Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 2, 2013	2013_191107_0006	H-000271-13	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

DUNDURN PLACE CARE CENTRE
39 MARY STREET, HAMILTON, ON, L8R-3L8

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

MICHELLE WARRENER (107), BERNADETTE SUSNIK (120), LALEH NEWELL (147), YVONNE WALTON (169)

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 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 2013

Critical Incident System (CIS) inspection H-000298-13 was completed concurrently with this RQI inspection and details are included in this RQI inspection report.
Complaint inspection H-000348-13 was completed concurrently with this RQI inspection. A separate report was issued for that complaint.

During the course of the inspection, the inspector(s) spoke with residents, family members, President of the Residents' Council, the Administrator, Director of Nursing and Personal Care (DOC), Assistant Director of Care (ADOC), Nurse Manager, Pharmacist, Physiotherapist, Skin Care Coordinator, Behavioural Support Ontario staff (BSO), Physician, Registered Dietitian (RD), Food Service Manager (FSM), Registered Nursing Staff (RN/RPN), front line nursing Personal Support Workers (PSW), dietary staff, Environmental Services Manager, Housekeeping staff, Laundry staff, Maintenance staff, Programs Manager, Programs staff, Resident Assessment Instrument (RAI) Coordinator, Social Worker, Convalescent Care staff, Business Manager, Admissions Nurse, Admission Coordinator, and Quality Improvement Lead

During the course of the inspection, the inspector(s) toured the home, observed meal service, reviewed food production, clinical health records of identified residents, relevant policies and procedures, the complaint log, Resident Council Meeting minutes, observed care of residents, observed the laundry, housekeeping and maintenance areas, observed medication administration

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
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 15(1)(a)]
Where bed rails were used, residents were not assessed when the bed systems were evaluated for entrapment zone risks. Beds that did not meet the measurement guidelines outlined in Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" that could not be altered or modified, continued to be used by residents.

The home evaluated all of their 201 beds on December 17-19, 2012 for entrapment zones one through seven. Approximately 115 beds failed one or more entrapment zones. Beds were adjusted where possible (head board, foot board, bed rails or mattress) and 62 new beds were purchased and installed June 19-21, 2013. Another evaluation was conducted June 25-27, 2013, identifying that 73 beds remain non-compliant with one or more entrapment zone guidelines.

According to both the Director of Care and Assistant Director of Care, no measures to mitigate risks had been instituted and residents had not been assessed for bed safety other than for falls risk. Foam wedges were purchased in February 2013 for approximately 12 residents to prevent falls from bed where one bed rail was removed.

During the inspection, beds were identified to be missing mattress keepers (hold the mattress in position and prevent it from sliding side to side - two identified rooms) and large gaps were noted between the end of the bed rail and the headboard (two identified rooms), between the headboard and the mattress (one identified room - a blanket was rolled up in the space), between the mattress and bed rail (three identified rooms) and between the mattress and the foot board (two identified rooms). Wobbly loose rails that could be moved from side to side were also noted in two identified rooms. Air mattresses were available in the home and used by residents (three identified rooms) who used bed rails, but had not been evaluated for the inherent risks associated with a very soft and compressible mattress. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(a)]
The plan of care for resident #806 did not set out the planned care for the resident related to eating. The plan of care did not indicate what level of assistance the resident required for eating. The resident required some assistance with eating at the lunch meal June 24, 2013 and was not consistently provided assistance with eating. The resident was unable to position their food in-front of themselves, was struggling to eat, and had not consumed much of the entree by 1355 hours (meal service began at 1200 hours). Direction was not available for staff in relation to the actual level of assistance required by the resident for eating. The resident was fairly new to the home. [s. 6. (1) (a)]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)] Previously issued March 29, 2011 as a VPC, March 30, 2011 as a VPC
The written plan of care for residents did not provide clear direction to staff and others who provided direct care to the residents.
A) The plan of care for resident #198 did not provide clear direction to staff in relation to oral care and was not individualized.
i) The plan stated the resident required total assistance with oral hygiene, however, did not direct staff on how or what care to provide. Staff stated the resident did not have any teeth and required specific interventions for oral care and required a cream to be applied to the lips due to dryness. The plan of care did not include direction for staff on either the oral care routine or application of the cream. The resident had thick ropey saliva and very dry flaking lips when observed on several occasions (June 5, 19, 24, 2013) during this review. (107/169)
B) The plan of care for resident #802 did not provide clear direction to staff positioning the resident at meal times. The resident was in a specialized tilt wheelchair and the chair was required to be in an upright position during meals (as per staff interview). The resident was observed in a reclined position and was coughing during the lunch meal service June 4, 2013. The plan of care did not include the requirement of the chair to be in an upright position during meal service. (107/169)
C) The plan of care for resident #807 did not provide clear direction for staff assisting the resident with eating. Staff stated that he resident required special feeding techniques, however, these techniques were not included on the resident's plan of care. The resident was being fed at the lunch meal June 4, 2013, however, staff stated the person assisting the resident did not know how to feed the resident in a way that worked for the resident and the resident did not eat well. Staff stated that the resident wouldn't eat unless the special techniques were used (not used by the person

assisting) and the Registered staff then proceeded to assist with an additional bowl of soup at the end of the meal service. The resident did not consume an entree that day. (107) [s. 6. (1) (c)]

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(2)]
The care set out in the plan of care was not based on an assessment of residents and the needs and preferences of those residents.
A) The plan of care for resident #198 was not based on an assessment of the resident and the resident's needs related to bathing. The plan of care stated the resident preferred a bath and was to receive a bath twice weekly. During interview, staff stated the resident was not safe in the bathtub and required a shower using a specialized chair. The resident was not able to communicate their preferences to staff. The plan of care did not include the need for the special shower chair and not all staff interviewed were aware of this need resulting in the resident receiving a bed bath versus shower on multiple occasions.
B) The care set out in the plan of care for resident #802 was not based on an assessment of the needs of that resident related to bathing. The plan of care stated the resident preferred a bath and was to receive a bath twice weekly. Staff stated the resident was not safe for a tub bath due to poor positioning and that the resident required a shower or a bed bath only. Interview with another staff member indicated that the resident was not safe for a shower either and required only a bed bath. The plan of care was not based on an assessment of the resident's needs related to bathing. [s. 6. (2)]

4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(a)]
Staff and others involved in the different aspects of care of residents did not collaborate with each other in the assessment of residents so that their assessments were integrated and consistent with and complemented each other.
A) Staff did not collaborate with each other in the assessment of resident #276 related to skin integrity and recreation.
i) Nursing staff identified open areas on the resident's skin, however, progress notes three days later from nursing and the Registered Dietitian indicated that the resident's skin was intact. "Twice daily skin checklist" forms for the same month identified open areas on the day shifts, however, night shift identified that skin was clear and intact and then the next day shift identified open areas again. This pattern was repeated throughout the skin checklist and sometimes indicated both intact and skin tears on the same shift. The assessments were not consistent related to skin integrity.

ii) The RAI-MDS coding for two recreation quarterly reviews were conflicting. The coding reflected an increase in the resident's participation from some of the time (1/3 to 2/3 of the time) to most of the time (more than 2/3 of the time), however, the coding also stated there was no change in the resident's participation in activities. The resident's Index of Social Engagement (ISE) score (which was supposed to highly correlate with actual time spent in activities) was not consistent with the RAI-MDS coding and reflected a decline over the same period. Activation participation records reflected that the resident was not meeting their participation goals. Discussion with Recreation staff identified inconsistencies in how staff were coding participation levels in the Activity Pro computer system. Information across the assessments did not correspond and made it difficult to evaluate the effectiveness of the program in relation to the goals identified for the resident. [s. 6. (4) (a)]

5. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued November 16, 2011 as a WN

The care set out in the plan of care for residents was not provided as specified in their plans.

A) Resident #803 was not provided care as set out in their plan of care related to bathing.

i) The resident had an order for medication every week when needed for bathing only. Staff stated they were often unable to provide showers and nail care for the resident due to the resident's behaviours, however, medication was not offered to the resident prior to bathing for two months reviewed. Registered staff were not coordinating the provision of the medication with the bathing schedule. The resident was not bathed at minimum twice weekly during the two months.

ii) The resident's plan of care stated the resident required two staff to assist with bathing, however, only one staff was provided on two documented occasions. The flow sheets did not indicate the number of staff that assisted with showering on two other occasions. (107)

B) Resident #260 was not provided care according to their plan in relation to falls. Clinical records indicated the resident had ten falls over a one year period. The plan of care, and interview with the registered staff, confirmed that the home had initiated interventions for the resident to minimize further falls. On June 12, 2013 at 1124 hours the resident was in bed without the interventions in place to minimize the risk of any further falls. (147)

C) The care set out in the plan of care for resident #806 was not provided to the resident as specified in their plan related to required fluid consistency. The resident's

plan of care required thickened fluids at meals, however, at the lunch meal June 19, 2013, the resident was provided and consumed thin fluids. A PSW then came and took the thin fluids away from the resident (after had been consuming them) and replaced them with the required consistency of thickened beverages.(107)
D) The care set out in the plan of care was not provided to resident #801, as specified in the plan related to hydration and required fluid consistency.
i) The resident had a plan of care requiring a fluid restriction. At the lunch meal June 17, 2013, the resident was offered more than double their allotted fluid amount for the meal. The resident was documented as consuming more fluids than their required fluid restriction on 13 days in one month and nine days the subsequent month.
ii) The resident had a plan of care requiring thickened fluids. The resident received thin coffee at the lunch meal June 17, 2013. Staff stated they added a bit of the resident's thickened milk to the coffee, however, it was not the required consistency. The resident was observed coughing after consuming the thin coffee. (107)
E) The plan of care for resident #198 required two staff to provide physical assistance with bathing. Staff stated the resident required two staff for bathing and was not safe with one person. The resident received a shower by one staff on one documented occasion. (107) [s. 6. (7)]

6. [LTCHA, 2007, S.O. 2007, c.8, s. 6(9)1]
The provision of care was not documented for resident #9051 related to toileting. Only night shift flow sheets had been signed as completed for toilet use/elimination on a specified date. Resident observation and interview with staff who provided care on that date identified the resident was toileted at 1720 hours. The RN confirmed the provision of care was not documented. [s. 6. (9) 1.]

7. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued March 30, 2011 as a VPC, June 28, 2011 as a VPC, August 12, 2011 as a VPC, May 25, 2012 as a VPC, January 30, 2012 as a WN
Residents were not re-assessed and their plan of care reviewed and revised at least every six months and at any other time when the residents' care needs changed or the care set out in the plans was no longer necessary.
A) The plan of care for resident #276 was not revised when their care needs changed related to cognitive status and bathing.
i) The resident's plan of care stated the resident was confused and not aware of their location, however, interview with the resident and staff confirmed the plan of care was not updated to reflect the current cognitive status of the resident (able to converse and

was not confused about location).
ii) The resident's plan of care required a shower twice weekly on specified days, however, the resident received a shower on different days. Staff confirmed the care plan had not been updated to reflect the current bath schedule. (107)
B) Resident #265 was not reassessed and their plan of care reviewed and revised when their care needs changed in relation to mobility.
The resident's plan of care and three Resident Assessment Protocol (RAP) summaries identified that the resident was reassessed for the use of their mobility device three weeks prior and did not pass the cognitive and safety assessment completed by the ADP authorizer. The resident was now utilizing a manual wheelchair for mobility on an off the unit. Interview with the Physiotherapist also confirmed that the resident was no longer using the mobility device. The resident's plan of care was not revised to indicate that the resident's mobility needs had changed and that the care set out in the plan was no longer necessary. (147)
C) The recreation plan of care for resident #194 was not revised when the resident's health status changed.
i) The resident had a significant change in status and was noted to be confined to bed due to a significant pressure ulcer. The resident's recreation plan of care was not revised and still reflected the resident was attending structured activity programs, however, the resident was no longer able to leave their room. There was no re-assessment of the resident's recreation needs and no change to the plan of care to ensure their recreation needs were met while the resident was in their room during the day. The Recreation Manager confirmed that the recreation plan of care was not revised for the resident based on their change in condition. (107)
ii) The resident had deteriorated and was bed bound, however, the resident's plan of care was not revised to reflect the change. The care plan stated the resident was eating meals in the dining room, however, the resident had been eating meals in their room.
iii) The Dietitian re-assessed the resident's energy and protein requirements after the development of an open area, however, the care plan was not revised to include the revised requirements. The resident lost a substantial amount of weight, however, the goals on the resident's plan of care were not revised in relation to the weight change. (107)
D) The plan of care for Resident #280 was not revised and updated with changes to the physician's orders for diabetes management.
i) The plan of care directed staff to monitor blood sugars at specific times daily, however the doctor's orders directed staff to monitor a different amount of times per

day.
ii) The plan of care directed staff to provide a specific amount of medication at bedtime and the doctor's orders directed staff to provide a different amount of medication.
iii) The plan of care directed staff to provide a specific amount of medication at meals and the doctor's orders directed staff to provide a different amount of medication. The nursing staff confirmed the direction on the plan of care was incorrect and had not been updated with changes to the physician's orders. (169) [s. 6. (10) (b)]

8. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(c)]
Residents were not reassessed and their plans of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.
A) Resident #801 did not have their plan of care revised when the care set out in the plan had not been effective in relation to weight loss and laboratory results.
i) At a nutritional review, the resident was noted to have a 5% weight loss over six months and was below their target weight set by a specialized clinic. The Dietitian discontinued the resident's nutritional supplement due to only partial consumption, however, the plan was not revised to include alternative strategies to address the weight loss below the resident's target weight.
ii) At a nutritional quarterly review, the Dietitian noted that the resident's lab value was elevated, however, noted that the resident was already on a restricted diet. An evaluation of the effectiveness of the restricted interventions did not occur and interventions were not revised in relation to the elevated laboratory value. Interview with staff identified the resident was refusing to follow the restricted diet and staff were only offering the regular menu.
B) Resident #276 did not have their plan of care revised when the care set out in the plan was not effective in relation to recreation. The resident had a goal for attendance at a specific minimum number of programs per month, however, the plan of care was not revised when the resident was not meeting this goal. The RAI-MDS RAPs did not reflect an evaluation of the recreation interventions in relation to the goals identified on the resident's plan of care. The resident was not meeting participation goals for four out of five months, however, an evaluation of the attendance in relation to the goal for a minimum programs per month did not occur. (107) [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002, 003, 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 with s. 6(2), s. 6(4)(a), and s. 6(10)(c), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

[O. Reg. 79/10, s. 17(1)(a)]
The home's resident-staff communication system was not easily seen, accessed and used by residents and staff.
A) On June 10, 2013, resident #320 was brought to the Activity room in the basement by a staff member so the resident could use the washroom. The resident was instructed to use the call bell when they were finished. The resident activated the call bell, however, staff did not come to answer the bell for at least 20 minutes. The resident was visually impaired and used a mobility aide and was unable to get out of the washroom without assistance. The resident was assisted by an inspector. Staff that eventually came to answer the call bell stated that call bell lit up on the panel on the second floor and they were unsure where the bell was coming from. (107)
B) The home did not have the call bell accessible to resident #250 while they were resting in bed. The call bell was wrapped over the bed rail and under the pillows and not within reach on June 6, 2013. The plan of care directed staff to pin the call bell to the resident's bedlinen to ensure it was accessible while in bed. (107)
C) On June 6, 2013 at 1136 hours resident #294 did not have their call bell within reach. The resident asked the inspector to activate the call bell for them and stated that staff always put the call bell on the other side of the bed which the resident could not reach. The resident required assistance with toileting. (107)
D) On Jun 26, 2013 at 1050 hours, resident #9051 did not have their call bell within reach. The resident stated that staff do not always place the call bell within reach and they could not use it. The resident described an incident that happened the day prior (June 25, 2013) where the resident could not reach their call bell and was calling out for staff assistance with toileting. (107)

[O.Reg. 79/10, s. 17(1)(e)]
A) The resident-staff communication and response system was not available in the second, third and fourth floor resident lounges and dining rooms.
B) The resident-staff communication and response system was not functional and therefore could not be used in the washroom of an identified room. The cording was strung from the activation station located behind the toilet all the way around the toilet to the side. When the cord was pulled, it could not activate the station.

[O.Reg. 79/10, s. 17(1)(g)]
The home was not equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

A) On June 6, 2013, the call bells in the 2nd and 3rd floor shower area in the spa were not audible to staff. Both call bells were activated in the shower area and the light outside the shower room clearly indicated it was activated. Staff confirmed the call bells were also to use sound to alert staff, which the two call bells by the shower area did not.
B) On June 5, 2013, the call bell in resident #163's room was not audible and did not clearly indicate where the signal was coming from to alert staff. Interview with the registered staff confirmed that the call bells were to light up and be audible when activated to ensure that the staff were properly alerted.
C) On June 6, 2013, the call bell in resident #309's room was not audible to alert staff when activated. Interview with the registered staff confirmed that the call bells were to be audible when activated to ensure that the staff were properly alerted.

Additional Required Actions:

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

WN #4: 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. (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 :

[O.Reg. 79/10, s. 26(4)(b)]
A) The registered dietitian did not assess resident #194's hydration status at a quarterly nutritional review. The resident's daily food and fluid intake records reflected the resident met their minimum fluid requirement of 1500ml/day on only 1/31 days for an identified month. The resident's hydration status was not mentioned at the review during the subsequent month. The resident was noted to have a significant weight loss of 13% over six months (identified in the subsequent month) and the resident had a significant open area on the skin. The resident continued to have poor hydration and did not meet their minimum fluid requirement on any day for the subsequent two months. A referral to the Dietitian related to poor hydration did not occur (only referrals for weight loss noted). There was no assessment of the resident's poor hydration or interventions to correct the poor hydration until the Dietitian assessed the resident three months later.
B) A referral to the dietitian did not occur for resident #800 when their food and fluid intake records reflected they did not meet their hydration requirement on 12/31 days for one month (9/15 days the second half of the month). The resident had a significant weight loss warning triggered the next month and the resident's hydration status was not assessed at that time in relation to the weight loss.

Additional Required Actions:

CO # - 006 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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

The maintenance services program does not have procedures in place for routine, preventive and remedial maintenance for the home's exhaust system, roof, windows, doors, walls, cabinetry, nurse call system, lighting and beds. Negative outcomes in these areas were identified as follows;

1. Exhaust system was not functioning in four identified bathrooms, and third and fourth floor tub rooms (1 unit not exhausting out of two). Many of the interior exhaust units were observed with thick layers of dust, some had their exterior baffles closed and two had paper taped over the opening. The one exhaust unit in the third floor tub room was noted to be blowing into the room instead of out of the room. The exhaust system was observed to be inadequate in all tub rooms. Tub rooms were stuffy and moist. Only two exhaust grilles were identified in all but the first floor tub room. These tub rooms had three showers, a toilet and a tub in each room. Procedure E-40-01 for the exhaust system required a bi-annual cleaning and procedure E-40-10 required that the exhaust motors were inspected monthly. According to the environmental manager, the exhaust system was checked by an outside contractor on May 28, 2013. However, no routine monitoring of the system was conducted to determine adequate function and cleaning was not done according to need and was not identified in any existing procedure.

2. Interior bathroom doors were observed to be misaligned and not able to close in four identified rooms. Maintenance records, reviewed for January to June 2013 completed by staff, identified that hinges or door closing issues were a problem in six identified rooms. These doors were all adjusted, but staff reported that they continued to come loose from the door frame. Maintenance staff reported that the frames were not secure and needed to be replaced. No procedures were identified to deal with interior door preventive maintenance.

3. Cabinetry in several lounge spaces and the second and fourth floor dining rooms were not in good condition. The laminate on the lower cabinets in the dining rooms was peeling away and was rough. The wooden cabinetry in several lounges was noted to be worn, exposing raw wood. An over bed table surface was damaged in an identified room, a gray shower chair seat was cracked exposing foam underneath in the 4th floor tub room, and a stool seat cover was cracked in the 4th floor dining room. Mattresses were noted to be in poor condition in two identified rooms. The water resistant cover had peeled away, exposing an absorbent inner layer. The home did not have any policies or procedures related to maintaining furnishings and equipment

(bathing and bed equipment) in good condition.

4. Water was noted to be dripping down into the first floor dining room from a pipe located in the ceiling on June 4 and June 27, 2013. Staff completed a maintenance request on May 29, 2013 indicating that a leak was coming from the ceiling. The maintenance supervisor stated that the roof company had been contacted but could not confirm when the roof could be repaired or what exactly was causing the leak. No procedures were available to identify what tasks were required of either in house staff or external contractors to keep the roof in good condition.

5. Windows located in the home were observed to be in poor condition. The seals and window hardware for the hopper windows on the fourth, third and second floors were not functioning as intended. Evidence of poorly sealed windows were observed in various bedrooms and dining rooms. Duct tape had been used to seal around the window where it connected with the frame to keep out drafts. Residents who were interviewed reported that it is drafty in the winter. The window locking hardware was observed to be worn down, incapable of locking or sealing shut the windows. The home, therefore, fixed slide locks onto the frames. The locks served to keep the windows from swinging open on their own but did not keep the windows sealed adequately to keep out drafts. The home's policy and procedure for windows E-75-20 required that the windows were in good condition, including the screens and that the opening be no greater than 10 centimeters. The policy did not provide any other guidance to staff.

6. Procedures were not available to determine how lighting would be maintained in the home and by whom. Burnt out bulbs were noted in the first floor dining room, resident washrooms and first floor corridor. Lighting levels varied due to the type and age of the tubes or bulbs. Lighting levels were lowered by staff based on a corporate policy requiring staff to keep indoor air temperatures more comfortable during heat alerts. However, this practice is no longer accepted for safety reasons and the requirements of O.Reg. 79/10, s. 18 to maintain acceptable lighting levels.

7. The resident-staff communication and response system policy and procedure E-75-5 did not include checks on the entire resident-staff communication and response system. The procedure required that call bell cords, hallway lights and the audio system be checked monthly, however it did not include checking the stairwell or perimeter door alarms and their connectivity to the panels located at the nurse's

station.

9. Holes in walls were noted in three identified rooms, wall surfaces were peeling in five identified rooms and cracked or chipped wall tile was noted in three identified washrooms. An audit was conducted of wall condition on March 19, 2013 and identified three washrooms to be cracked or damaged. The environmental services supervisor stated that the walls throughout the home would be repaired and repainted by the end of the summer. A policy or procedure was not available to advise staff how walls and tiles would be maintained throughout the year.

10. The licensee had not ensured the furnishings were maintained in a good state of repair. On June 4, 2013, the dining chairs on the second floor were noted to be very worn with several areas of the wood worn down. The stools used by staff to assist residents with feeding had several cracks in the vinyl and the square table with the microwave on it had four legs which were extremely rusty. Dining furniture in the first floor dining area was also noted in poor repair. (107) [s. 90. (1) (b)]

Additional Required Actions:

CO # - 007 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. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 231(a)]
Resident records were not maintained for each resident of the home and records were not accessible to staff.
A) Flow sheets were requested for resident #198, however, several of the flow sheets were unable to be found. Flow sheets from April 15-May 26 and June 1-9, 2013 were unavailable for review.
B) Flow sheets were requested for resident #802, however, several of the flow sheets were unable to be found. Flow sheets from May 13-June 9, 2013 were not available for review.
C) Flow sheets were requested for resident #803, however, several of the flow sheets were unable to be found. Flow sheets from April 8-May 12, 2013 were not available for review.
D) Resident records were not kept in an accessible location (stacked in a closet or stored in various locations at the nursing station) and were not available for staff to review/use for the three month quarterly reviews. [s. 231. (a)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

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1. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)8]
Resident #805 was not provided privacy in treatment and in caring for their personal needs. On June 24, 2013 at 1227 hours, resident #805 was visible from the hallway while being showered by staff. The resident was naked and standing at the grab bar in the shower while both the shower curtain and door to the hallway were open and the resident was clearly visible. [s. 3. (1) 8.]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)11.iv]
On June 6, 2013, staff did not provide privacy while discussing a resident's personal health information on an identified floor. A discussion occurred with the Behavioural Supports Ontario(BSO), nursing staff and the family member in front of the nursing station, beside the elevator. Visitors and other residents were walking around and able to listen to the information being discussed such as psychiatric history and plans. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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1. [LTCHA, 2007, S.O. 2007, c.8, s. 5]
The home was not safe or secure on June 25 and June 27, 2013.

A) Industrial sized floor fans were blocking fire exit doors to the stairwells. On June 25, 2013 a fan was blocking the first and second floor stairwell doors on the North side. The fans were repositioned by the inspector in order to get through the door on the second floor. On June 27, 2013, the fan was once again found blocking the second floor North stairwell exit door.
B) Loose toilet seats were observed in the washrooms of eight identified rooms (one raised seat). The seats moved side to side on the toilet frame and could cause a resident to fall off a toilet.
C) The stairwell alarms on the third and fourth floor South corridors did not sound if the door was held or remained open less than a few inches away from the door frame. The sensors were noted to be located in a different location on the door frame from other doors in the home that were alarmed.
D) Television cable was not secured and was left open as a tripping hazard in two identified resident rooms. In one room, an upright portable fan on a stand was placed with the cord running across the width of the room (trip hazard) on June 25, 2013. [s. 5.]

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 with ensuring a safe and secure environment for residents, to be implemented voluntarily.

WN #9: 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. [O.Reg. 79/10, s. 8(1)(b)
A) The policy related to managing hypoglycemia was not complied with. The plan of care for resident #280 included an intervention to include a package of sugar in orange juice when the resident was hypoglycemic. The policy from the Resident Care Manual, Section: Clinical Issues, Subject: Diabetic Protocol-Hypoglycemia directed staff not to provide sugar to juice as this could cause spikes in blood sugar. The resident received juice with sugar added for the treatment of hypoglycemia, which was not consistent with the home's policy, and was not direction from a physician order. (169)
B) The licensee did not ensure that the home's policy "Medication Administration, Subject Self Administration of Medications Index I.D. F-40 was complied with.
i) Residents #920, #921, #922, #923 and #926 were all observed to have medication sitting on their bedside tables, accessible. The policy directed residents who were self-administering medications to store them in a safe place (in bedside table).
ii) On June 06, 2013 at 1326 hours a bottle of medication was accessible to residents and stored on top of a storage bin in a shared bathroom in an identified room. (107)
iii) The policy directed staff to re-assess, at a minimum weekly, the resident's ongoing cognitive and physical ability to self-administer their medications and document this on the E-MAR. This was not completed for residents #920, #921, #922, #923 and #926. This was verified by the nursing staff. (169)
C) The home's skin care and wound care program binder was not consistent with the practices at the home. The program directed staff to document skin integrity every shift using the Point of Care (POC) system. The home was not currently using the POC system and a policy was not in place to direct staff in the completion of the form the home was currently using (Twice daily skin checklist). Direction was not provided to staff on using the Twice daily skin checklist and it was being completed incorrectly. (107) [s. 8. (1)]

2. [O.Reg. 79/10, s. 8(1)(a)]
The home's hydration and dietitian referral policies did not include direction for staff on the monitoring and referral of residents with poor hydration (unrelated to hot weather monitoring). The policies did not provide direction for staff related to when to intervene for poor hydration and the action to take to address the poor hydration. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the home's plans, policies, protocols, procedures, strategies and systems are in compliance with and implemented in accordance with all applicable requirements under the Act and complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 11(2)]
Not all residents were provided with food and fluids that were safe and the correct consistency to prevent choking.
A) The texture of the pureed food was too chunky and created a risk for choking. At the lunch meal June 24, 2013 the pureed pork, pureed wax beans, pureed apples were noted to be chunky and not smooth. At the lunch meal June 19, 2013 the pureed chicken and tuna sandwich were chunky and not smooth.
B) The texture of the pureed food was too thin and created a risk for choking for residents requiring thickened fluids. At the lunch meal June 4, 2013, the pureed blueberries were very thin and did not have thickener added (frozen blueberries). At the lunch meal June 24, 2013, the pureed bread was soupy, was not cohesive (a layer of milk and a layer of bread) and was not an appropriate consistency for residents requiring thickened fluids.

Not all residents were served foods that were nutritious and varied:
A) The texture of the pureed meals was too runny for some items (too much fluid added), resulting in reduced nutritive value of the portion served, and reduced appearance as fluid was observed running into other items on the plate. On June 4,2013, the pureed vegetables and pureed chicken were too runny and not holding their form on the plate. On June 24,2013, the pureed bread was soupy, the pureed beans were runny and leaking fluid, and the pureed pork had both a liquid and solid when portioning onto the plate (separated).
B) The snack menu offered to residents was repetitious and not varied. The afternoon snack was either cookies and pudding or cookies and ice cream on all but two days of at four week menu cycle and mainly sandwiches at the evening snack. Pudding, ice cream and sandwiches were also offered numerous times throughout the cycle menu, resulting in a snack menu that was not varied. Numerous residents voiced concerns over the menus to the inspector during this review. [s. 11. (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 with ensuring that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 16]
Sliding upper windows located in each of the resident bedrooms on the first floor were identified to be open more than 15 centimeters. No window restrictors were identified. [s. 16.]

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 with ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 centimeters, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 18]
The lighting requirements, as set out in the lighting table, had not been maintained in most resident washrooms, all bedrooms, all dining rooms, all corridors and the first floor lounge.

Lights were found to be turned half off on the first floor upon arrival to the home (Approximately 9:30 a.m.) on both June 25 and June 28, 2013. On June 25, 2013, a senior staff member was advised by the inspector to switch the lights on and to inform staff that minimum lighting levels must be maintained.

All four floors had a short south corridor and a long north corridor. Each floor had the same type and number of light fixtures (fluorescent tube lights running perpendicular to the floor down each corridor). The short corridor had light fixtures that held four tubes and the long corridors contain only one tube per fixture. The spacing between light fixtures ranged between 9 and 14 feet thereby creating shadows between light fixtures and a lux of zero. Lighting levels of the various light fixtures in the corridors were measured to be between 900 (with 4 tubes) and 150 (single tube)lux. The minimum requirement of a continuous consistent lux of 215.28 was not achieved.

Resident's bedrooms, on the first floor and three other identified rooms, did not have any central room lighting and therefore could not meet the minimum requirement of 215.84 lux (with the over bed lights on). Central room lux levels ranged from zero to 10 lux when the curtains were closed and with entrance and over bed lights on. The central room lighting in second, third and fourth floor rooms also did not meet the minimum standard. When tested directly under the light, no more than 100 lux could be achieved with the room drapery closed and over bed lights on.

All resident rooms had over bed lights located above the head of each bed and a light over the entrance into the room. Only the first floor had fluorescent tube lights about 1 meter in length while the others had a small square shaped fixture with two spiral or incandescent bulbs. The small square light fixtures were measured and provided only 50 lux and the longer tube lights provided between 220 and 400 lux. The minimum requirement is 376.73 lux.

Resident washrooms had different styles of light fixtures. The first floor had fluorescent tube lights about 1 meter in length located on the wall between the vanity and the toilet. Lux levels were tested over toilets and vanities. In general, the levels

were 150-200 lux over the toilet and 150-210 lux over the sink. The second, third and forth floor washrooms had a small fixture mounted over the mirror & sink area which could accommodate two light bulbs, either incandescent or spiral. Many were noted to have only one bulb in the fixture. Lux levels over the sinks ranged between 190 and 205 lux and levels were generally no more than 50-90 lux over the toilets. Washrooms with both spiral bulbs in place were generally well above the minimum requirement of 215.84 lux.

First floor dining room had a large sky light in middle of room, providing 500 lux (overcast day) for a small diameter of the room. Where the ceiling height of the room increased from 8 feet to over 12 feet, the lighting levels dropped from 310 to 150 lux directly below the square fluorescent tube lighting. Levels dropped to 100 lux between fixtures. Two chandelier light fixtures were also provided and the level for both were 100 lux.

Second, third and fourth floor dining rooms had a total of four light fixtures, with four tube lights in each fixture. When one dining room was tested, half of the window curtains in the room were drawn and it was overcast outside. Lux levels were between 50 and 100 between fixtures and each light fixture gave off a different level of lux ranging between 650 and 250 lux. The perimeter of the room was in shadow and the level of lux dropped to zero the further away from the light the meter was placed. General room lighting requirements for dining rooms is 215.28 lux.

First floor lounge had four recessed pot lights for a room that was 17x16 feet. Pot lights were 220 lux directly underneath and the value dropped to zero lux between pot lights and 150 lux when standing centrally in the room. The minimum lighting requirement is 215.84. [s. 18.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 24(1)2]
The licensee did not immediately report the suspicion of abuse and the information upon which it was based to the Director when there was reasonable grounds to suspect that abuse of a resident occurred.
A) The licensee had reasonable grounds to suspect Resident #9051 was treated in an abusive way or neglected by a Personal Support Worker (PSW) that resulted in harm or risk of harm. At 1500 hours (change of shift) resident #9051 requested to have their brief changed and was told by the PSW it was not their job and the day shift should have changed it. The resident was afraid to ask again, and therefore, continued to sit in their brief. By 1900 hours the resident requested to be changed as their brief was extremely wet. The same PSW told the resident if they changed it, they would be putting the resident to bed. The resident did not want to go to bed at that time and liked to stay up and watch TV in the lounge until 2100 hours. The resident became upset. The licensee did not notify the Director at any time. (169)
B) A resident informed the inspector of an allegation of abuse regarding a co-resident #956. The resident stated a PSW told the resident the following, "You go to bed when I say" The resident was also removed from their room and taken to another room where they claimed to be afraid. The resident stated the resident's overall health had declined since this incident. The resident requested the inspector take the information to the Administrator and this was completed. As of seven days later, a critical incident had not been received by the Director. The resident was non-interviewable. On the sixth day after the incident had been reported to the Administrator, the inspector inquired about the findings of the investigation and the Administrator identified they did not know or remember being told.
C) The licensee had reasonable grounds to suspect Resident #276 was treated in an abusive way by a Personal Support Worker (PSW) that resulted in harm or risk of harm. The resident informed the Administrator that a PSW had spoken to the resident in a threatening and demeaning way. The same story was told to the inspector during interview. This incident was not reported to the Director.
D) Interview with the Director of Care (DOC) on June 14, 2013 at 1517 confirmed that the home did not report the suspicion of abuse to the director after a resident alleged abuse by a staff member. The DOC stated there were several residents with complaints about a particular staff member, however, as they were not able to discipline the staff and could not prove the abuse occurred, it was not reported to the Director. [s. 24. (1) 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 with ensuring that a person who has reasonable grounds to suspect that abuse or a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s.33(3)]
The home failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #265 was using one bed rail when they were in bed. Staff confirmed that the resident used two bed rails in bed to assist with turning and positioning themselves. It was confirmed that the bed rail would be considered a PASD. A review of the most current care plan in the resident's health records, revealed that there was no mention of bed rails for the resident. The plan of care for resident #265 did not include the use of bed rails that were considered to be a PASD. [s. 33. (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 with ensuring that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #15: 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. [O.Reg. 79/10, s. 33(1)]
Not all residents were bathed, at a minimum, twice a week, by the method of their choice.
A) Resident #198 was bathed only once per week, on two occasions during a two month period, without supporting documentation to indicate the resident refused or documentation to support why a second bath was not offered. During interview, staff stated the resident was to receive at least one shower per week in addition to a bed bath and there was no reason why the resident would not receive the required two baths/showers per week. The resident was non-communicative and was unable to verbally refuse a bath/shower.
B) Resident #802 received a bed bath only once during a one week period. Documentation did not reflect rationale for not providing a second bath during this time and staff interviewed stated the resident should be receiving two baths per week. Flow sheets were missing for a three week period and could not be reviewed.
C) Resident #803 was bathed only once a week on four occasions over a three month period. Flow sheets and progress notes did not indicate that the resident refused a second shower or bath.
D) The plan of care for resident #803 indicated they preferred a shower not a tub bath. Interview with staff confirmed that resident did not like tub baths. Flow sheets indicated a tub bath was provided on two occasions. Documentation did not provide an explanation as to why a tub bath versus a shower was provided and staff interviewed were unable to say why a tub bath was provided and again stated the resident did not like tub baths. [s. 33. (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 with ensuring 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, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 35(2)]
Not all residents received fingernail care, including the cutting of fingernails, as frequently as required.
A) Resident #803 was observed with very long serrated fingernails. The PSW providing care to the resident stated the resident was aggressive and would not allow care to be provided. The resident had a plan of care indicating that fingernail care was to be provided on bath days and the resident was to receive medication prior to bathing, as needed. The resident was not provided the medication on any day prior to providing a bath/shower over a two month period. Registered staff stated that PSWs had not requested the medication and they were not aware if the resident was refusing bathing or nail care. Bathing flow sheets did not indicate that the resident's nails were cut and trimmed for two months except on one occasion that indicated the resident refused to have their nails cut.(107)
B) On two days observed, resident #190 had soiled fingernails. The resident had cognitive impairment and the plan indicated the resident required extensive staff assistance for personal hygiene. Documentation supported that the nails were not cut or cleaned during the identified time period. (147) (169) [s. 35. (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 with ensuring that each resident of the home receives preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #17: 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. [O.Reg. 79/10, s. 50(2)(a)(ii)]
Not all residents at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Resident #276 was sent to hospital and returned 9.5 hours later. The resident was noted to have open areas (as per the RAI-MDS quarterly assessment) prior to going to hospital, however, a skin assessment by a member of the registered nursing staff upon return from the hospital was not completed. During interview staff stated they did not complete skin assessments upon return from hospital unless it was more than 24 hours. [s. 50. (2) (a) (ii)]

2. [O.Reg. 79/10, s. 50(2)(b)(i)]
Not all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #276, who was documented with open areas did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. The RAI-MDS quarterly review identified the resident had wounds and the twice daily skin checklists completed by PSWs also indicated problems with skin integrity during that time frame. Interview with Registered staff confirmed that a skin assessment using the home's assessment instrument was not completed for over one month. [s. 50. (2) (b) (i)]

3. [O.Reg. 79/10, s. 50(2)(b)(ii)]
Not all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Resident #276 was documented as having open areas, however, interventions were not implemented for over one month. The area did not have an assessment using a clinically relevant assessment tool until over one month later when interventions were implemented by the wound care nurse. During interview, staff stated that the wound should have been added to the Treatment Administration Record (TAR) when it was identified, however, was not. [s. 50. (2) (b) (ii)]

4. [O.Reg. 79/10, s. 50(2)(b)(iii)]
Not all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Resident #276, who was documented as having open areas, did not receive a comprehensive assessment by the registered dietitian related to the altered skin integrity. Documentation by the Registered Dietitian, at the Nutritional Status Resident Assessment Protocol (RAP), identified increased needs for energy and protein related to wounds, however, did not identify what the increased needs were or if current intake was enough to meet the resident's needs. The resident consistently refused the breakfast meal. Interview with the Dietitian confirmed that the assessment did not identify if the resident's intake was meeting those increased needs and interventions on the nutritional plan of care were not revised in relation to wounds. [s. 50. (2) (b) (iii)]

5. [O.Reg. 79/10, s. 50(2)(b)(iv)]
Not all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A) Resident #276, who had skin breakdown, including pressure ulcers, was not reassessed at least weekly by a member of the registered nursing staff for over one month after the open areas were identified. Interview with the Registered nursing staff confirmed that weekly skin assessments would be required for this resident's open areas. Staff stated the wound care nursing position just started and during the identified time frame the position did not have consistent staffing.
B) Resident #801 had an open area that required re-assessment weekly by nursing staff. The order for weekly wound assessments was initiated by the physician, and was signed as completed on two occasions. Staff confirmed the wound assessment for the one date was not completed as required, however, was signed as completed. [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 with regulations sections 50(2)(a)(ii), 50(2)(b)(i), 50(2)(b)(ii), 50(2)(b)(iii), and 50(2)(b)(iv), to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 51(2)(b)] Previously issued November 17, 2011 as a VPC
Not all residents who were incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.
A) Review of resident #194's bowel and bladder continence Resident Assessment Protocol (RAP) for the past three quarters indicated that the resident had been incontinent of both bowels and bladder and had not been on a toileting routine during this period. Review of the Continent Management Assessment and the Minimum Data Set (MDS) coding also confirmed that there had been no changes in the resident's urinary continence status and the resident continued to be incontinent of both bladder and bowel. Interview with the registered staff on the unit confirmed that the resident had been bedridden and had not been on a toileting routine due to being unsafe on the toilet and to assist with healing of the pressure ulcer wound.
The plan of care reviewed for the resident was not updated to reflect the resident was incontinent of both bowel and bladder and did not require a toileting routine. (147)
B) Resident #9051, who was incontinent and unable to toilet independently, did not have their continence plan implemented. The resident's plan of care directed staff to check for wetness every two hours and render pericare after each episode of incontinence.
i) The resident came to the nursing station at 1715 on a specified date, stating they had not been changed all day and that their clothes were now wet and their skin was itchy (witnessed by the inspector). The resident stated that their brief was put on around 1100 hours and staff came and checked the resident at 1330 hours saying the brief was okay until the next shift change. The resident stated incontinence was more of an issue in the afternoon. The resident stated they went to the nursing station at 1520 hours and was told that all the nurses were busy and the resident would have to wait. The resident stated they went to their room and called out to a staff member who said, "I heard you, I'll be there in another 10 minutes". The resident stated staff did not come and they called out again at 1545 hours and nobody answered. At 1645 hours the resident stated they went out to the nursing station again and asked for assistance, however, was told, "it's nearly supper time and you have to wait until after supper". The resident stated they went out again at 1715 hours (witnessed by the inspector) and told staff that their clothes were wet the charge nurse then got two staff to change the resident. Interview with the PSW providing care to the resident that afternoon, indicated they were unaware that the resident needed to be toileted. Staff did not check the resident for wetness at least every two hours as per the resident's continence plan of care. (107)

ii) At change of shift on a different specified date, resident #9051 requested to have their brief changed and was told by the PSW it was not their job and the day shift should have changed it. The resident was afraid to ask again, and therefore continued to sit in their brief. By 1900 hours the resident requested to be changed as their brief was extremely wet. The same PSW told the resident if they changed it, they would be putting the resident to bed. The resident did not want to go to bed at that time and liked to stay up and watch TV in the lounge until 2100 hours. The resident became upset. The resident's continence plan of care was not followed by staff. (169) [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #19: 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 :