Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 20, 2015	2015_334565_0002	T-1759-15	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

TRUE DAVIDSON ACRES
200 DAWES ROAD TORONTO ON M4C 5M8

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

MATTHEW CHIU (565), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), STELLA NG (507)

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): January 19, 20, 21, 23, 26, 27, 28, 29, 30, February 2, 2015.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection: T- 1075-14 and T- 1333-14.
The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection: T- 573-14, T- 1076-14 and T- 1098-14.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), nurse managers (NMs), registered dietitian (RD), nutrition manager, manager of resident services (MRS), supervisor of building services (SBS), social worker (SW), skin care coordinator (SCC), resident assessment instrument (RAI) lead, volunteer coordinator (VC), recreation staff, registered staff, personal care aides (PCAs), dietary aide (DA), volunteers, residents, substitute decision maker (SDM) and family members of residents.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right of having his or her personal health information within the meaning of their Personal Health Information Protection Act, 2004 is kept confidential in accordance with that Act.

On an identified date, the inspector observed an identified registered staff leaving a medication cart unattended on two occasions during the medication pass, with the medication administration binder (MAR) open to an identified resident's profile.

On the same day, the inspector observed the identified registered staff disposing an empty medication pouch into the regular garbage. The medication pouch identified the resident, medication and dose of the medication.

Interview with the identified registered staff confirmed that the MAR binder should be closed when the medication cart is left unattended.

Interview with an identified NM confirmed that the empty medication pouches are routinely thrown out with the regular garbage. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right of having his or her personal health information within the meaning of their Personal Health Information Protection Act, 2004 is kept confidential in accordance with that Act, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

a. Review of the progress notes of resident #41 indicated that the resident becomes agitated in the evenings when his/her family leaves after supper, and the resident often asks and attempts to look for the family since his/her admission to the home. Interviews

with PCAs and registered staff revealed that providing reassurance to the resident is effective, and the resident usually calms down after the intervention.

Interview with the RAI lead confirmed that the completion of Minimum Data Set (MDS) assessment and care plan development is based on the resident's documentation, including progress notes, medical order, admission package, lab work, nursing data and Nursing and Personal Care Record (NPCR), nursing assessment and input from all disciplines. Record review revealed and interviews with an identified registered staff and identified nurse manager confirmed that the above mentioned intervention is not included in resident #41's written plan of care, and staff and others involved in the different aspects of care of the resident did not collaborate with each other in the development and implementation of resident #41's plan of care.

b. Interviews with identified PCAs and registered staff revealed that resident #42's preference is to return to bed after lunch, and stay in bed until supper time. The identified PCAs confirmed that the day shift PCAs put the resident back to bed after lunch, and the evening shift PCA gets the resident up for supper.

Record review and interview with the identified registered staff confirmed that the above mentioned intervention is not included in the resident's plan of care. [s. 6. (4) (b)]

2. The licensee has failed to 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.

Record review of resident #10's plan of care indicated that the resident is at high risk for falls and has falls prevention interventions in place.

Interview with an identified PCA confirmed that he/she has been providing direct care to the resident but that he/she is not aware that the resident is at high risk for falls and has documented interventions in place. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, and to 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, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the equipment is kept clean and sanitary.

On an identified date, the inspector observed the inside door of the walk-in Dairy refrigerator being soiled with dried food. It had dust and mold around the door frame. The inside white protective coating on the walk-in Dairy refrigerator was peeled off.

The observations were confirmed by an identified dietary aide. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home's equipment is maintained in a good state of repair.

On an identified date, the inspector observed that the ice machine located on the second floor dining room was not in a good state of repair.

Staff interview confirmed that the ice machine was not producing ice cubes, as result the cold food items were stored on the counter without ice cubes. The food service manager proceeded to call maintenance to service the machine. [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 equipment is kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Record review revealed that on an identified date, resident #41 physically abused resident #42. As a result, resident #42 sustained injuries. Review of resident #41's progress notes revealed the following in relation to his/her responsive behaviours prior to the incident:
• The resident exhibited responsive behaviours since his/her admission to the home.
• The resident usually exhibits responsive behaviours when his/her family leaves after the day's visit in the evenings.
• The resident exhibited responsive behaviours to staff on a few occasions.
• The resident exhibited responsive behaviours in the evenings after his/her family left on two identified dates, and refused medication on one of the identified dates. The progress notes dated on the same date, indicated that the resident required one on one close observation.

Record review and interview with an identified registered staff confirmed that resident #41 was in his/her wheelchair in the TV lounge on the identified date after his/her family left. The resident moved around among the residents in the TV lounge slowly in his/her wheelchair by moving his/her legs. The resident refused the evening snack and medication despite encouragement from three staff members. However, the resident remained in the TV lounge with other residents in close proximity. At an identified time, an identified PCA observed resident #41 physically abuse resident #42.

Interviews with the DOC and an identified NM confirmed that resident #41 has history of responsive behaviours after his/her family leaves and his/her responsive behaviours escalated at the beginning of the summer of 2014. This piece of evidence indicates that the resident poses a risk to other residents who are placed in his/her close proximity when he/she is exhibiting responsive behaviours, and resident #41 was not placed on one to one observation as indicated in the progress note dated on the identified date. [s. 19. (1)]

2. The licensee has failed to ensure that residents are protected from abuse by staff in the home.

Interview with an identified PCA revealed that on an identified date, resident #45 declined to go to the dining room for diner. After serving other residents, the identified PCA warmed up the meal reserved for resident #45 and asked the resident to go to the dining room. The resident declined and started exhibiting responsive behaviours with the PCA.

A review of the home's investigation records indicated that the identified PCA made a threatening comment to the resident.

Interview with the VC indicated that he/she witnessed the interaction between the PCA and the resident. The resident was emotionally upset. The VC comforted the resident and took the resident out of the dining room.

A review of the home's investigation records indicated and interview with the identified PCA confirmed that he/she made the threatening comment to resident's #45 and the PCA was disciplined. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident 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 is specifically designed for skin and wound assessment.

Record review revealed that on an identified date, the physician had assessed resident #38 for altered skin integrity and ordered a medicated skin care treatment daily for two weeks. On an identified date, the physician documented a recurrence of the previously mentioned altered skin integrity. Health record review further revealed that registered staff did not complete a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin assessment.

Interviews with an identified registered staff and the skin care coordinator confirmed that a skin assessment was not completed using a clinically appropriate assessment instrument for resident #38. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.

Record review revealed that on an identified date, the physician had assessed resident #38 for altered skin integrity and ordered a medicated skin care treatment daily for two weeks. On an identified date, the physician documented a recurrence of the previously mentioned altered skin integrity.

Record review and interview with the RD confirmed that a nutritional assessment related to the resident`s impaired skin integrity has not been completed. [s. 50. (2) (b) (iii)]

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 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 is specifically designed for skin and wound assessment, and to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation section 50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a RD 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.

The home's policy titled "Skin Care and Wound Prevention and Management", reference # RC-0518-02, dated October 1, 2010, indicates that residents who have stage II or greater pressure ulcers are to be referred to the RD for nutritional assessment. This policy is not in accordance with the regulation that states the RD is to make an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown. [s. 8. (1) (a)]

2. The licensee has failed to ensure that the home's Dining Room – Point of Service Tools policy is complied with.

Review of the home's Dining Room – Point of Service Tools policy, reference #RC-0523-06, revised January 9, 2013, indicated that when staff serve meals, they must use the information documented on the diet information sheets.

On an identified date, the inspector observed an identified DA serving the residents the lunch without referring to the diet information sheet.

Interview with an identified DA confirmed that he/she was not using the information documented on the diet information sheets when serving the resident's meals because the PCAs order food by resident's name and diet, and he/she has been working in the home for many years and is aware of the resident's diet. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are kept locked when they are not being supervised by staff.

On an identified date, the inspectors observed that in two identified home areas, the doors leading to two electrical rooms and two data rooms were closed but not locked while unsupervised by staff.

Interviews with an identified registered staff and an identified NM confirmed that these doors are to be kept locked at all times, and they locked the doors. [s. 9. (1) 2.]

WN #8: 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 :

1. The licensee has failed to ensure that the resident-staff communication and response system is easily accessible and used by residents at all times.

On an identified date, the inspector observed in a shared bathroom of an identified home area, the call bell cord wrapped several times around the grab bar located to the right of the toilet.

Interview with an identified PCA confirmed that the communication and response system could not be activated when the wrapped call bell cord was pulled. The identified PCA immediately unwrapped the call bell cord and then was able to activate the communication and response system. [s. 17. (1) (a)]

2. On two identified dates, the inspector observed in the bathrooms of residents #29, #36 and #38, the call bell cords were wrapped around the grab bars and were not be able to be activated.

This was brought to the attention of two identified staff members. The identified staff members confirmed that the call bells cannot be activated when wrapped around the grab bars and they unwrapped the call bell cords. [s. 17. (1) (a)]

WN #9: 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. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan includes any risk the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

Record review revealed that resident #43 was admitted to the home on an identified date. Review of the Nursing and Personal Care Record indicated that the resident was exhibiting identified behavioral triggers during the evening shift on the same day. Interview with an identified PCA confirmed that he/she observed the resident exhibiting his/her behavioral trigger to a male/female resident and had them separated, and the identified PCA reported the incident to the registered staff on the same day.

Record review of the 24-Hour Admission Care Plan for resident #41 and interviews with an identified registered staff, an identified nurse manager and the DOC confirmed that the above mentioned responsive behaviour was not included in the 24-Hour Admission Care Plan. [s. 24. (2) 2.]

WN #10: 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. The licensee has failed to ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur that resulted in harm or a risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director.

Record review revealed that on an identified date, resident #41 physically abused resident #42. As a result, resident #42 sustained injuries. The incident was reported to the Director two days later.

Record review and interview with the DOC confirmed that the above mentioned incident was not reported to the Director immediately as required by the Act. [s. 24. (1)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the licensee withholds approval for admission, the licensee give to persons described in subsection (10) a written notice setting out, a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements of care, and an explanation of how the supporting facts justify the decision to withhold approval.

Record review of the correspondence dated on an identified date, from the home to the applicant in relation to the withholding approval of his/her application for Respite Admission, and interview with the administrator confirmed that the written notice given to the applicant did not include a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements of care, and an explanation of how the supporting facts justify the decision to withhold approval. [s. 44. (9)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving the Family Council advice related to concerns or recommendations.

Record review of the Family Council meeting minutes revealed and interview with the Family Council president confirmed that the council had raised concerns about the loss of clothing in laundry, communication with staff, volunteer assignments and use of follow-up request form during the council meeting in the fall of 2014.

Interview with the administrator confirmed that the home has received the meeting minutes from the council in the following month after the meeting, and the meeting minutes have listed the council's concerns. The home did not respond to the Family Council in writing until early 2015, over 10 days after receiving the Family Council advice related to the concerns. [s. 60. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have receive retraining annually relating to the following:
* The home's policy to promote zero tolerance of abuse and neglect of residents
* The duty to make mandatory reports under section 24
* The whistle-blowing protections.

Record review of the staff training records revealed and interview with an identified NM confirmed that 16.14 per cent of staff did not receive training in above mentioned areas in 2014. [s. 76. (4)]

2. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in behaviour management.

Record review and interview with the DOC confirmed that 17.9 per cent of direct care staff did not receive training in behaviour management in 2014. [s. 76. (7) 3.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Record review and interview with the DOC confirmed that on an identified date, resident #45 was allegedly verbally abused by a staff member. The home has conducted an internal investigation and the involved staff member was disciplined.

Record review revealed and interview with the DOC confirmed that that resident's SDM was not notified upon becoming aware of the above mentioned allegation. [s. 97. (1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to a staff member concerning the operation of the home is investigated.

Interview with resident #36 indicated that his/her item went missing in the end of 2014, and he/she complained to a registered staff.

Interview with resident #29 indicated that his/her item went missing and he/she reported that to a laundry staff and complained to the social worker in early 2015.

Interview with an identified SW confirmed that he/she had received a complaint from resident #29 related to his/her missing item, but he/she had not initiated any investigation.

Review of the home's complaints log revealed and interview with the DOC confirmed that the home did not investigate the above identified complaints. [s. 101. (1) 1.]

2. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Interview with a family member confirmed that he/she had reported a suspected incident of abuse of an identified resident to the home in early 2014.

Record review and interviews with an identified NM and the DOC confirmed that no documented record is kept related to the above mentioned incident. [s. 101. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart is used exclusively for drugs and drug related supplies.

On an identified date, the inspector observed in an identified medication cart, the narcotic bin contained two clear small bags with digi-pen refill cartages, a zip locked bag containing money and a package containing a y-port for an enteral feeding tube.

Interview with an identified registered staff confirmed that they routinely store the above mentioned items in the narcotic bin and he/she is aware that the medication cart should be used exclusively for drugs and drug related supplies. [s. 129. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Record review revealed and interview with an identified NM who is the lead of the infection prevention and control program confirmed that the infection prevention and control program was not evaluated in 2014. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On an identified date, the inspector observed in an identified spa room two care caddies with three unlabeled containers of zinc cream, one unlabeled tube of barrier cream, one unlabeled tube of AIM toothpaste, one unlabeled grey hairbrush with hair in it and an unlabeled container of Vaseline.

Interview with an identified registered nursing staff revealed that the PCAs use the above mentioned items during residents bath care and could cause cross contamination.

Interview with an identified NM who is the lead of the infection prevention and control program confirmed that the above mentioned items are to be labeled with identified resident names and should not be used for multiple residents. [s. 229. (4)]

Issued on this 2nd day of March, 2015

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

Original report signed by the inspector.