relating to abuse occurred on March 4th, 2014 and was not reported until March 7th, 2014. Inspector #543 spoke with the Site Administrator and she confirmed that anybody who witnesses or suspects any form of abuse must report it immediately.

The home's policy- Zero Tolerance of Abuse and Neglect, states that any employee or volunteer who witnesses, or becomes aware of, or suspects resident abuse shall report it immediately. The actions to be taken by staff (specifically) stated in the policy are; to report any witnessed, suspected, or alleged abuse to a supervisor or manager immediately.

Consequently, the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm did not immediately report it to the Director. [s. 24. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm reports the incident immediately to the Director, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).**

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).**

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

---

**Findings/Faits saillants :**

1. Inspector #544 reviewed resident #3342's MDS assessment. The assessment identified that this resident does not require visual correction, although vision is impaired. The inspector reviewed resident #3342's care plan. The care plan identified that there is no focus, goals or interventions regarding visual deficits. The only mention of visual deficit is under risk for falls.

Consequently, the licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of this resident's vision. [s. 26. (3) 4.]

2. Inspector #544 reviewed resident #3353's MDS assessment. The assessment identified that this resident has highly impaired vision. The inspector reviewed this resident's care plan. The care plan identified that there is no focus, goals or interventions in regards to visual care deficits or attention to the visual component of

care.

Consequently, the licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of this resident's vision. [s. 26. (3) 4.]

3. Inspector # 544 interviewed resident # 3413 and this resident insists that oral care is not being performed twice a day.

The Resident was assessed by a Dental Hygiene Student on June 13, 2011 and no other dental assessment was identified in the health record. This resident feels that more assistance with care is required stating, "less able to do things on their own since my stroke". The last time this resident's plan of care was revised as far as Hygiene/Grooming(which includes mouth care) was on June 15, 2011.

There was a new plan of care completed on May 29, 2014 and under the Interventions for Hygiene/Grooming it identifies that little assistance is needed for grooming, to keep items within easy reach and little oversight is required.

Consequently, the licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming. [s. 26. (3) 7.]

4. Inspector # 544 reviewed resident #3422's health care records and identified that a head to toe assessment was not conducted after the resident had a fall in 2014, nor with a previous fall.

Inspector #544 reviewed this resident's health care record. There is no documentation under the interpersonal team review and the inspector could not find a Morse Fall Scale Assessment on admission or since this resident's admission to the long-term care home. This was further confirmed by the Assistant Director Care that these assessments were not completed.

A head injury routine was initiated on the fall that occurred in 2014 as it was unwitnessed. Health care records and documentation on the chart identified that a head injury routine was not completed every shift for 48 hours on two subsequent days.

There is no Morse Fall scale assessment for this resident to date.

A Physiotherapy assessment was conducted in 2011 on the resident's admission, but there are no subsequent assessments or re-assessments by the Physiotherapist.

Consequently, the licensee failed to ensure that the plan of care is not based on an interdisciplinary assessment with respect to this resident's health care conditions including allergies, pain, risk of falls and other special needs. [s. 26. (3) 10.]

5. Inspector # 544 reviewed the Resident's # 3382 health care records and identified that a head to toe assessment was not conducted after a fall in 2014. The Resident has not had a Morse Fall Scale assessment.

There is no documentation under the interpersonal team review to provide information if the Resident was referred to the team post fall.

There is no physiotherapy assessment on the Resident's health care record, nor is there a referral for the physiotherapy department to see this resident due to a fall in 2014.
The plan of care is not based on an interdisciplinary assessment with respect to the resident's health care condition including risk for falls. [s. 26. (3) 10.]

6. Inspector # 544 reviewed resident # 3395's Falls/Post Falls assessments. The assessments identified that resident # 3395 had twelve falls in 2014.

Inspector #544 reviewed Point Click Care documentation for this resident. The documentation identified that a Physiotherapy assessment was done on admission in 2010. There was a Falls risk assessment conducted in 2010 which identified that this resident is at a moderate risk for falls. There are no further physiotherapy assessments on the present health care record in Point Click Care. Inspector did not find any referral sent to physiotherapy for an assessment after any of these falls.

As well, there are no head to toe assessments completed for each of these falls. The only Morse Fall Scale was completed in 2014 when the resident was identified as being at a high risk for falls. This was completed only after the Resident had twelve falls in 2014.

The resident also has not had an assessment using other evidence-based

assessment tools used by the home such as: "Timed Up and Go Test, Berg Balance Scale and Elderly Mobility Scale".

Consequently, the licensee failed to ensure the plan of care is based on an interdisciplinary assessment with respect to this resident's health condition including risk of falls. [s. 26. (3) 10.]

7. Resident # 3395 was admitted into the home in 2010. The resident's admission nutritional assessment was completed by the FSS in 2010, however, the resident's fluid requirement was not documented.

Although an assessment by the dietitian was completed in 2013, the resident's fluid requirement was not documented.

Recently, the Dietitian assessed resident # 3395 and identified that the resident is at a high nutritional risk. It was also identified that to maintain the resident's adequate hydration, staff need to cue and encourage increased intakes of fluid at every opportunity. Although a specific amount of fluid was not identified to maintain the resident's hydration in the dietitian's assessment, the home's hydration policy indicates that "each resident will be provided with a minimum of 1500 ml of fluids a day".

A review of resident 3395's fluid flow sheets identified the following:
- it was documented that 3/14 days in April 2014 the resident consumed less than 500 mls of fluid in a day
- it was documented that 3/14 days in April 2014 the resident consumed over 1000mls of fluid of fluid in a day
- it was documented that 1/14 days in May 2014 the resident consumed over 1000mls of fluid in a day.

This resident's care plan did not identify poor fluid intake or the resident's risk of dehydration.

Consequently, the licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration. [s. 26. (3) 14.]

8. Inspector #158 reviewed resident # 3353's care plan. The care plan identified that

resident # 3353 has dementia. This resident's care plan identified that staff need to feed this resident at all meals and also encourage and cue this resident to drink fluids. On admission (5/12/2005) the dietitian assessed the resident as requiring 1500 mls of fluid daily. A current assessment of the resident's fluid requirement was not found.

The quarterly nutritional assessment (under assessments) completed by the FSS in 2014 and August 26, 2013 identified that the resident has poor fluid intake (less than 1000 ml/day).
The quarterly MDS assessment (oral/nutritional section) completed in 2014 by the FSS, had no section to identify the resident's fluid intake nor assess the risk. A quarterly nutritional assessment which would identify the risk was not completed.

Inspector #158 reviewed the resident's fluid intake flow sheets for 2014 and the following was identified:
-5/14 days, the resident consumed more than 1000 mls /day
-0/14 days, the resident consumed more than 1000 mls /day
-1/14 days, the resident consumed more than 1000 mls /day
-2/14 days, the resident consumed more than 1000 mls /day
This resident's care plan did not identify poor fluid intake or the resident's risk of dehydration.

Consequently, the licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration. [s. 26. (3) 14.]

9. Inspector #544 reviewed resident #3360's health record, progress notes and MDS assessment. The inspector identified that this resident was sent to the hospital in 2013 from an injury requiring sutures. The physician provided orders for the care of injury. These orders were discontinued, however, the resident asked to keep the dressing on for protection and fear of having the wound open again. Subsequently, the wound became a skin tear and a dry dressing order was initiated.

There was no indication in this resident's health care record that identified a Braden Scale Assessment or a head to toe assessment was completed after the injury that occurred in 2013. This Resident has also suffered from pressure ulcers to coccyx in the recent past. The inspector identified that the last head to toe assessment was conducted on August 29, 2013 when the Resident returned from hospital for another reason.

The inspector identified that the above information is not indicated in this resident's care plan. The care plan does not identify this resident's preference nor were any of the treatment orders on the care plan. The inspector identified that the last care plan review was completed recently.

Inspector #544 reviewed the home's Wound and Skin Care program. The program indicates that care plans are developed based on these assessments in order to direct the nursing, personal care and other needs of the Resident.

Consequently, the care plan is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's special treatments and interventions. [s. 26. (3) 18.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration as well as special treatments and interventions related to skin and wound, to be implemented voluntarily.***

---

**WN #3: 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).**

**s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,**
**(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).**

---

**Findings/Faits saillants :**

1. - On June 2, 2014, Inspector #158 observed the lunch meal service in one of the neighbourhoods. It was written on the menu board in the residents' dining room, that the second choice for the vegetable was brussel sprouts. The Inspector observed that only beans were served. The FSW identified that brussel sprouts were not provided for the meal service.

Consequently, the licensee failed to ensure that all menu substitutions were communicated to residents and staff. [s. 72. (2) (f)]

2. On June 12, 2014, Inspector # 158 observed the supper meal service in one of the neighbourhoods. It was written on the menu board that Italian style vegetables were the vegetable for the first meal choice. The Inspector observed that mixed vegetables were served. The FSW identified that only regular mixed vegetables were provided.

Consequently, the licensee failed to ensure that all menu substitutions were communicated to residents and staff. [s. 72. (2) (f)]

3. On June 2, 2014, Inspector #158 observed the following in one of the neighbourhoods serveries prior to the start of the meal service:

-the counters in the neighbourhood servery were sticky to touch and had food debris (crumbs) on it
-the floor in the neighbourhood was littered with paper debris, food debris, sand and grit
-obvious juice spillage was observed in the refrigerator in the neighbourhood
-a white and rust coloured residue present on the ice machine
-the walls in the servery areas had possible food splatters
-equipment such as the freezer doors, paper towel holders and microwave were stained and in need of cleaning
-the floor of the area between the serveries was littered with paper debris, food debris, sand and grit
-a build-up of dirt and debris was present in the corners in both serveries
The home does have a "Servery Kitchen Cleaning "schedule, which outlines the breakdown on how, what and when the specific cleaning tasks are done. Specific tasks, such as daily wiping the refrigerators, nightly sweeping of the servery floor, nightly wiping the paper towel holders and weekly wiping the walls down were outlined.

Consequently, the licensee failed to ensure that the staff complied with the cleaning schedule for one of the neighbourhood serveries. [s. 72. (7) (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 staff comply with the cleaning schedule for the serveries in the home, to be implemented voluntarily.***

---

**WN #4: 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:**
**6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**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. Inspector # 158 observed the lunch dining service in one of the neighbourhoods on June 2, 2014. The Inspector observed that the temperatures of the food were taken by the Food Service Worker once, which was at the start of the meal service. The items for this meal service included barley soup, macaroni and cheese, beans, chicken salad sandwiches, brussel sprouts in regular, minced and puree texture.

The regular food items were in open containers on top of the "suzy q" cart while the puree food items were stored in a compartment in the cart.

The food temperature values documented were between 168 degrees F and 190 degrees F. The meal service started at 12:15h and concluded at 13:00h. The

Inspector # 158 took the food temperatures at 12:45h, when there were 4 residents remaining to be served. Two of these remaining residents requested the regular textured macaroni and cheese with beans and one resident requested the sandwich. The fourth resident was provided with the puree textured macaroni and cheese. The temperature of the regular textured macaroni/cheese was 122 degrees F, the temperature of the puree macaroni and cheese was 138 degrees F, the temperature of the beans were 126 degrees F, and the temperature of the puree beans were 120 degrees F.

Inspector #543 spoke with resident #3360 who stated that food is often too cold. Inspector #158 spoke with resident #3351 who stated that the food is not what this resident would normally eat and the food is cold.

Consequently, the licensee failed to ensure that the food and fluids are served at a temperature that is both safe and palatable to the residents. [s. 73. (1) 6.]

2. The Inspector observed the supper meal in one of the neighbourhoods on June 12/14. It was observed that the Food Service Worker (FSW) from this neighbourhood, took the temperatures of the food items at 17:05h. It was also observed that the cook, who was responsible for servicing in the Lakeview neighbourhood did not take the food items temperatures.

Throughout, the service, the Inspector observed that the lids on the food items were not always covering the food, the drawer with the puree/minced diets was left opened at times, the dietary aide did not refer to any diet list and the dietary aide did not follow any table rotation.

The Inspector took the temperatures of the food items at 1735h, when there were 6 residents remaining. ( 30 minutes from the start of the service). Three of the residents were provided with the minced texture 2nd choice and four residents were provided with the regular texture of the first choice. The temperature values of the food items were registered below 140F.

The home's policy- "Food Service Temperatures" identified that the temperature of hot foods are held at 140F. The policy also identifies that the temperature of the food items are taken immediately prior to serving.

Consequently, the licensee failed to ensure that the food and fluids are served at a

temperature that is both safe and palatable to the residents. [s. 73. (1) 6.]

3. Inspector # 158 observed the lunch dining service one of the neighbourhoods on June 10, 2014. The Inspector observed that not all the temperatures of the food items were taken by the FSW at the start of the meal service. The Inspector observed that the table across from the resident lounge area, was served the meal first at 12:15h. At 12:50h, when resident #3395's table was served, resident #3395's family stated the hot dogs the resident was served, were cold. With permission, the Inspector took the temperature of the hot dogs which registered at 91 degrees F. The FSW admitted that she had not taken the temperature.

Consequently, the licensee failed to ensure that the food and fluids are served at a temperature that is both safe and palatable to the residents. [s. 73. (1) 6.]

4. Inspector # 158 observed the dining service in one of the neighbourhoods on June 2 and 12, 2014. On June 2, 2014, the Inspector observed that soup was placed in front of resident #3393 ten minutes before a staff member was present to assist the resident.

On June 12, 2014, the Inspector observed that the entree was placed in front of resident #3393 twelve minutes before a staff member was available to assist this resident. The Inspector reviewed this resident's plan of care which indicates this resident requires constant encouragement, to remain with resident during meals and provide intermittent assistance with eating. The home's policy -" Meal Service Routine" identified that a resident who requires assistance with eating is helped within 5 minutes of receiving their meal.

Consequently, the licensee failed to ensure that a resident, who requires assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident. [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 the food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.***

---

**WN #5: 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. Inspector #543 reviewed education attendance sheets relating to Abuse Training for the year 2013. The attendance sheets identified that 38% of the Registered Nurses, 25% of the Registered Practical Nurses and 19% of the Personal Care Assistants attended the training in 2013.

Therefore, the licensee did not ensure that all staff have received retraining annually relating to the home's policy-Zero Tolerance of Abuse and Neglect. [s. 76. (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 ensure that all staff receive retraining annually relating to the home's policy-Zero Tolerance of Abuse and Neglect, to be implemented voluntarily.***

---

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. On Jun 10, 2014, Inspector # 158 observed that a resident #3376's bed was not made and 3 urine filled urinals were on the resident's table. The urine filled urinals were again observed on the resident's table on June 11 and June 12, 2014. On June 11, 2014, this resident voiced displeasure of the bed not being made and of the urinals not having been emptied. This resident stated to the Inspector on June 11, 2014 that this happens all the time.

Consequently, the licensee failed to ensure that 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 [s. 3. (1) 1.]

**WN #7: 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).**

---

**Findings/Faits saillants :**

1. Inspector #544 reviewed resident #3418's health care record. An MDS assessment identified that the resident requires extensive assistance with personal hygiene. The assessment also indicated that the resident has dental problems and requires daily cleaning by staff or resident.

Inspector #544 reviewed resident #3418's care plan. The care plan identified a care deficit pertaining to the teeth or oral cavity characterized by problems with dentures/teeth/gums related to carious teeth. The goal identified, is to attain/maintain unbroken oral membranes and for the resident to be able to eat and drink free of pain and to provide appropriate oral hygiene. The care plan does not clearly identify interventions in providing oral care for this resident.

Consequently, the licensee failed to ensure that the plan of care sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector #544 reviewed resident #3371's care plan. The care plan identified that the resident receives nail care by an outside source (Retire at Home). Inspector spoke with this resident's family member, who indicated that the service was paid for, but the resident did not receive the care due to behaviours the resident exhibits. Inspector spoke with the RPN who confirmed that the statement "toe nail care is provided by an outside source" is referring to Retire at Home services. The inspector also spoke with

a PCA who provides regular care to this resident, and confirmed that the resident does exhibit behaviours which makes it difficult for the outside source to provide nail care to the resident.

Consequently, the licensee failed to ensure that the plan of care sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Inspector # 544 reviewed Resident # 3380's care plan. The care plan indicated that Resident # 3380 was at high risk for skin issues and ulcers. The care plan did not identify a current skin tear that has been ongoing since July of 2013.

Consequently, the licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Inspector #158 reviewed resident #3371's MDS assessment and identified that the resident requires the assistance of two staff members relating to toileting and transferring. On June 9, 2014, Inspector observed the PCA providing toileting assistance to resident #3371 as per the care plan. The inspector reviewed the resident's care plan. The care plan indicated that this resident requires one person constant supervision and total physical assist for toileting and transferring.

On June 12, 2014, Inspector #158 spoke with the RPN, who verified that resident #3371 is a one person total assist with transferring and toileting. The RPN also identified that they did not complete the assessment and was unaware that the MDS assessment identified that resident # 3371 required the assistance of two staff related to toileting and transferring assistance.

On June 12 at 16:45h, Inspector # 158 observed a resident wandering the halls of one of the neighbourhoods, wearing pajamas. The resident had previously been observed (14:45h) wearing street clothes. A PSW stated, that the resident's care plan identifies that the resident can be changed into pajamas before supper. Inspector # 158 reviewed the resident care plan. It is documented that if the resident refuses to change and clothes that are still clean, the resident can stay in previous outfit. There is no direction to change the resident into pajamas before supper.

Consequently, the licensee 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 of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. [s. 6. (4) (b)]

---

**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. Inspector #543 reviewed three census sample residents' immunization records and identified that there were some discrepancies in regards to TB testing/screening. Therefore, Inspector reviewed a larger size sample, a total of 9 resident immunization records and the following was identified:

-resident# 3380 : TB screening step 1 was administered November 22nd, 2013 and Step 2 was administered December 5th, 2013. (Resident admitted to home June 5th, 2009). This does not comply with the home's Policy- TB Skin Testing which states that the resident will be screened for TB within 14 days of admission. Inspector #543 spoke with DOC who confirmed that the TB screening was not done according to the home's policy.

-resident# 3353: TB screening step 1 was administered May 16th, 2005 and Step 2 was administered May 24th, 2005. (Resident admitted to home May 10th, 2005). This does not comply with the home's Policy- TB Skin Testing which states that the Step 2 of the TB screening will be done 2-3 weeks after Step 1, in this case Step 2 was done 8 days after step 1.

-resident# 3393: TB screening step 1 was administered August 5th, 2010 and Step 2 was administered September 24th, 2010. (Resident admitted to home July 13th, 2010). This does not comply with the home's Policy- TB Skin Testing which states that

the resident will be screened for TB within 14 days of admission. Inspector #543 spoke with DOC who confirmed that the TB screening was not done according to the home's policy. Also, this does not comply with the home's Policy- TB Skin Testing which states that the Step 2 of the TB screening will be done 2-3 weeks after Step 1, in this case Step 2 was done more than 1 month after step 1.

-resident# 3357 : TB screening step 1 was administered July 19th, 2006 and Step 2 was administered July 26th, 2006. (Resident admitted to home July 3rd, 2006). This does not comply with the home's Policy- TB Skin Testing which states that the Step 2 of the TB screening will be done 2-3 weeks after Step 1, in this case Step 2 was done 7 days after Step 1.

-resident# 3371: TB screening step 1 was administered January 27th, 2009 and Step 2 was administered February 9th, 2009. (Resident admitted to home October 7th, 2008). This does not comply with the home's Policy- TB Skin Testing which states that the resident will be screened for TB within 14 days of admission. Inspector #543 spoke with DOC who confirmed that the TB screening was not done according to the home's policy.

Consequently, the licensee did not ensure that their Policy- TB Skin Testing was complied with. [s. 8. (1)]

2. Inspector # 544 reviewed the Medical Pharmacies Pharmacy Policy and Procedure Manual for LTC Homes (Section 3- Medication System- The Medication Pass Policy 3 -6). The policy indicates that staff are to administer medications and ensure they are taken. It was noted at the bottom of the policy, in a square box written in bold letter - Do NOT leave resident's medication at the bedside unless following self-administration policy and procedure (St. Joseph's Villa Clinical Services Manual- Issued April 5, 2013- self- Administration of Medications).

On June 2, 2014, Inspector #544 observed in the Hillcrest neighbourhood that resident#3441 had six pills in a medication cup at their table. The resident had completed their meal and the pills were still not taken by resident #3441. The inspector spoke with the RPN who admitted to leaving the medication on the dining room table and did not give the medication to the resident and did not wait to ensure that the medications were taken. The RPN confirmed that this method of giving medications did not follow the home's policy.

On June 2, 2014, Inspector # 158 observed that resident # 3342 prescribed medicated cream was left on the bedside table. The label on the topical cream identified that the cream was to be applied 1 or 2 times a day. The label did not indicate that the cream could be left at the bedside or self- administered by the resident. On June 12, 2014, Inspector # 544 observed that this same cream was still at the resident's bedside. The Inspector notified the RPN and it was promptly removed and placed in the discard bin.

The home's policy- Self- Administration identifies that a doctor's order stating that the resident could self-administer their medication, the resident is in consultation with the doctor to determine the resident's capability to self-administer these medications and the resident is to meet with the Pharmacist to educate the resident about the need for proper use of the medication.

On June 5, 2014, Inspector #544 observed resident #104 with pills in a medication cup at the breakfast table. There was no staff member at the table at that time. A short time later, the RPN gave a pill to resident #104 via spoon from that container and a drink and then left the table. The rest of the medications were still on the table. The RPN returned to give this resident another medication and left the table again with the remaining pills on the table during the breakfast meal. The pills remained in the medication cup for 3 minutes more on the table (unattended) and then the medication cup, with medications in it, was removed by the RPN.

On June 10, 2014, Inspector # 544 observed medication being given in the Lakeview Neighbourhood. The inspector observed the RPN leaving resident #101's medications in a medication cup, at the breakfast table, for the resident to take their medications alone without supervision. The RPN did not ensure that the medications were taken.

Consequently, the licensee did not ensure that their policy- Medical Pharmacies Pharmacy Policy and Procedure Manual was complied with. [s. 8. (1)]

---

**WN #9: 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. On June 6, 2014, Inspector # 158 observed posted on the board in the resident's room that the family requests that the resident receives a jam sandwich at bedtime. Inspector noted that resident # 3371's bedroom was littered with bread crusts from a jam sandwich and grapes at 10:00h. The family member who was present at the time of the observation stated to the Inspector that bread crumbs and debris are often on the floor, when they come in at 11:00h. [s. 15. (2) (a)]

2. On June 2, 2014, at 1230hrs, Inspector # 544 observed that the piano stool's seat cover was stained with dark fluid-like splashes. In an interview with Inspector # 544, resident # 3395's family stated "My mother's room is clean but the common areas and dining rooms are not. The table tops are not washed after the tablecloths have been removed." The Inspector observed that the dining room chairs in the Hillcrest neigbourhood had a sticky like jam substance and other food materials on the arms. [s. 15. (2) (a)]

3. On June 2, 2014, Inspector noted that the dining room chairs and tables in one of the neighbourhoods were sticky and soiled. Although the tables were covered by a tablecloth, the tables were sticky with food debris. This was once again observed on June 10 and 12, 2014.

Inspector # 544 also observed that the dining room chairs and tables in one of the neighbourhoods were sticky and soiled. Although the tables were covered by a tablecloth, the tables were sticky with food debris.

Consequently, the licensee failed to ensure that the furnishings in one of the neighbourhoods are kept clean and sanitary. [s. 15. (2) (a)]

4. Throughout the Inspection random audits of the four home area neigbourhoods was

conducted.

On June 03, 2014, Inspector # 158 observed that walls in rooms 101,106,117,110 in one of the neighbourhoods were scratched and required painting. Lingering urine odour noted in halls, some resident chairs and sitting areas are stained.

On June 04, 2014, Inspector # 158 observed that the hallways and handrails in one of the neighbourhoods were scratched and required painting. Scratches and gouges were observed on the resident's walls in bedrooms/bathrooms # 107, 111, 118, 131 located in one of the neighbourhoods.

On June 09, 2014, Inspector # 158 observed that the hallways and handrails in one of the neighbourhoods were scratched and required painting. Scratches and gouges were observed on the resident's walls in bedrooms/bathrooms # 202, 203, 212, 214, 222, 216, 225 and 232, located in one of the neighbourhoods. Scratches and gouges were observed on the resident's walls in bedrooms/bathrooms # 208, 215, 218, 214 and 220, located in one of the neighbourhoods.

Consequently, the licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

5. On June 2, 2014, Inspector #544 observed during her tour that the condition of the floors in the elevators and in all of the neighbourhoods hallways and common areas floors were scratched and marked with black marks.

Consequently, the licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

---

**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care**

**Specifically failed to comply with the following:**

**s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
**(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).**
**(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).**
**(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

**s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).**

**Findings/Faits saillants :**

1. Resident # 3418 was admitted to the long-term care home in 2011. The Resident's SDM signed a consent form for an oral assessment to be conducted. The inspector could not find any dental assessment on admission. No documentation on this resident's dental status on admission or thereafter was identified.

Inspector # 544 reviewed the home's Policy-Dental Services. The policy indicated that "annually, the dentist visits the Villa to screen all consenting residents".
Inspector #544 reviewed resident # 3418's health record and identified that the assessment was never performed. The assessment forms in this resident's health record are blank.

Therefore, the licensee failed to ensure that this resident received oral care to maintain the integrity of the oral tissues that includes, an offer of an annual dental assessment and other preventative dental services. [s. 34. (1) (c)]

2. Inspector #544 reviewed resident #3338's health record, care plan and point of care documentation for personal hygiene which includes mouth care.

Inspector #544 reviewed resident #3338's care plan which identified that due to this resident's inability to use utensils, this resident needs to be fed. Also, because this resident suffers from dysphagia and chokes easily, there is still a need for adequate

hydration and maintain a stable weight. This resident's care plan also identified that resident # 3338 requires thorough oral care three times daily, after meals and at bedtime. This resident has upper and lower dentures and staff will provide total assistance with removing and brushing dentures every morning, after each meal and at bedtime.

This resident's Point of Care documentation indicated that denture care is only being done twice during the day, once on day shift and once on afternoon shift.
The inspector spoke with resident #3338 who confirmed that oral care is only being provided once a day.

Therefore, the licensee failed to ensure this resident received assistance to insert dentures prior to meals and at any other time as requested by the resident. [s. 34. (2)]

3. Inspector #544 interviewed resident #3395's family member who stated that this resident does not get their oral care as per the care plan. This resident's care plan identified that the "resident requires staff to provide total assistance to remove and brush dentures after meals and at bedtime". Inspector #544 interviewed resident #3395's regular PCA who stated that she is the regular caregiver on day shift for this resident. She states she puts this resident's dentures in, in the morning, and afternoon staff will remove them at bedtime. Mouth care should be provided twice a day. This resident does not receive mouth care after meals. The PCA confirmed that what is included in this residents' plan of care related to personal support services and mouth care is not correct.

This resident's family member stated that they often find food in this resident's mouth post meals and their dentures, partial plate and mouth are not cleaned. This resident takes a long time to eat and tends to "pocket food" and needs to be reminded to swallow.

Inspector #544 spoke with this resident's family member who stated, "I sit with this resident almost everyday for 6-8 hours and have not seen mouth care being provided. This resident does resist care at times but when I am with them, they are quieter."

Inspector #544 spoke with Life Enrichment Assistant (LEA) who stated that this resident joins in activities after breakfast almost daily. After breakfast this resident is left in the dining room for the exercise program.

Inspector #544 observed that resident #3395 remained in the dining room from 0930 hours to 1000 hours sitting in their wheelchair awaiting the activity. The PCA did not take the resident back to their room to provide mouth care after breakfast.

Inspector # 544 reviewed the documentation of tasks in Point Click Care which identified that resident #3395 receives mouth care twice a day, once in the morning and once at bedtime. This is not consistent with the care plan. Also, the MDS assessment for this resident indicated that mouth care is to be provided daily.

Therefore, the licensee failed to ensure this resident received assistance to insert dentures prior to meals and at any other time as requested by the resident. [s. 34. (2)]

---

**WN #11: 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,**
**(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,**
**(i) within 24 hours of the resident's admission,**
**(ii) upon any return of the resident from hospital, and**
**(iii) upon any return of the resident from an absence of greater than 24 hours;**
**O. Reg. 79/10, s. 50 (2).**

**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. Inspector #544 reviewed resident #3395's health care record, care plan, progress notes, inter-professional team notes and wound care assessment tools. The inspector could not find any documentation or records regarding a skin assessment having been completed after this resident returned from the hospital after a fall in 2014. This fall resulted in injuries.
Consequently, the licensee failed to ensure that resident #3395 received a skin assessment by a member of the registered nursing staff upon returning from the hospital. [s. 50. (2) (a) (ii)]

2. Inspector # 544 reviewed resident #3380's health record which identified that this resident was admitted to the home in 2009 and this resident's first head to toe assessment was completed in November 2009. Another head to toe assessment was completed in November 2011 and there has not been another since this date. In 2012 a Braden Scale assessment was done as well as documentation indicating a pressure

sore on this resident's heel and that this resident is identified as being at high risk for wounds. This resident's care plan did not identify a skin tear from 2013 that is still present.

The inspector identified that there has not been a head to toe assessment completed or a skin assessment completed using an appropriate clinical tool since November 2011 even though skin tears persist even now.

Consequently, the licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdowns, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

3. Inspector #544 reviewed resident #3360's health record, progress notes and MDS assessment. The inspector identified that this resident was sent to the hospital in 2013 from an injury that required sutures. The physician provided orders for the care of injury. These orders were discontinued in January 2014. In February 2014, the resident asked to keep the dressing on their leg for protection and fear of having the wound open again. Recently, the wound became a skin tear and a dry dressing order was initiated.

There was no indication in this resident's health care record that identified a Braden Scale Assessment or a head to toe assessment was completed after the injury that occurred in 2013. This Resident has also suffered from pressure ulcers to coccyx in the recent past. The inspector identified that the last head to toe assessment was conducted in 2013 when the Resident returned from hospital for another reason.

Consequently, the licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdowns, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. Inspector #158 reviewed resident #3382's progress notes which indicated that in 2014 this resident had taken their brief off, voided on the floor and slipped and fell. According to the progress notes, resident #3382 is incontinent of urine daily, saturates their bed and removes the brief. There were two documented episodes of urinary incontinence in 2014, where the resident was incontinent of urine and removed their brief. There were no documented episodes of urinary incontinence in March 2014. There were eight documented episodes of urinary incontinence in April 2014, where the resident was incontinent of urine and removed their brief. In May 2014, there were six documented episodes, where the resident was incontinent of urine and removed their brief. In June 2014, there were 6 documented episodes where the resident was incontinent of urine and removed their brief.

An MDS assessment was completed by the RPN on May 8, 2014 which identified that resident #3352 is incontinent, however, the assessment did not include the type and frequency of physical assistance necessary, daily patterns of incontinence or environmental risk factors or conditions that may affect continence.

Therefore, the licensee failed to ensure that the resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

1. On June 2, 2014, Inspector # 544 spoke with resident #3351 who stated they are in constant pain and winced when touched by Inspector #544. On June 5, 2014, the resident stated to Inspector #158 that the pain is mostly on the left side and although they receive analgesia, the pain remains. The RPN stated to the Inspector that resident #3351 was in daily pain and receives Tylenol on a regular basis, which is not always effective. When questioned by the Inspector as to the assessment of the resident's pain and the evaluation of effectiveness of their pain management, the RPN stated that this resident's pain is assessed at the time of the administration of the medication and documented in the MARS. The RPN was not aware of any other pain assessment form to complete.

The inspector reviewed the home's policy-Pain Management Program which stated that an assessment of a resident's pain is completed on admission and whenever necessary (prn). The policy further stated that the strategies to manage the resident's pain are documented on the plan of care and that Registered staff evaluate the plan of care quarterly.

The DOC identified that a formal assessment is completed in Point Click Care on admission. She stated that the evaluation of pain is documented in the progress notes.
Inspector #158 reviewed resident #3351's health care record, which included assessments, the progress notes and the plan of care. It was identified in the RAI quarterly assessment (under health conditions) completed in 2014, that the resident has moderate pain. An assessment using a clinically appropriate assessment instrument specifically designed for pain assessment was not found. The last pain assessment found in Point Click Care was from 2010.
Interventions, such as, reposition every two hours, administer pain medication as per MD order and document effectiveness and complete a pain assessment tool quarterly and PRN were documented on resident #3351's care plan.

Inspector #158 reviewed resident #3351's Medication Record. The physician ordered

Tylenol which was given as ordered on June 9, 2014 at 11:05hrs. Although, it was documented that the pain medication was effective, the Inspector observed at 11:30h, that when this resident moved in bed, they winced in pain and the resident stated that the medication only lasts a short while.
Resident #3351's progress notes were reviewed and in 2014, resident #3351's pain was not assessed using a clinically appropriate assessment instrument when the pain was not relieved by the initial interventions.

Consequently, the licensee failed to ensure that when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

---

**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

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

---

**Findings/Faits saillants :**

1. On June 2, 10, and 12, 2013, Inspector # 158 observed the meal service in one of the neighbourhoods. The Inspector observed that the meal service started at the same table each time. The FSW stated to Inspector # 158, that they do not follow a specific plan for table rotation for the meal service. The home's policy titled "Meal Service Routine" identified that the order of the meal service is rotated so that residents have the opportunity to be served first.

The home's policy- Meal Service Routine related to table rotation was not implemented.

Therefore, the licensee failed to ensure that the nutrition care and hydration policies and procedures relating to nutrition and dietary service were implemented. [s. 68. (2) (a)]

2. A new routine for meal service using "suzy q" carts to deliver resident's food at the dining room table was implemented in the fall of 2013. This cart, which houses all of the cooked food items for the meal, is pushed to each table by the FSW. Together with the FSW, the RN/RPN assists, by referring to the diet list and providing the correct diet to the FSW so that the proper diet is given to the resident. The routine further identifies that the PSWs will refer to the diet list and seating plan when beverages are distributed to the residents. The routine also indicates that, the staff will wash their hands between residents and after clearing dishes from the table and that desserts are served after the soup bowls and entrée plates are removed.

During the Inspection, Inspector # 158 observed three meal services in one of the neighbourhoods. The Inspector did not observe that the diet list or seating plans were referred to at any time during the service. The RN/RPN only identified the residents' choice and not their diet. The Inspector observed that on the first day of observation (June 2, 2014), some of the PCA staff did not wash their hands after feeding a resident or after removing the soiled bowls or plates. It was also observed that the staff did not ensure that resident hands and faces were cleaned of food debris when they are finished their meal.

The home did not implement its new procedure related to the use of "suzy q" carts.

Therefore, the licensee failed to ensure that the nutrition care and hydration policies and procedures relating to nutrition and dietary service were implemented. [s. 68. (2) (a)]

**WN #15: 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. On June 2, 2014, Inspector #544 noted a lingering urine odour in one of the neighbourhood hallways and in room #218. Inspector #158 noted this odour on June 10, 11 and 12, 2014. As well, Inspector #158 noted that a urine odour was present in one of the neighbourhoods on June 3, 4, 9 and 10, 2014.

During an interview on June 9, 2014 with Inspector #158, the Environmental Services Manager, verified the presence of the odours.

Therefore, the licensee failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. Inspector #543 reviewed a complaint log regarding concerns of abuse for resident #3395. Upon further review of the complaint log inspector identified that resident #3395 was transferred to hospital and assessed for a fall resulting in injuries that occurred in 2014. Inspector noted that there was no critical incident submitted for the fall incident. Inspector #543 spoke with Site Administrator, who confirmed that in fact no critical incident was submitted.

Consequently, the licensee failed to ensure that the Director is immediately informed of an incident that caused an injury to a resident for which the resident is taken to a hospital and that resulted in significant change in the resident's health condition. [s. 107. (3)]

**WN #17: 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. On June 2, 2014, at 1530 hours, Inspector #158 observed that the medication cart, which was in the hallway in one of the neighbourhoods, was unlocked and unattended. The RPN was in resident's room #129 with the door closed. Two other residents, who were wandering in the hallway, were observed in this area at this time.

On June 9, 2014 at 0850 hours, Inspector #544 observed that the medication cart, which was in the dining room in one of the neighbourhoods, was unlocked and unattended while the RPN was giving medication to a resident in the dining room The RPN had his back turned away from sight of the cart.

Consequently the licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)]

2. On June 2, 2014, Inspector #158 observed that resident #3342 prescribed medicated cream was at left on their bedside table. The label did not indicate that the cream could be left at the bedside.

On June 12, 2014, Inspector #544 witnessed that this same cream remained on the resident's bedside table and was removed by the RPN and placed in the discard bin.

Consequently the licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)]

**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply**

**Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:**

**1. All areas where drugs are stored shall be kept locked at all times, when not in use.**

**2. Access to these areas shall be restricted to,**

**i. persons who may dispense, prescribe or administer drugs in the home, and**

**ii. the Administrator.**

**3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.**

**Findings/Faits saillants :**

1. On June 11, 2014 at 0910 hours, Inspector #544 witnessed the RPN, in one of the neighbourhoods, give the medication room keys to the dietitian. The dietitian opened the medication room door and proceeded to look at a chart for a very short period of time. She then ensured the medication room door was locked and returned the keys to RPN.

Consequently, the licensee failed to ensure all areas where drugs are stored, are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

**WN #19: 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. On June 05, 2014, Inspector #544 observed the RPN administering medication, to the residents in one of the neighbourhoods, in the dining room during the lunch meal.

One resident received insulin in their arm while waiting for lunch. Another resident received their medications while eating lunch. The inspector also observed that the RPN did not wash her hands in between giving the resident's their medications. As well, the RPN kept pulling their hair back away from their face while giving the medication and no hand-washing was observed in between. The inspector did not observe any sanitizer on the cart for the RPN's to use in place of washing their hands at a sink.

Inspector #544 observed the RPN on June 5, 2014 administer medications to the residents in one of the neighbourhoods. After administering the medications to the residents, the RPN began feeding residents and did not wash their hands before starting to feed the residents.

On June 9, 2014, Inspector # 544 observed the RPN administer medications again at breakfast and noted that they did not wash their hands between giving medications to the residents. Again, no sanitizer was observed on the medication cart to use on their hands when the RPN was not near a sink.

Inspector #544 observed on June 10, 2014 in one of the neighbourhoods where the RPN was administering medications to the residents while they were eating. The inspector also noticed there was a hand sanitizer on the cart, however the RPN did not use the sanitizer.

On June 11, 2014, Inspector #544 observed the RPN returning medications to the medication cart that was in the medication room. The RPN put them aside on the medication cart, picked up the stylis and signed off on the eMar. This same RPN then proceeded to the dining room, put a blue apron on and started feeding some residents who required assistance. Not once did the Inspector observe the RPN wash their hands or sanitize their hands between these tasks.

Consequently, the licensee failed to ensure that all staff participate in the implementation of the Infection Control Prevention and control program. [s. 229. (4)]

2. Inspector # 158 observed the lunch meal in one of the neighbourhoods on June 9, 2014. The Inspector observed that the PSW was clearing the dirtied dishes off the resident's tables and then assisted a resident without washing their hands prior to providing assistance.

Consequently, the licensee failed to ensure that all staff participate in the implementation of the Infection Control Prevention and control program. [s. 229. (4)]

---

**Issued on this 23rd day of June, 2014**

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