Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 18, 2014	2014_250511_0016	H-000952-14	Resident Quality Inspection

Licensee/Titulaire de permis

MENNONITE BRETHREN SENIOR CITIZENS HOME
1 Tabor Drive, St. Catharines, ON, L2N-1V9

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

MENNONITE BRETHREN SENIOR CITIZENS HOME
1 Tabor Drive, St Catharines, ON, L2N-1V9

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

ROBIN MACKIE (511), MICHELLE WARRENER (107), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 22, 23, 25, 28, 29, 30 and 31, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director, Director of Care (DOC), Assistant Director of Care (ADOC), Maintenance Supervisor, Nutrition Manager and Environmental Services Supervisor, Therapeutic Recreation Supervisor, Registered Dietitian (RD), registered staff, Personal Support Workers (PSW), RAI Coordinator, residents and family members.

During the course of the inspection, the inspector(s) observed the provision of resident care, reviewed clinical and administrative records, and the home's applicable policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #042 had their right to be properly cared for in a manner consistent with their needs.

In July 2014, it was observed by the inspector that resident #042 was seated in a wheelchair and had requested multiple times to go back to bed. A staff member seated in the area responded to the resident each time the resident asked to go back to bed and told them they would have to wait until after lunch.

When the inspector inquired why they had not put resident #042 to bed when the resident requested this, the staff member indicated that full time staff had told them the resident was to stay up until after lunch. A review of the resident's clinical record indicated that the resident had pain issues and during the interview with this staff member, the staff confirmed that the resident had pain.
It was confirmed by the Director of Care that the staff should have put the resident to bed when the resident had requested. The DOC also confirmed resident #042 had ongoing issues of pain. [s. 3. (1) 4.]

2. The licensee did not ensure that the following right of residents were fully respected and promoted: 11. Every resident had 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.

In July 2014, during an observation of the medication administration process it was observed that the residents' discarded medication pouches were placed in the general garbage for disposal. Interview with the registered staff confirmed the discarded medication pouches contained the residents' names and name of prescription drugs and were not altered for the removal of personal information prior to being discarded in the general garbage.
The Director confirmed the residents' personal health information, within the meaning of the Personal Health Information Protection Act, 2004 had not been kept confidential in accordance with that Act. [s. 3. (1) 11. iv.]

3. The licensee did not ensure that the resident's rights were fully respected and promoted: 19. Every resident had the right to have his or her lifestyle and choices respected.

During this inspection, it was identified that there were several complaints from residents that the temperature of the building was not comfortable for them. Residents' indicated that the home was too cold in some of the resident's rooms and several areas throughout the home. A review of the Resident Council minutes indicated that the issue had been brought forward during these meetings and these complaints had been acknowledged by the home's management team.
The Director confirmed that there had been on going concerns related to the temperature of the building. [s. 3. (1) 19.]

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 rights of residents are fully respected and promoted and specifically that the residents have their 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 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
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).

Findings/Faits saillants :

1. The licensee did not ensure that there was a process that food service workers and other staff that assisted residents were aware of the residents' diets, special needs and preferences.

The "Resident Profile" reference book, located in the servery on the third floor for staff reference during meal service, did not provide direction to dietary staff in relation to the special dietary needs identified in resident #007's plan of care. Staff stated during interview that the information in the "Resident Profile" should have been consistent with the information in the resident's plan of care.

The plan of care for resident #007 directed staff to provide extra meat servings and extra vegetable servings at meals. This information was not provided for dietary staff in the reference binder. At the noon meal service July 28, 2014, the resident was not offered extra servings of meat. The therapeutic extension menu identified a portion as one #10 scoop of pureed salmon (94.5 millilitres, mL). The resident was served one #8 scoop (118 mL) instead of two #10 scoops (189 mL). Dietary staff confirmed that only one scoop was provided. The resident was below their target body weight range and had significant weight loss noted. The resident was at a nutrition risk. [s. 73. (1) 5.]

2. The licensee did not ensure that all food was served at a temperature that was both safe and palatable to the residents.

A) Several residents voiced concerns of cold food during the Stage One interview of this inspection. Cold food was also identified by residents as an issue in the Residents' Council meeting minutes for November 4, 8, 2013, and through the Resident Satisfaction Survey discussed at the November 8, 2013 meeting.

B) A review of food temperature monitoring records for the month of July 2014, reflected that not all of the hot food was served at a minimum of 140 degrees Fahrenheit (F)/ 60 degrees Celsius (C) and cold foods below 40 degrees F/4 degrees C (as per the home's policy "Meal Service Standards", dated April 2013).

i) First floor temperature monitoring records for month of July /14:
- July 27/14 Breakfast - hard boiled egg 131 F
- July 26/14 dinner - cheddar cheese - 57.4 F, pureed cheddar cheese plate - 61.8 F
- July 25/14 dinner - minced Scandinavian vegetables - 139F
- July 13/14 Breakfast - boiled eggs 113.4 F, pureed scrambled eggs 130.8 F
- July 12/14 dinner - apple crisp 120.8 F
- July 9/14 breakfast - hard boiled egg 106 F
- July 7/14 dinner - no food temperatures recorded (mac and cheese, broccoli, pork roast, choc mousse)

ii) Second Floor food temperature monitoring records for July /14:
- No food temperatures recorded July 19/14 dinner; July 17/14 dinner, July 1/14 dinner
- July 13/14 breakfast - oatmeal recorded at 210 F, cream of wheat recorded 204 F
- July 6/14 breakfast - hard boiled egg 137F
- July 3/14 dinner - pureed farmers sausage 132F

iii) Third Floor food temperature monitoring records for June 30-July 29/14:
- June 30/14 lunch - minced broccoli 132 F
- July 6/14 breakfast - hard boiled eggs 123.6 F, butterscotch pudding 61.7 F
- July 9/14 breakfast - boiled egg 139 F
- July 15/14 dinner - baked apple - 118 F
- July 17/14 dinner - no food temperatures recorded - chicken, ham, broccoli, waffles, soup
- July 19/14 - dinner - no food temperatures recorded (cabbage rolls, pudding, grilled cheese, potato salad, italian veg mix,
- July 25/14 breakfast - hard boiled eggs 137F
- July 26/14 dinner - only 1 meal choice had food temperatures recorded

iv) Fourth Floor temperature monitoring records for July/14:
- July 29/14 breakfast - French toast 139 F
- July 28/14 lunch - pureed boiled potatoes - 138 F, broccoli 138 F
- July 27/14 - breakfast - hard boiled egg 135F
- July 23/14 lunch - mashed potatoes pearls - 138 F
- July 23/14 breakfast - hard boiled egg 118 F
- July 22/14 lunch - mashed potatoes 138 F
- July 20/14 lunch - mashed potatoes instant 136 F
- July 20/14 breakfast - pureed muffin 138 F
- July 19/14 breakfast - hard boiled egg 120 F
- July 17/14 breakfast - hard boiled egg 136 F
- July 15/14 dinner - no food temperatures recorded
- July 15/14 lunch - mashed potato pearls 133 F
- July 13/14 breakfast - pureed scrambled eggs - 138 F, hard boiled eggs 125 F
- July 9/14 breakfast - hard boiled eggs 119 F
- July 8/14 dinner - food temperatures not recorded
- July 6/14 lunch - instant mashed potatoes - 127 F
- July 6/14 breakfast - hard boiled eggs 123 F
- July 5/14 lunch - instant mashed potatoes 134 F
- July 2/14 breakfast - hard boiled egg 122 F [s. 73. (1) 6.]

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 all food is served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee did not ensure that a drug was destroyed by a team acting together and composed of, (a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist.

During a review of the July, 2014 Resident Individual Narcotic and Controlled Drug Count Sheet, for resident #041, it was identified that a whole narcotic patch (25mcg) was provided by pharmacy, only half the patch (12.5mcg) was applied to the resident and the remaining 12.5 mcg of the narcotic was not accounted for by a registered staff member prior to disposal. A review of the clinical record identified in April, 2014, confirmed the treating physician ordered half of a 25 mcg patch to be applied to the resident's skin every 72 hours and the used patch to be removed at the same time. Interview with the registered staff member confirmed the used patch, that was removed, still had 12.5 mcg of the narcotic still unused when it was discarded in the home's biohazard waste container and that there was only one nursing signature for the disposal and destruction of the narcotic.
It was confirmed by the Director that the home did not ensure that a controlled drug was destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Care and Personal Care, and (ii) a physician or a pharmacist. [s. 136. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a controlled drug will be destroyed by a team acting together and composed of, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the staff participated in the implementation of the infection control program.

It was observed by the inspector on July 28, 2014, that in the first, second, and fourth floor spa rooms, more that 50 per cent of the nail clipper drawers contained nail clippings sitting in the bottom of the drawers. In the second and fourth floor spa room, it was observed that unlabelled items were lying on the counters which included used nail clippers, a hair brush, and roll on deodorants.
It was confirmed by staff that the nail clippings should be discarded to prevent nail clippings from getting into the drawers and that the unlabelled personal items should have been labelled to identify which resident they belonged to for infection control. [s. 229. (4)]

2. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission.

Residents #035, #036 and #038 were admitted to the home in August, 2013. These residents were not screened for tuberculosis (TB) until October, 2013.
It was confirmed by the ADOC and the Director that the residents were not screened for TB within 14 days of admission. [s. 229. (10) 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 staff participate in the implementation of the infection control program as it relates to the spa rooms and unlabelled personal items, to be implemented voluntarily.

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out, (a) the planned care for the resident; (b) the goals the care was intended

to achieve; and (c) clear directions to staff and others who provided direct care to the resident.

A) Resident #041's September 2013 Minimum Data Set Resident Assessment Instrument (MDS-RAI) had indicated the resident had been usually continent of their bowel's upon their admission. In December 2013, according to the MDS-RAI the resident had demonstrated worsening bowel incontinence in which they were frequently incontinent. A review of the resident's written plan of care did not include planned care, a goal or clear direction to staff and others who provided care with respect to bowel elimination to resident #041. Interview with the RAI Coordinator confirmed the resident's written plan of care did not include planned care, goals or clear direction for bowel elimination to staff and others who provide direct care to the resident.

B) The plan of care for resident #032 did not provide clear direction to staff who provided direct care to the resident. The plan of care related to bathing identified the resident received a bath on Sunday and Thursdays. The Kardex, which provided direction to the staff, also referenced Sundays and Thursdays for the resident's scheduled bath. The posted bathing schedule identified the resident received a bath on Tuesdays and Fridays.
The PSW that provided care to the resident stated they were unable to identify which days of the week the resident had been bathed. Clear direction was not provided to staff and others who provided direct care to the resident. (107) [s. 6. (1) (c)]

2. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #008 so that their assessments were integrated, consistent with and complemented each other.

The Minimum Data Set (MDS) coded for resident #008 in September, 2013, indicated that the resident did not have verbal and or physical abusive behaviours present. The resident's clinical records in September, 2013, indicated that the resident did have incidents of verbal and physical aggression, which were also identified as a focus on the resident's care plan.
It was confirmed by the RAI Coordinator that the assessments were not integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee did not ensure that the care set out in the plan of care was provided to residents as specified in the plan.

A) The care set out in the plan of care was not provided to resident #016 as specified in their plan at the lunch meal on a specific day in July, 2014.
The plan of care for resident #016 stated that the resident was to be provided a glass of soda at lunch, supper and afternoon nourishment. In addition, staff were to offer juice, white and chocolate milk at meals. The plan of care also directed staff that a beverage should be diluted to avoid overly hot liquid. The resident was offered the soda and no other fluids. During interview, a Personal Support Worker (PSW) stated that the resident had always been given only one soda at meals. The resident was not meeting their hydration goal on 8/13 days during July, 2014.

B) In June, 2014, resident #008 fell out of a wheelchair. The clinical record indicated that the staff seated the resident in the wheelchair for dinner which did not have a seat belt that could be properly applied, contributing to the resident's fall. Resident #008's care plan indicated that staff were to ensure a seat belt was in place when the resident was in the wheelchair.
It was confirmed by the RAI Coordinator that the staff had not provided care to resident #008 as specified in the plan.(508) [s. 6. (7)]

4. The licensee did not ensure that the residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident # 017's lower dentures were reported missing in 2012 and were not replaced. The PSW accessed the most recent plan of care on July 29, 2014 and indicated the resident had both upper and lower dentures. Interview with the RAI Coordinator confirmed the plan of care was not reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

B) Resident #008 required a front fastening seat belt when up in the wheelchair for safety. The clinical records indicated that the resident's restraint had been reassessed in March, 2012, however, the resident had not received another restraint assessment until a year later in March, 2013. The resident's restraint was reassessed in June, October, and December, 2013, however had not been reassessed again until July, 2014.
It was confirmed by the RAI Coordinator that resident #008 had not been reassessed and the plan of care reviewed or revised.(508) [s. 6. (10) (b)]

5. The licensee did not ensure that different approaches were considered in the revision of resident #007's plan of care when the care set out in the plan was not effective.

A) Resident #007 had a significant weight loss over one month in 2014. During a 2014 nutritional assessment, the Registered Dietitian initiated a nutritional supplement to prevent further weight loss. The nutritional supplement was discontinued the following month in 2014 due to the resident's refusal of the supplement. The resident had a long history of refusing nutritional supplements and documentation in and prior to 2013 reflected the resident preferred no nutritional supplements. The supplement was discontinued without the implementation of alternative strategies for the prevention of further weight loss. [s. 6. (11) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #007 was observed to have 2 quarter rails raised when the resident was in bed. Review of the clinical records did not demonstrate the resident was assessed and their bed system was evaluated in accordance with evidence-based practice to minimize risk to prevent resident entrapment.
Interview with the Director confirmed that new beds, mattresses and bed rails were purchased however none of the residents that utilized bed rails were assessed to minimize risk to the residents to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (a)]

WN #7: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences for resident #012.

Resident #012 identified during an interview that they had sleep preferences where they regularly preferred to sleep in the morning and regularly after lunch. The resident's plan of care, that staff referred to for direction in providing care to the residents, did not identify any sleep patterns or preferences.
It was confirmed by the RAI Coordinator that the resident's plan of care did not include the resident's sleep patterns and preferences. [s. 26. (3) 21.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee did not ensure that resident #032 was bathed, at a minimum, twice a week by the method of their choice during a seven day period in July, 2014.

Resident #032 stated they did not receive their scheduled bath on an evening in July, 2014 due to staffing changes. During interview, PSW staff confirmed there were staffing changes and that the resident's bath was not completed, however, were signed as completed. Staff indicated that if a make-up bath was provided it would be documented in the Point of Care (POC) computer system. Documentation in the POC system identified that an additional bath had not been offered/provided during a seven day period in July, 2014. The resident did not receive a minimum of two baths over a seven day period in July, 2014. [s. 33. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that resident #024 who exhibited altered skin integrity, including pressure ulcers, was assessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A) Resident #024 clinical record indicated they had altered skin integrity. The resident's clinical records indicated that the resident had received a skin assessment on one day in January, two days in February, two days in March, one day in April, three days in May, one day in June, and three days in July, 2014. The resident's altered skin integrity had not been assessed at least weekly by a member of the registered nursing staff on several occasions over a seven month period.
It was confirmed by the RAI Coordinator that the resident did not receive a weekly skin assessment by a member of the registered nursing staff.

B) Resident #015's clinical record indicated that the resident sustained altered skin integrity in June, 2014. The resident was reassessed twice in June, twice in July, 2014. Resident #015 was not reassessed at least weekly by a member of the registered nursing staff, when clinically indicated. [s. 50. (2) (b) (iv)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that each resident who was 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #017 had been identified as having a change in their level of bowel and bladder continence between specified dates in June, 2013, September, 2013 and November, 2013 as documented in the resident's MDS RAI assessment. A review of the clinical records did not indicate the resident received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. Interview with the RAI coordinator confirmed an assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence for the resident's changes noted in 2013. [s. 51. (2) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure they responded in writing within 10 days of receiving the Residents' Council concerns at the meetings in October and November, 2013. At the October, 2013 meeting for the third floor, residents voiced concerns about the breakfast meal being late, not enough staff to get residents up, requests for salt shakers at the table, Bingo program, cold rooms, questions about the library and banking. A response was provided December, 2014, however, the response did not include the concerns regarding not enough staff to get residents up in the morning. At the 4th floor meeting November, 2013 residents voiced concerns about quantity of food being served at meals, too much chicken, and labelling of laundry. A response was not provided by the licensee until December, 2014. Concerns about menu variety and quantity were not addressed in the home's response.
The Administrator confirmed a response was not provided until December 2013 for the concerns voiced in October and November 2013. [s. 57. (2)]

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,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee did not ensure the menu cycle included an alternate choice of entrées and vegetables at the dinner meal.

A) An alternative vegetable choice was not provided for the Week 4 Wednesday

dinner meal to accompany the Zesty Tuna Pasta Salad. A spinach salad was on the original planned menu; however, was removed, resulting in no alternate vegetable/side dish for the pasta meal. The Assistant Nutrition Manager who was responsible for the food order confirmed that spinach was not ordered for that meal and staff confirmed a side was not served with the Zesty Tuna Pasta Salad.
B) An alternative vegetable or side was not included on the planned Week-at-a-Glance menu for Week 2 Thursday dinner meal. The menu reflected Borscht soup with soda crackers, cheddar cheese and Rollkuchen. A side dish or fruit/vegetable choice was not included. The original menu included fresh watermelon, however, this was removed from the Week at a Glance menu.
C) Green salad was listed for both meal choices at the dinner meal Sunday Week 2. Residents who did not prefer salad would not have an alternative choice of vegetable.
D) An alternative choice of entrée was not available on the therapeutic extension menu for Week 2 Tuesday dinner meal for the Renal menu. [s. 71. (1) (c)]

2. The licensee did not ensure the menu cycle was approved by a Registered Dietitian who was a member of the staff of the home.

A) The home was unable to provide evidence that the menu cycle was approved by a Registered Dietitian who was a member of the staff of the home. Residents voiced concerns during Stage One of this inspection about the menus being repetitious. Numerous menu items were noted to be repeated within the week and throughout all weeks of the menu. Some examples:
i) Cookies were served 7/7 days on all four weeks of the menu cycle. Documentation did not reflect this was a resident preference.
ii) Sandwiches were served at the evening snack five to seven out of seven days in all weeks of the menu cycle. Sandwiches were also served at the dinner meal on 20 days in the menu cycle.
iii) Week 1 - tossed salad was served Week 1 Monday dinner, Wednesday dinner, Thursday dinner, Friday dinner; Pudding was served two days in a row Tuesday and Wednesday Week 1 dinner; the same desserts repeated in the week - mandarin oranges, pudding, assorted desserts.
iv) Week 2 - salad served at dinner on Monday, Tuesday, Wednesday, Saturday and both choices on Sunday;
v) Week 3 - fruit cup is served at the dinner meal two days in a row, followed by fruit salad and diced pears the next two days at lunch (Friday, Saturday,, Sunday and also on Monday dinner), pears again on Tuesday dinner and peaches on Friday lunch (peaches and pears in the fruit cup/fruit salad).

vi) Week 4 - tossed salad lunch Thursday and Friday and Friday and Saturday dinner meal; peaches/pears/fruit cup served Monday dinner, Tuesday dinner, Wednesday dinner, Thursday dinner, Saturday dinner, Sunday lunch; Lemon cranberry muffin served at Sunday dinner and glazed cranberry loaf served at evening snack.

B) Several items had been removed from the planned menu without being approved by the Registered Dietitian, resulting in significant changes to the nutrient profile and appearance of the menu.
i) Ham was planned to accompany the Perogies (three Perogies) at the dinner meal Week 2 Monday. The ham was removed from the menu and only Perogies and sautéed cabbage were provided (The Cook and Assistant Nutrition Manager confirmed that the ham was not ordered, nor served to residents). A protein choice was not offered with the meal, resulting in reduced nutritional value and appearance of the meal.
ii) Peameal bacon was planned to accompany the Perogies (three Perogies) at the dinner meal Week 4 Thursday. The peameal bacon was removed from the menu and bacon bits were substituted. A protein choice was not offered with the meal, resulting in reduced nutritional value of the meal.
iii) The planned menu for Week 4 Wednesday included a spinach salad to be served with the Zesty Tuna Pasta Salad. The spinach salad was removed from the menu and not replaced with an alternative vegetable/side dish. The pasta was not served with a side/vegetable choice, resulting in reduced nutritional value of the meal and reduced visual appeal.
iv) Condiments (pickles, coleslaw, lettuce) were removed from the planned menu, resulting in reduced visual appeal and quality. [s. 71. (1) (e)]

3. The licensee did not ensure the menu cycle was reviewed and updated at least annually.
The home was unable to provide evidence that the menu cycle was reviewed and updated at least annually. The menu the home was using was labelled 2011/2012. Documentation in the Resident's Council meeting minutes, reviewed from February 2012 to present, and Dining Committee meeting minutes reviewed from September 27, 2011 to present, did not reflect that the menus were revised or reviewed by the Resident's Council since November 25, 2012. [s. 71. (1) (g)]

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. (1) Every licensee of a long-term care home shall ensure that there is an organized food production system in the home. O. Reg. 79/10, s. 72 (1).

Findings/Faits saillants :

1. The licensee did not ensure there was an organized food production system in the home.
A) The Week at a Glance menus, therapeutic extension menus, production sheets, and recipes were not consistent in identifying the menu items to be prepared by staff. Menu items were listed on some documents and not others.
B) Yield identified on recipes for various items were not consistent with the actual quantities of menu items identified on the production sheets (e.g. Production sheets required 18 egg salad sandwiches for Week 2 Tuesday dinner, however, the recipe available in the binder for Week 2 Tuesday dinner identified a recipe for 1 homemade egg salad sandwich and did provide direction for staff on how to prepare the egg salad filling).
C) Not all recipes were available to direct staff in the consistent preparation of menu items. (e.g. Recipes for parsley carrots, egg salad filling, mashed potatoes, and green salad were not available in the recipe binder for Week 3 Thursday lunch). The Cook confirmed that not all recipes were consistently available and substitutions were made due to lack of ingredients or lack of recipes. [s. 72. (1)]

Issued on this 2nd day of October, 2014

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