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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jul 31, 2013	2013_202165_0010	H-000299-13	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

TELFER PLACE
245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8

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

TAMMY SZYMANOWSKI (165), LISA VINK (168), MARILYN TONE (167)

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): June 6, 7, 8, 9, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25 and 26, 2013.

A Complaint inspection was conducted concurrently with this inspection H-000292-13: Findings of non-compliance are contained in this inspection report.

H-000292-13 was completed during the RQI.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), RAI Coordinator, Director of Nutrition Services (DNS), Director of Environmental Services, Associate Director of Business Relations, Restorative Care Coordinator, Program Manager, Recreation aide, Lifestyle Coordinator, Personal Support Workers (PSW), Registered nursing staff, Dietary staff, Housekeeping and laundry staff, family members, physiotherapist, and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all resident home areas and reviewed relevant documents including, but not limited to: policies and procedures, meeting minutes, menus, and health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

s. 6. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. Every licensee did not ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) Resident #290, had no natural teeth, wore dentures and required assistance with oral care as per family and staff interviews. The resident's plan of care did not include the need for oral care, the level of assistance required or the use of dentures. The signage posted in the resident's closet noted the use of dentures only. Point of care documentation completed by PSW staff, in the past 30 days identified the cleaning of the resident's natural teeth, however the resident had dentures only. Staff confirmed that the residents plan of care did not include the planned care for the resident related to oral care.
B) Resident # 990 was noted to have two half side rails elevated on their bed. The registered staff member confirmed that the resident used two half rails when in bed and that the resident was not capable of getting out of bed nor did the resident attempt to get out of bed. The registered staff member indicated that the side rails were used to prevent the resident from rolling out of bed and to assist with bed mobility. The plan of care and the Point of Care Kardex that directed staff related to the care for the resident, did not identify the use of bed rails for the resident.
C) Resident # 446 was noted to have one half side rail elevated on their bed. The registered staff member confirmed that the resident used one half rail when in bed and that the resident was capable of getting out of bed on their own. The registered staff member indicated that the one bed rail would not prevent the resident from getting out of bed and that the side rail was used to assist the resident with mobility when in bed. The Minimum Data Set (MDS) assessment indicated that the resident used one side rail in bed daily. The plan of care and the Point of Care Kardex that directed staff related to the care for the resident, did not identify the use of bed rails for the resident. [s. 6. (1)]

2. The plan of care did not set out clear directions to staff and others who provided direct care to the resident.

A) The plan of care for resident #085 did not provide clear direction related to oral care. The focus statement related to eating indicated that dentures were to be in place before each meal and that the resident had a partial bridge. The statement related to dental care identified that the resident had some or all natural teeth and no dentures. Interview with family and PSW staff confirmed that the resident had not used a partial plate for some time and that it was no longer available.

B) The plan of care for resident #085 identified that the resident used a front closure seat belt as a reminder not to get up on their own and they were able to undo it. The resident was not observed wearing a seat belt. Interview with PSW staff and the physician's order confirmed that the resident did not use a seat belt while a resident at the home. The plan of care did not give clear direction regarding safety and security needs.
C) The plan of care for resident #830 did not provide clear direction regarding supplement use. The interventions on the plan, indicated for staff to offer Boost or a two-Calorie supplement every three hours when awake however; it also indicated to provide Boost or a liquid supplement with meals and in between as tolerated.
D) Resident #446's plan of care indicated for staff to follow "bowel protocol as per policy". The homes "Continence Care policy LTC-E-50" did not include a bowel protocol. Registered staff confirmed that the home did not have a bowel protocol and the DNS confirmed that there was no standard nutritional and hydration protocols for the prevention of constipation. Registered staff indicated the expectation was for staff to call the physician for an "as' needed" order if they did not already have an "as needed" order in place however; resident #446's plan of care indicated for staff to follow "bowel protocol as per policy".
E) The plan of care regarding bowel and bladder continence for resident #085 included interventions, created in August 2012. These interventions included to toilet before and after meals, and at bedtime. It also indicated that the resident was on the containment protocol to check before and after meals, at bedtime and on rounds during the night. Interview with PSW staff confirmed that the resident was only toileted before or after breakfast and otherwise used a product for containment only. The plan did not provide clear direction regarding the interventions related to continence care.
F) An assessment was completed by the physiotherapist related to resident #086's ability to transfer. It was determined that the resident required two persons to assist with transfers. The SALT assessment (Assessment Form for Lifts and Transfers) completed, confirmed that the resident required two person side by side assistance with a transfer belt for transfers on day, evening and night shifts. The computerized plan of care was revised in June 2013, to include this new intervention. The plan of care located in the care plan binder one week later indicated that the resident was still transferred during the day shift using one person with a transfer belt. The care plan located in the care plan binder that was accessible to staff did not provide clear direction related to the resident's transferring ability.
G) The plan of care for resident # 086 did not provide clear direction related to the

resident's ability to smoke safely. It was determined that it was no longer safe to allow the resident to keep their cigars/cigarettes and lighter in their possession and a decision was made to keep these items locked in the medication room. It was also determined that the resident required supervision when smoking. Documentation in the progress notes indicated that the resident had become unsafe to smoke independently or keep the cigarettes and lighter on their person. The computerized plan of care was revised to include this information however; the plan of care that was located in the care plan binder two weeks later, and was accessible to staff indicated that the resident was going out independently to smoke and kept their cigarettes and lighter in their possession. The care plan that was accessible to staff providing care did not provide clear direction related to the resident's safety when smoking. [s. 6. (1) (c)]

3. Staff involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were consistent with each other.

A) Resident #830 was observed to have one short bed rail in the raised position, which was confirmed by PSW staff. The coding during MDS assessment for June 2013, identified that the resident did not use any rails. The Point of Care documentation completed for seven days prior to the assessment identified the use of the bed rail for turning or repositioning. The RAI Coordinator confirmed that the information recorded on the assessment was an error and not consistent with the needs of the resident.
B) Resident #085 had a Pressure Ulcer Risk Scale (PURS) score of three for the assessment completed in November 2012. The score increased to five for the next quarterly assessment completed. The Resident Assessment Protocol (RAP) completed for pressure ulcers for the quarterly assessment indicated that the PURS score was unchanged. The increase in the PURS score indicated that the resident was at a higher risk of skin breakdown. The two assessments were not consistent with each other.
C) Resident #830 had a MDS assessment completed in December 2012. This assessment related to mood and behavioural patterns identified that the resident had behaviours identified up to five days a week, including three different indicators of verbal expressions of distress and one indicator of sad, apathetic or anxious appearance, in addition to two other behavioural symptoms which occurred one to three times in the past seven days. The MDS assessment completed the next

quarter, identified a reduction in indicators of verbal expressions of distress to two and no indicators of sad, apathetic or anxious appearance, and a change in the previous specific behavioural symptoms identified, however included the occurrence of a new behaviour. This assessment identified that the resident had no change in mood or behavioural symptoms compared to the status of 90 days ago, which was not consistent with the assessment of December 2012.
D) Resident #819 had a MDS assessment completed with in May 2013. Section "J" of the MDS indicated the resident experienced "none of the above" indicators of fluid status which included "insufficient fluid; did not consume all or almost all liquids provided during the last three days" however; a review of the resident's fluid records indicated the resident had poor fluid intake during the three day observation period. The triggered nutritional RAP signed by the RAI Coordinator had not changed from the nutritional RAP completed the previous quarter by the RD . The RD and RAI coordinator confirmed that the RAP did not identify the correct current or previous weight, and that there was no collaboration in the completion of the assessment.
E) Nursing staff identified that resident #568 had poor daily fluid consumption and sent six referrals to the RD over a three week period. The clinical record indicated that the RD had assessed the resident and documented; that the resident was meeting their fluid requirements and no interventions were needed. Daily fluid intake records over a two week period prior to the assessment, indicated the resident consumed only 55% of their established fluid requirement. The assessment completed by the RD was not integrated and consistent with the resident's needs. [s. 6. (4)]

4. 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) Documentation in resident #819's clinical health record indicated that a nutritional supplement was initiated by the DNS and an entry by the RD in the progress notes the same day indicated for staff to continue the supplement. The nutritional risk plan of care indicated the resident was to receive a two calorie supplement at specified times. Registered staff confirmed that only registered staff provide the two calorie supplement and that the resident did not receive the supplement and was not one of the five residents that routinely received a supplement according to the medication administration records (MAR). The RD confirmed there was no written order and was unaware the resident did not routinely receive the supplement since it was ordered three months earlier. The resident had significant weight loss over the past year.
B) The plan of care for Resident #819 directed staff to toilet the resident before meals,

after meals and at bed time. On June 20, 2013, the resident was not observed to be toileted after breakfast or before lunch. During an interview with PSW staff, it was confirmed that the resident had been toileted prior to the breakfast meal and would be toileted again after lunch but was not toileted after breakfast or before lunch as was the direction in the resident's plan of care.
C) Resident #506's plan of care for high nutritional risk indicated staff were to provide 125 ml of prune juice at breakfast daily however; this was not offered and provided during the breakfast meal observed June 20, 2013.
D) Resident #506's plan of care for bladder and bowel incontinence identified that staff were to check for wetness before meals, after meals, every evening and on rounds during the night. The resident was observed June 20, 2013, from 0841 hours to 1055 hours and was not checked by staff during this time period. Staff interviewed at 1315 hours confirmed that the resident had not been toileted since the resident first got up prior to breakfast at least four and a half hours prior.
E) Resident #822's plan of care for bowel incontinence had an intervention for staff to provide 125 ml of prune juice at breakfast. On June 20 and 24, 2013, breakfast meal was observed and the resident was not provided with the prune juice as specified in the plan of care.
F) Resident #822's plan of care for nutritional risk had an intervention that the resident was to have a labeled snack and beverage at the morning snack. On June 12, 2013, the labeled snack and beverage were still in the basket at the nursing station at 1154 hours. Staff interviewed confirmed that the nourishments should have been given to the resident mid morning and removed them from the nurses station. It was identified that it was too close to lunch to offer the snacks to the resident at 1154 hours.
G) Resident #822's plan of care identified that the resident required assistance with toileting and was to be toileted before meals, after meals and at bedtime. On June 20, 2013, the resident was observed in the dining room from 0813 hours until 1015 hours. Staff interviewed at 1315 hours identified that the resident was last toileted at approximately 0830 hours and not again over the past five hours.
H) The Snack Report indicated that resident #855 was to have a labeled beverage at morning snack. On June 12, 2013, the labeled beverage was observed in the basket at the nursing station at 1154 hours. Staff interviewed confirmed that the beverage should have been given to the resident mid morning and removed it from the nurses station. It was identified that it was too close to lunch to offer the beverage, which was now warm to the resident at 1154 hours.
I) Resident #278's plan of care identified that staff were to monitor for overeating or

eating off other resident's plates. On June 20, 2013, the resident was observed to enter the dining room at 0825 hours and took food off of a cart and began to eat, when no staff were in attendance. Dietary staff were not in constant attendance and nursing staff were not able to come to the dining room until 0852 hours to assist and supervise residents with eating. The resident was not monitored as per the plan of care.
J) Resident #603's plan of care identified that the resident required assistance with toileting and was to be toileted before and after meals. On June 20, 2013, the resident was observed entering the dining room at 0829 hours. The resident was removed from the dining room following the breakfast meal at 1100 hours. Staff interviewed at 1315 hours confirmed that the resident was last toileted before the breakfast meal. The resident was not toileted as per the plan of care.
K) Registered staff indicated that resident #963 had not eaten more than 50% of their meals on six or more occasions in the past three days and as a result a 72 hour food intake study would be initiated. There was no food intake study initiated as of June 26, 2013, and staff interviewed confirmed that they had not completed an intake study for this resident.
L) Resident #807's plan of care for inadequate fluid intake indicated that staff were to provide a labeled snack at morning nourishment however; this was not provided when observed June 18, 2013. Staff confirmed the morning nourishment cart was not distributed.
M) Resident #819's plan of care for nutritional risk indicated staff were to provide a labeled beverage at nourishments. It was observed June 18, 2013, from 0950 hours to 1130 hours that the resident was not offered and provided their labeled beverage. Staff confirmed that morning nourishments were not distributed for the morning.
N)Resident #807's plan of care for high nutritional risk indicated the resident was to receive 125 ml prune juice at breakfast and lunch however; the resident was not offered and provided prune juice at breakfast June 20 and June 24, 2013. [s. 6. (7)]

5. The licensee did not ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.
Staff confirmed that they access resident's plan of care by the printed version placed in a binder at the nurses station. Restorative care staff confirmed that staff who provide direct care to resident's have access to the resident's kardex through point of care however; staff were unable to access the resident's full plan of care through the computerized system.

A) Resident #819 and resident #409 did not have a plan of care printed and placed in the binder when reviewed by the inspector June 12, 2013. The RAI Coordinator confirmed the expectation was for all plans of care to be placed in the binder however; confirmed the plans of care for the identified residents were not in the binder for staff to reference.
B) Resident #446 had revisions to their computerized plan of care that were not included on the printed version. For example, the potential for dehydration related to inadequate fluid intake was created on the computerized plan of care however; the focus, goals and interventions were not available for staff to reference on the printed version.
C) The plan of care for resident #830, was revised by registered nursing staff to include the use of supplements. The revision to the plan regarding the use of supplements was not communicated to the dietary department as confirmed during interviews with the RD and the DNS. The registered staff interviewed indicated that staff were required to manually make additions to the electronic Medication Administration Record (e-MAR), when trialing a supplement to communicate this need to staff, so that the plan would be implemented. The e-MAR did not include the use of the supplement as confirmed by the registered staff and the same nurse was not aware of this change to the resident's plan of care when initially interviewed.
D) The printed copy of the plan of care for resident #830, which was available to the PSW on June 20, 2013, was not the most recent version of the plan, as available in the computer. PSW staff confirmed that they do not have access to the computer and rely on the printed copy. The resident's plan of care had numerous revisions recently due to a change in the residents diagnosis. [s. 6. (8)]

6. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when, the resident's care needs changed.

A) The Power of Attorney (POA) for resident #086 reported a change in the resident's status to nursing staff in the early afternoon, in June 2013. This change in status was not immediately documented nor communicated to other members of the care team until the next day, which was confirmed during a staff interview. As a result, the plan of care was not reviewed or revised based on this change in care needs. The resident sustained a fall in the early evening of the day the change in the resident status was reported, when attempting to self transfer, which was not a common behaviour for the resident.
B) Resident #830 had a down grade in diet texture, which was identified by the RD in

May 2013. The plan of care was not revised to reflect this change in care need until two weeks later when it was modified by the registered nurse, to reflect the current need of the resident.
C) Resident #506's plan of care for responsive behaviour indicated for staff to document resident's location hourly on the wanderers checklist however; staff confirmed that the resident no longer wanders and was not monitored on the wanderers checklist. It was reported that the resident no longer exhibited wandering behaviour.
D) Staff confirmed that resident #506's aggressive behaviour with other residents was routinely reactive and identified the specific triggers. Staff were able to identify specific residents that provoke the resident and strategies to manage the behaviour however; the plan of care was not revised to reflect these strategies. [s. 6. (10)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 sets out clear directions to staff and others who provided direct care to residents, to ensure that the staff and others who provide direct care to residents were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, and to ensure that the resident was reassessed and the plan of care reviewed and revised when, the resident's care needs changed or no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration
Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee did not ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents and an organized program of hydration for the home to meet the hydration needs of residents.

A) Breakfast meal service extended over a three hour period when observed June 20, 2013. It was observed throughout the inspection that breakfast meal service was extended and staff indicated this to be routine. It was observed and confirmed by staff and the Executive Director that a hot breakfast was to be available at least until 0930 hours and then muffins/yogurts were available after that time. During the breakfast meal June 20, 2013, only nineteen residents were in the dining room by 0930 hours and only seventeen residents were observed in the large dining room by 0930 hours June 24, 2013. The home did not have a finalized policy detailing the time of the breakfast meal service.
B) It was observed and confirmed by staff that residents were not always brought to the dining room for a hot breakfast service despite being awake.
i) Resident #819 was still in bed at 0950 hours June 24, 2013, however; the plan of care indicated that the resident preferred to get up at 0800 hours. The resident was deemed at high nutritional risk and staff confirmed the resident was only provided applesauce and one glass of apple juice for breakfast June 24, 2013. The resident had a significant weight loss over the past year.
C) Residents were not provided sufficient fluids to meet their hydration needs. The DNS confirmed that staff use the beverage list to provide beverages to adhere to residents preferences. It was observed during the breakfast meal June 20 and 24, 2013, that several residents were only provided one beverage with their meal. Staff used the beverage list to provide beverages however; the beverage list only indicated one beverage for several residents The DNS indicated that the expectation was staff were to also offer additional beverages including tea and coffee with meals. The homes menu indicated that fruit juice, water, milk and coffee/tea would be offered for breakfast and water, milk and coffee/tea would be offered for lunch and dinner however; staff did not offer all beverages at breakfast and lunch meals observed.
i) Resident #807 deemed at risk for dehydration only received 125 ml of apple juice and additional fluids were not offered. The resident had been admitted to hospital with dehydration one month prior.
ii) Resident #506 received boost supplement 2x 125ml at breakfast June 20, 2013, and additional fluids were not offered.
iii) Resident #822 received 250 ml of milk and additional fluids were not offered.

iv) It was observed during breakfast and lunch meals that coffee/tea were only provided to a few residents that were able to request it.
D) Since breakfast meal service June 20, 2013, was extended until 1100 hours morning nourishments were not distributed and morning fluids were not offered to residents. Observation and staff confirmed that morning nourishments and fluids were not routinely distributed as a result of extended breakfast service eliminating additional fluids for residents. [s. 11.(1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. 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:
8. Continence, including bladder and bowel elimination. 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The responsive behaviour plan of care was not based on an assessment of resident # 830 that included an identified behaviour or the potential behavioural triggers.

A) The RAP identified that the resident was frequently unhappy with their roommate. Progress notes identified that the resident had conflict with their roommate, including altercations, since admission and on an ongoing basis. The plan of care identified that the resident had behavioural problems and alterations in mood state however; did not include the behaviour related to conflict with their roommate or the specific trigger, which was identified in the assessment. [s. 26. (3) 5.]

2. The plan of care was not based on an interdisciplinary assessment with respect to resident #446 continence, including bladder and bowel elimination.

A) The MDS assessment completed indicated the resident was continent of both bladder and bowel and toileted independently without any physical help from staff. The registered nurse, personal support worker and the restorative care aide confirmed that the resident was able to toilet independently. The Restorative Care Aide confirmed that the computerized plan of care and the printed plan of care did not reflect the resident's continence status and level of assistance required for toileting as identified in the assessment. [s. 26. (3) 8.]

3. The plan of care was not based on an interdisciplinary assessment with respect to the resident's sleep patterns and preferences.

A) The plan of care, in the care plan binder, for resident #085 did not include the resident's sleep preference for rising time in the morning. On June 24, 2013, the resident was still in bed at 0930 hours.
B) The plan of care, in the care plan binder, for resident #963 did not include the resident's sleep preference for rising time in the morning. On June 24, 2013, the resident was still in bed at 0930 hours.
C) The plan of care, in the care plan binder, for resident #568 did not include the resident's sleep preference for rising time in the morning. On June 24, 2013, the resident was still in bed at 0950 hours.
D) The plan of care, in the care plan binder, for resident #603 did not include the resident's sleep preference for rising time in the morning. On June 24, 2013, the resident was still in bed at 1000 hours, despite the fact that the resident was awake and alert at 0800 hours. [s. 26. (3) 21.]

4. The licensee did not ensure that a registered dietitian who was a member of the staff of the home, assessed resident's nutritional status, including any risks relating to nutrition.

A) A dietary requisition was sent to the DNS to trial a textured diet for resident #819. Staff were concerned about the resident's ability to swallow and indicated that the resident had been holding food in their mouth. Review of the resident's clinical health record revealed there was no nutritional assessment completed by the RD when reviewed by the inspector three months later. The resident was observed holding food in their mouth for an extended period of time during the lunch meal June 6, 2013. Staff confirmed that the resident routinely held food in their mouth during meals. The RD confirmed there was no assessment completed related to the resident's swallowing.
B) Registered nursing staff revised the plan of care for resident #830 to include the use of supplements. Interview with the RD, the following day, identified that she became aware of the use of the supplements in preparation for the quarterly assessment that day and that this change in the plan of care was not communicated by nursing staff. The RD did not complete an assessment related to this change in nutritional status when reviewed by the inspector one week later. Interview with the DSM confirmed that they became aware of the use of supplements for this resident from the nursing staff one week later.
C) Resident #290 returned from hospital with a specific diet order. A review of the clinical record indicated that the resident's diet was changed by nursing two days later and five days later the DNS indicated that the resident's fluid consistency was changed and a referral was sent to the RD. On the ninth day the DNS received a diet requisition from nursing to trial a regular texture diet. On the eleventh day the RD indicated in the clinical record that the resident had an unplanned weight loss over the past month and that the resident was currently trialing a regular texture. A nursing progress note two weeks from the residents return from hospital, reported that the resident stated that it hurt to swallow. Review of the resident's clinical health record one month after they returned from hospital revealed there was no nutritional assessment completed by the RD related to the resident's swallowing and diet changes. [s. 26. (4)]

5. The licensee did not ensure that a registered dietitian who was a member of the staff of the home, assessed residents hydration status and any risks relating to

hydration.

A) Resident #603 had 10 referrals to the RD related to poor fluid consumption over a one month period. Progress notes indicated that the resident did not void for a recent evening shift. The resident's plan of care identified the resident as high nutritional risk and at increased risk for dehydration. Food and fluid records indicated the resident's average daily fluid consumption over a one month period, was 836 ml/day which only met 43% of the resident's established fluid requirements. There was no assessment by the RD of the resident's hydration status and any risks relating to hydration.
B) The plan of care for resident #807 indicated the goal was for the resident to meet their fluid requirements. Nursing staff sent eight referrals to the RD related to poor fluid consumption over a one month period. Food and fluid records over the one week period prior to the RD assessment, indicated the resident's average fluid intake was 714 ml/day and only meeting 35% of their fluid requirements. The RD completed a nutritional quarterly assessment however; there was no assessment of the resident's hydration status and any risks associated with hydration by the RD at that time. The resident was admitted to hospital five days later with a diagnosis of dehydration. [s. 26. (4) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 resident's that exhibit mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day have a plan of care that is based on an interdisciplinary assessment, ensure that residents have a continence, including bladder and bowel elimination and a sleep pattern and preferences plan of care that are based on an interdisciplinary assessment, to be implemented voluntarily.

WN #4: 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 of the long term care home did not ensure that each resident of the home was 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.
A) Resident #855 did not have two baths per week each week over a one month period reviewed. Staff confirmed that when baths did not occur in the home it was documented in point of care as "Activity did not occur". This was identified for the second day of the week for the identified weeks. Staff interviewed stated that the baths were not rescheduled.
B) A review of six resident's Point of Care bathing documentation indicated that the following residents did not receive baths twice a week over a one month period of time reviewed.
i) Resident #990's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur for resident #990 on three occasions over three weeks, as scheduled.
ii) Resident #836's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on three occasions over three weeks, as scheduled.
iii) Resident #031's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on four occasions over four weeks as scheduled.
iv) Resident #364's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on May 29, June 5 and 19, 2013.
v) Resident #409's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on three occasions over three weeks, as scheduled.
vi) Resident #856's plan of care directed staff to provide two baths per week and as required. Bathing records confirmed that this activity did not occur on three occasions over three weeks, as scheduled.
Staff interviewed indicated that they have been told that when they are working short that they should defer baths and that these baths will be caught up later. There was no evidence that these baths were caught up the next day or at any later date.
C) Bathing documents confirmed that resident #002 had only received one bath over an 18 day period since they were admitted to the home.
B) Bathing records indicated that 22 residents received only one bath per week and seven residents did not receive any baths over one week. Staff and residents

interviewed confirmed that bathing did not occur when the home did not have sufficient staff to fill their staffing complement. It was confirmed that baths were not always made up when missed.
C) Bathing records indicated that 19 residents received only one bath per week and five residents did not receive any baths for over one week.
D) Bathing documents indicated that 17 residents received only one bath per week and three residents did not receive any baths over one week.
E) During a review of the minutes from the Resident's Council Meetings, it was noted that there were concerns expressed by residents that they were not getting their baths in February 2013, and March 2013, related to staff shortages. It was confirmed by the DOC that baths were eliminated when staff shortages occur. [s. 33. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the nutritional care program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.
A) Resident #819 did not have a monthly weight taken and recorded for the month of May 2013. The RD confirmed there was no weight taken and recorded on the 2013 resident weight record or in Point Click Care.
B) Resident #446 did not have a monthly weight taken and recorded for the month of May 2013. The RD confirmed there was no weight taken and recorded on the 2013 resident weight record or Point Click Care.
C) Residents did not have their weights taken and recorded monthly. The Restorative aide confirmed that monthly weights were taken by staff and then recorded in Point Click Care when completed. The following residents did not have the following monthly weights taken and recorded in Point Click Care: resident #855 did not have a weight taken and recorded for January 2013, resident #542 and #807 did not have a weight taken and recorded for February 2013, resident #836, #995 and #409 did not have a weight taken and recorded for March 2013, resident #446, #221, #852 and #005 did not have a weight taken and recorded for May 2013, and resident #990 did not have a weight taken and recorded for January, March, April or May 2013. The RD confirmed that monthly weights were not always taken and recorded in Point Click Care. [s. 68. (2) (e) (i)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that residents with weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated for a change of five per cent of body weight, or more, over one month. A change of ten per cent of body weight, or more, over six months. Any other weight change that compromises the resident's health status.

A) Resident # 819 experienced a significant weight loss of 7.6% change over 3 months in May 2012. The resident's weight fell below their ideal body weight range established by the RD the following month. The resident's weight continued to decline and triggered a significant weight loss on three more occasions in 2012 with two significant weight losses triggering over six months and one significant weight loss triggering over one month and one significant weight loss triggering over one month in 2013. The resident was reviewed quarterly by the RD in September and December 2012, however; no action was taken despite the resident's continued weight loss. The RAP completed by the RD February 2013, indicated the resident had a gradual weight loss however; weight records indicated that the resident had experienced a significant unplanned weight loss over the past year. Action was not taken by the RD to prevent further weight decline. Point Click Care indicated the resident has continued to loose weight since the quarterly review. There were no referrals initiated and the RD confirmed that significant weight loss had occurred however; there was no assessment completed using an interdisciplinary approach that included actions taken and outcomes evaluated related to the resident's weight changes. [s. 69.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that each resident was offered a minimum of a between-meal beverage in the morning.

A) On June 13, 2013, resident #003 was observed not to be offered a between meal beverage in the morning. The documentation of the resident's intake at snacks for the morning beverage was not completed.
B) It was observed and confirmed by the staff that on multiple days of the review the morning nourishment cart was not distributed to residents. It was observed that some residents do not leave the dining room from breakfast until 1100 hours or later which did not allow sufficient time between breakfast and lunch to distribute the nourishments. It was observed June 18, 2013, from 0950 hours to 1200 hours that the nourishment cart was not distributed, this was confirmed by staff. [s. 71. (3)]

2. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.
A) The nourishment menu for week 2 Wednesday, indicated that residents were to be offered carrot loaf however; this was not available and offered June 26, 2013, for the afternoon nourishment pass.
B) The planned menu for week 2 Thursday, included puree textured side salad, minced textured marinated vegetable salad and minced textured side salad. It was observed that these menu items were not offered and available during the lunch meal June 6, 2013. This was confirmed by the cook and resulted in residents that required minced texture being served puree textured vegetables.
C) The planned menu for week 2 Thursday, included watermelon however, staff and the DNS confirmed this was not offered and available during the lunch meal June 6, 2013, resulting in no alternative dessert choice for resident's who received puree textured diets.
D) The planned menu for week 2 Monday, included puree textured lasagna and california vegetables. It was observed that these menu items were not offered and available during the lunch meal June 17, 2013. This was confirmed by the cook and resulted in no alternative entree and vegetable choice for resident's who received puree textured diets.
E) The planned menu week 2 Thursday, indicated that 2 #8 scoops of puree textured vegetable stew was to be served however, a #16 scoop was used instead which resulted in smaller quantities being served during the lunch meal June 6, 2013.
F) The planned menu week 1 Monday, indicated that a #8 scoop of puree textured assorted deli meat was to be served however; a #12 scoop was used instead which

resulted in smaller quantities being served during the lunch meal June 17, 2013.
G) The planned menu week 1 Thursday, included stewed prunes. It was observed that this menu item was not offered and available in the large dining room during the breakfast meal June 20, 2013.
H) The planned menu week 2 Monday, included sliced pears. It was observed that this menu item was not offered and available in the large dining room during the breakfast meal June 24, 2013.
I) The planned menu week 1 Monday, included sliced pears. It was observed that puree textured pears was not offered during the lunch meal June 17, 2013. Staff confirmed that the menu item was not available. [s. 71. (4)]

Additional Required Actions:

CO # - 008, 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. Where the Act or this Regulation required the licensee of the long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A) The Licensee did not ensure that the home's protocol for the checking of expired drugs was complied with. The home's "Registered staff Nightly Checklist" that was posted in the medication room directed staff to check the expiry dates for all medications, medication carts, cupboards and the stat box on the 15th of each month. On June 12, 2013, during a review of the medication room it was noted that there were seven bottles of Tylenol 325 milligrams found in the stock cupboard dated with an expiry date of May 2013.
B) The homes policy for "Nutritional Assessment and Care LTC-G-10" indicated that an order would be obtained for a new diet, diet change and nutritional supplement. The RD confirmed that the home's process for supplements did include a written order by the RD or Physician. A review of resident #819's clinical health record indicated that the RD recommended that the resident continued to receive a two calorie supplement three times daily at medication pass however; there was no order written for the supplement when the inspector reviewed the record three months later. Registered staff confirmed that the supplement was not on the MAR and that the resident did not receive the supplement. The RD confirmed that there was no order written in the resident's clinical health record or in Point Click Care.
C) The home's "Weight Management policy LTC-G-60" stated that "residents will be weighed and weight documented by the 7th day of each month. If a weight loss or gain is 2.0 kg or greater from the preceding month, a re-weigh will be completed immediately". The RD confirmed that all reweighs were documented in Point Click Care.
i) Resident #819 did not have a reweigh completed on two occasions when the resident experienced weight loss. The RD confirmed there were no reweighs recorded for this resident.
ii) At least 16 residents did not have their weight taken and recorded when weight records were reviewed in the tub rooms and Point Click Care on June 21, 2013. [s. 8. (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 plans, policies, protocols, procedures, strategies or systems are complied with, to be implemented voluntarily.

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. The licensee did not ensure that the home was maintained in a safe condition and in a good state of repair.

A) Water was noted to be dripping from the ceiling into a pail at the entrance to the Evergreen unit and ceiling tiles were noted to be missing or stained in the hallways. Interview with residents and staff identified that the roof was leaking and that it had been going on for some time. The Director of Environmental Services confirmed that the roof had been intermittently leaking since replaced approximately four to five years ago. A number of attempts have been made to repair the flat roof, by an outside contractor, however the leaking continued. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

s. 24. (7) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it. O. Reg. 79/10, s. 24 (7).

Findings/Faits saillants :

1. The licensee did not ensure that a 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.

A) Resident #002 did not have a Resident Admission Assessment/Plan of Care initiated or a computerized plan when reviewed five days after admission. The RAI Coordinator confirmed that the resident did not have an initial plan created, to communicate to direct care staff the needs of the resident. [s. 24. (1)]

2. The licensee did not ensure that the staff and others who provided direct care to a resident had convenient and immediate access to the care plan.

A) Resident #001 had a computerized care plan initiated on the day of admission. PSW staff confirmed that they access care plans in the dedicated care plan binder kept at the nurses station. The restorative care aide confirmed that staff were able to access the kardex only, through Point of Care. The resident's plan was not printed and available in the care plan binder eight days after admission for staff to have convenient or immediate access as confirmed by the RAI Coordinator. [s. 24. (7)]

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 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the residents admission to the home, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation shall keep a written record relating to each evaluation under paragraph three that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) The Executive Director confirmed there was no written evaluation completed in 2012, for the Responsive Behaviour program and the staffing plan as part of the Nursing and Personal Support Services program for the home.
B) The DOC confirmed there was no written evaluation completed in 2012, for the Infection Prevention and Control program.
C) The DNS confirmed there was no written evaluation completed in 2012, for the Nutrition Care and Hydration programs. [s. 30. (1) 4.]

2. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions were documented.

A) Resident #819's meal consumption report had 14 missing meals and 44 missing nourishments from the food and fluid intake record over a one month period. The RD confirmed that assessments could not accurately be completed as a result.
B) The clinical health record for resident #819 indicated that nursing staff initiated at least 13 referrals to the RD related to poor fluid consumption over a two month period. Fluid records for one month, confirmed the resident had consumed less than their established fluid goals each day for the month. The clinical record indicated the RD responded to the referrals for poor fluid intake and staff were to provide a 250 mls beverage at nourishment however; there was no assessment documented of the resident's hydration status and risks associated with hydration completed by the RD. The RD confirmed that a hydration assessment was not documented for this resident.
C) Resident #446's meal consumption report had 25 missing meals and 45 missing nourishments from the food and fluid intake record over a one month period. The RD confirmed that a hydration assessment during that month, could not accurately be completed related to the missing entries.
D) Resident #990 sustained a fall during the night shift and was transferred and admitted to hospital. The resident's progress notes indicated that the resident's family

would be notified in the morning by the day nurse. The area related to notification of the family on the "Resident Fall Documentation" form related to the resident's fall was blank and did not indicate that the family had been notified. The progress notes for the day shift following the fall did not include any information related to notification of the resident's family. There was a note in the unit day planner the next day reminding the day nurse to call the family related to the fall but it was not checked off as noted and there was no documentation to indicate that the resident's family were notified the next morning. The registered staff member who was in charge the morning after the resident sustained that fall, confirmed that they did notify the resident's family related to the fall and their transfer to hospital however; it was not documented.

E) The clinical health record indicated that nursing staff initiated at least five referrals to the RD related to poor fluid consumption for resident #963 over a two week period. Fluid records over the two week period confirmed the resident had consumed less than their established fluid goals each day which only met 39% of their fluid goal. The clinical record indicated the RD responded to the referrals for poor fluid intake by stating staff were to provide a 250 mls beverage at nourishment however; there was no assessment documented of the resident's hydration status and any risks associated with hydration by the RD.

F) The clinical health record indicated that nursing staff initiated at least seven referrals to the RD related to poor fluid consumption over a 19 day period. Fluid records over a two week period, confirmed resident #852 had consumed less than their established fluid goals each day which only met 46% of their fluid goal. The clinical record indicated the RD responded to the referrals for poor fluid intake by stating staff were to provide 250 mls of a beverage at nourishments however; there was no assessment documented of the resident's hydration status and any risks associated with hydration by the RD. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The staffing plan did not provide for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

A) The provision of morning care/routine, by the nursing staff, was continuously monitored during the day shift of June 24, 2013, beginning at approximately 0730 hours. Staff were observed to work consistently, without interruption of breaks or to deal with acute situations.
i) Resident #409 was up and dressed for the day at 0805 hours, however was not transported to the dining room for breakfast until 0849 hours.
ii) Resident #930 was up and dressed for the day at 0740 hours, however was not transported to the dining room for breakfast until 0853 hours.
iii) At 0930 hours, nine residents, who required assistance of staff, had not been provided with morning care or transferred out of bed. At 1000 hours, seven residents, who required assistance of staff, had not been provided morning care or transferred out of bed.
iv) Recreation staff began to transport residents into the large dining room, for breakfast at 0847 hours, followed by a nursing staff member at 0850 hours. It was not until 0850 hours that the large dining room was continually supervised by nursing staff.
v) Nursing staff interviewed reported that the observed shift was "typical" for a day shift in the home at the present time. The current practice was for a second PSW to assist in the large dining room at approximately 1000 hours, when residents on the Evergreen unit had received care.
B) It was observed and the Executive Director reported that the current morning routine in the home was the availability of a traditional hot breakfast in the large dining room until at least 0930 hours, after that time a continental breakfast of muffins and yogurt was available. The home did not have a finalized policy detailing the time of the breakfast meal service. During the course of the inspection residents were observed in the large dining room at 1100 hours, eating the breakfast meal, on a number of occasions during the inspection.
C) A PSW reported that on June 20, 2013, resident #042 was provided morning care and was fully dressed for approximately 50 minutes before a second PSW was available to assist with transferring the resident out of bed. As a result, the resident was not brought to the dining room for breakfast until 0938 hours.
D) A PSW reported that resident #001 was not provided morning care and transferred out of bed on June 21, 2013, until approximately 1100 hours, with no specific rational

identified. Family arrived shortly after and staff informed them that the resident had not been offered breakfast as they had just gotten out of bed. The family provided the resident an early lunch at approximately 1115 hours, from the food they had brought into the home, as lunch for the resident. The resident did not have breakfast on June 21, 2013.
E) The breakfast meal service was not organized to meet the needs of residents evidenced by residents having to wait extended periods of time to receive assistance into the dining room and during the breakfast meal.
i) Resident #042 was in the dining room by 0757 hours June 24, 2013, however; was not provided breakfast until 0929 hours when the PSW was available to assist the resident with eating.
ii) Resident #819 was still in bed at 0950 hours June 24, 2013, however; the plan of care indicated that the resident preferred to get up at 0800 hours. The resident was deemed at high nutritional risk and staff confirmed the resident was only provided applesauce and one glass of apple juice for breakfast June 24, 2013. The resident had a significant unplanned weight loss over the past year.
F) Interview with PSW staff confirmed and it was observed on multiple days of the inspection that morning nourishments were not distributed, due to time constraints as breakfast was still ongoing at 1100 hours. It was observed on June 18, 2013, from 0950 hours until 1200 hours that the nourishment cart was not circulated to residents.
i) A number of residents interviewed confirmed that morning nourishments were not routinely offered. One resident reported that in the morning they themselves got the nourishment, out of the dining room.
G) A family member reported that a resident, who required assistance of staff for transfers, had transferred independently, as in their opinion it was taking too long for staff to provide the assistance required.
H) A review of a the progress identified that resident #855, who required extensive assistance of staff to transfer safely, attempted to transfer independently resulting in a fall. It was reported that the resident had been told by different staff members four times, not to transfer without assistance however; the resident was found on the floor in their room after supper. It was reported by staff that they asked the resident to wait until their partner returned from supper break and then they would assist the resident into bed.
I) A PSW transferred resident #855 independently with the use of a mechanical lift. The staff member indicated that other staff were occupied at the time of the transfer feeding residents and providing morning care.
J) A number of residents/representatives reported that there were not always enough

staff available to ensure they received the care and assistance they needed without having to wait a long time. Three residents/representatives identified concerns with staff availability to assist with toileting in a timely fashion. One resident reported that they have just "learned to wait". Another resident identified that staff did not always have time to assist them with getting up in the morning, when the resident was ready and as a result they had to wait.

K) End of Shift Report sheets and staffing schedules reviewed for the time period of June 1- 24, 2013, identified that the nursing department worked short on 7 of 24 occasions during the day shift and on 12 of 24 occasions during the afternoon shift. Staff interviewed indicated that when they worked short baths were rarely completed. Interview with management staff confirmed that direction had been provided to front line staff that baths may be deferred if needed when they worked short and that an additional shift would be scheduled to complete any missed baths. Additional shifts were only recorded on the schedule for 2 shifts between June 1 - 24, 2013, specifically on the day shifts of June 3 and 4, 2013.

i) The nursing department was short staffed on the evening shift of June 1, 2013. The End of Shift Report sheet identified that no scheduled baths were completed for residents on the evening shift.

ii) The nursing department was short staffed on the day shift of June 2, 2013. The End of Shift Report sheet identified that sponge baths were given to residents on the Maple wing as the tub was not working.

iii) The nursing department was short staffed on the evening shift of June 3, 2013. The End of Shift Report sheet identified that no scheduled baths were completed for residents on the evening shift.

iv) The nursing department was short staffed on the evening shift of June 5, 2013. The End of Shift Report sheet identified that no scheduled baths were completed for residents on the evening shift.

v) The nursing department was short staffed on the day and evening shifts of June 6, 2013. The End of Shift Report sheet identified that five residents did not receive their scheduled baths.

vi) The nursing department was short staffed on the day shift of June 8, 2013.

vii) The nursing department was short staffed on the evening shift of June 12, 2013. The End of Shift Report sheet identified that seven residents did not receive their scheduled baths.

viii) The nursing department was short staffed on the day and evening shifts of June 14, 2013. The End of Shift Report sheet identified that seven residents did not receive their scheduled baths.

ix) The nursing department was short staffed on the evening shift of June 15, 2013. The End of Shift Report sheet was not available for review, however; bathing documentation in Point of Care indicated that four residents did not receive their scheduled baths.
x) The nursing department was short staffed on the evening shift of June 16, 2013. The End of Shift Report sheet identified that no scheduled baths were completed on the evening shift.
xi) The nursing department was short staffed on the day and evening shifts of June 17, 2013. The End of Shift Report sheet was not available for review, however; bathing documentation in Point of Care indicated that eight residents did not receive their scheduled baths.
xii) The nursing department was short staffed on the day shift of June 19, 2013.
xiii) The nursing department was short staffed on the day and evening shifts of June 21, 2013. The End of Shift Report sheet identified that five residents did not receive their scheduled baths on the day shift and that no residents received their scheduled baths on the evening shift.
xiv) The nursing department was short staffed on the evening shift of June 23, 2013. The End of Shift Report sheet identified that four residents did not receive their scheduled baths.
xv) Baths were not completed on June 25, 2013, between 0830 and 1800 hours due to planned hot water shut off. Staff interview confirmed that no additional baths shifts were scheduled for June 24, 2013, and that the nursing department was working short staffed on the day shift of June 26, 2013. Not all scheduled baths for the day shift were completed prior to water shut off on June 25, 2103, according to staff interview.
xvi) A number of residents interviewed were aware that the staff in the home were frequently working short, and identified that this was one reason for bathing not being completed as scheduled. This concern was also identified a number of times in recent Residents' Council meeting minutes.
L) It was identified on seven occasions in June 2013, which the home had full nursing staff coverage however; not all baths were able to be completed on these identified dates.
i) The nursing department was fully staffed on June 7, 2013. The End of Shift Report sheet identified two residents who did not receive their scheduled baths on the evening shift.
ii) The nursing department was fully staffed on June 9, 2013. The End of Shift Report sheet identified three residents who did not receive their scheduled baths, due to humidex levels in the bathing area.

iii) The nursing department was fully staffed on June 10, 2013. The End of Shift Report sheet identified three residents who did not receive their scheduled baths, on the evening shift.
iv) The nursing department was fully staffed on June 11, 2013. The End of Shift Report sheet identified two residents who did not receive their scheduled baths on the evening shift.
v) The nursing department was fully staffed on June 13, 2013. The End of Shift Report sheet identified two residents who did not receive their scheduled baths on the evening shift.
vi) The nursing department was fully staffed on June 18, 2013. The End of Shift Report sheet identified three residents who did not receive their scheduled baths on the evening shift.
vii) The nursing department was fully staffed on June 20, 2013. The End of Shift Report sheet identified four residents who received bed baths as their scheduled bath during the evening shift. [s. 31. (3)]

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 staffing plan provides for a staffing mix that is consistent with residents assessed care and safety needs that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that staff used safe transferring and positioning devices or techniques when assisting resident.

A) A staff member transferred resident #855 to the toilet by themselves while using a mechanical lift. The staff member confirmed that another staff member was not present during the transfer as other staff were feeding in the dining room or providing care to other residents when the resident requested assistance. The residents plan of care for transferring stated that the resident required two person assist using mechanical lift/sit to stand lift, when getting out of bed in the morning and for toileting. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the skin and wound care program was fully implemented.

A) The "Revera Skin and Wound Care Program. LTC-E-90", last revised August 2012, indicated "a referral will be made to the Wound Care Champion/Occupational Therapist (OT)/Physiotherapist (PT) for all residents assessed with a PURS score of four or greater".
i) Resident #085 had a change in the Pressure Ulcer Risk Scale (PURS) score that increased by two over one quarter. There was no evidence of a referral to the Wound Care Champion/(OT)/(PT) in the record reviewed, during the period of time identified. Interview with the DOC and registered staff identified that the home did not have a referral form in place for this purpose. The Wound Care Champion confirmed that they had not received any referrals, for any resident, due to a change in PURS score only. [s. 48. (1)]

2. The licensee did not ensure that the pain management program was fully implemented in the home.

A) The policy "Pain Assessment and Symptom Management - Ontario, LTC-E-80-ON", last revised October 2012, identified that "if pain identified, complete a quick pain assessment on the resident using PQRST and document in the multidisciplinary progress notes". Interview with registered staff confirmed the expectation that the PQRST assessment be used with the onset of new pain.
i) Resident #855 returned from hospital with skin breakdown. The MDS assessment completed one week later, indicated the resident had pain daily at times when it was horrible or excruciating. The MAR confirmed that the resident had been receiving pain medication two four times daily for the pain. There was no PQRST assessment completed until three months later, despite the onset of new pain previously identified, this was confirmed by the registered staff.
ii) Resident #830 had a history of pain for which treatment was ordered and administered. The resident had the onset of new pain identified. This pain was further investigated and diagnosed two months later, which resulted in a change in the analgesic. The resident did not have a PQRST assessment completed for six months, despite the onset of new pain identified, this was confirmed by the registered staff. [s. 48. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the skin and wound care program and the pain management program are developed and implemented, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that a post falls assessment using a clinically appropriate assessment instrument was completed when a resident sustained a fall.
A) Resident #836 sustained multiple falls over a five month period. The resident was assessed for physical injury after each fall using the "Resident Fall Incident Documentation Form" and documentation in the progress notes but no post fall assessment was completed. The DOC confirmed that the home did not currently have a clinically appropriate assessment instrument in place that staff utilized post fall for residents.
B) Resident #086 sustained a fall with an injury and was transferred to hospital. The resident sustained two subsequent falls. It was noted that there was no clinically appropriate assessment instrument completed post fall for any of these falls. During an interview with the DOC and registered staff, it was confirmed that the home was not currently completing a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

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

WN #16: 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. The licensee did not ensure that the resident received a skin assessment, by a member of the registered nursing staff, within 24 hours of admission.

A) Resident #002 was admitted to the home however; there was no documentation of a head to toe skin assessment completed in the hard copy or electronic record when reviewed one week after admission. Interview with staff indicated that the head to toe assessment would be documented under the "assessment" tab in the computer program. [s. 50. (2) (a) (i)]

2. The resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had not been reassessed at least weekly by a member of the registered nursing staff.

A) The progress notes for resident #085, identified areas of altered skin integrity, which required treatment or monitoring. These areas were not reassessed weekly in point click care by a member of the registered nursing staff.
i) Skin breakdown was identified which was treated. There was no further mention of an open area for two months until a new treatment was applied.
ii) In January 2013, an open area was noted to be bleeding, the area was treated. This area of altered skin integrity was not recorded on the TAR nor was there further mention of this area documented in the record reviewed.
iii) In January 2013, scratch marks were noted and treatment was applied. There was no additional information documented regarding this area identified in the record reviewed.
iv) In March 2013, a new scratch was identified which was treated. This area of altered skin integrity was not recorded on the monthly TAR nor was there additional assessments documented in the record reviewed.
v) In May 2013, altered skin integrity was noted. There was no additional information documented regarding the residents shin in the record reviewed, including on the monthly TAR. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff and residents that exhibit altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The actions which were taken to meet the needs of the resident with responsive behaviours including interventions and the resident's response to interventions were not consistently documented.

A) Resident #830 had identified responsive behaviours. Staff interviewed were aware of the needs of the resident and were knowledgeable of successful interventions to assist in the management of the behaviours. A review of the progress notes for a six month time period included documentation of specific incidents of behaviours, however did not consistently include the interventions for staff when the events occurred or the response of the resident as a result of the interventions. [s. 53. (4) (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 actions which are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #18: 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 respond within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A) A review of the minutes of the Residents' Council meetings for 2013, indicated that on February 11, February 20, and March 26, 2013, there were concerns expressed by the Residents' Council members about missing laundry and other laundry issues. No response was provided to the Council members related to their concerns until March 28, 2013.
B) It was noted that in the Council minutes for February 20 and March 26, 2013, there were concerns expressed by Council members about residents not receiving their baths on their scheduled days. No response was provided to the the Council related to these concerns.
C) During a review of the Resident's Council Board located in the residents' lounge it was noted that the minutes of the May 28, 2013, Residents' Council meeting were posted, but no response to the identified concerns were posted or available to view. [s. 57. (2)]