Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 12, 2014	2014_321501_0005	T-100-14	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

SUSAN SEMEREDY (501), JOELLE TAILLEFER (211), 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): April 11, 14, 15, 16, 17, 22, 23, 25, 28, and 29, 2014.

This inspection occurred concurrently with complaint inspections T-714-13, T-175-13, and T-191-13 and critical incident inspection T-450-13.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), manager of resident services, supervisor of building services, nutrition manager, registered dietitian (RD), nurse managers, registered nursing staff, physiotherapist, resident assessment instrument (RAI) co-ordinator, personal care aides (PCAs), food service workers (FSWs), cooks, housekeeping staff, residents and substitute decision makers (SDMs).

During the course of the inspection, the inspector(s) conducted observations and reviewed resident and home records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 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:
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity is fully respected and promoted.

Interview with resident #377 revealed that an identified staff member calls him/her by a nickname which hurts his/her feelings, makes him/her feel not respected and he/she does not like it. The resident has informed staff and requested not to be called this way. An identified PCA confirmed he/she is aware of this resident's preference but admits he/she sometimes forgets and occasionally calls him/her that way. [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident has the right not to be neglected by the licensee or staff.

Interview with resident's SDM revealed that resident #452 was found in soaked double briefs on identified dates.

Record review of the plan of care, indicated that resident #452 is totally dependent at night. The plan of care indicates that the resident is to wear two briefs during the night and one staff member should change the continent brief when the brief is soiled and provide hygiene care to the resident. During the day, the resident wears one brief and

is to be changed in the morning, before or after meals, and when the brief is soiled assisted by one staff.

Record review revealed and staff interview confirmed that a family member found resident #452 wearing two incontinent briefs and the briefs were soiled. Interview with an identified PCA revealed that on that day, another identified PCA dressed resident #453 in the morning without changing his/her brief. Staff interview also confirmed that the family member changed the resident before a meal because they did not want the resident to wait with a wet brief until the next scheduled routine.

Record review revealed and staff interview confirmed that a family member found resident #452 wearing two incontinent briefs and the briefs were soiled on an identified date, before a meal. The resident was changed by his/her family member.

Interview with an identified registered staff confirmed that he/she was aware that the resident's brief was soiled and he/she was wearing two incontinence products on identified dates. The registered staff instructed the PCAs to follow the plan of care related to incontinence care.

Interview with the nurse manager confirmed that the incident is a form of neglect pending the outcome of the investigation. [s. 3. (1) 3.]

3. The licensee failed to fully respect and promote the resident's right to meet privately with his or her spouse or another person in a room that assures privacy.

Interview with resident #437 revealed that he/she did not feel there was a private place to meet with his/her family members as he/she is in a semi-private room. Interview with resident #371 and their family member revealed they did not know of a private place to meet to discuss personal and confidential issues. Interview with registered staff revealed that the activity room was available for such meetings but agreed that this may not be communicated to residents and family members other than during a tour before admission. Review of the admission package does not include a section to describe how residents and family members can meet privately. [s. 3. (1) 21.]

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 residents' right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity and the resident's right to meet privately with his or her spouse or another person in a room that assures privacy are fully respected and promoted, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff who provide direct care to the resident.

Record review revealed that on an identified date, resident #501 reported that he/she was hit and grabbed by staff members which caused bruising. The home investigated these allegations and police were involved. Interview with the DOC revealed that in order to prevent further possible allegations, staff members were verbally instructed by the DOC to have two people attending this resident at all times. Interview with registered staff and a PCA confirmed that two people are to provide care to this resident; however, record review revealed that this information was not included in the resident's plan of care. [s. 6. (1) (c)]

2. The licensee failed to ensure that 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 consistent with and complement each other.

Interview with resident #377 revealed that an identified staff member calls him/her by a nickname which hurts his/her feelings, makes him/her feel not respected and he/she does not like it. The resident has informed staff and requested not to be called that way.

Staff interview confirmed that staff are aware of the resident's preference not to be

called by that nickname, and also confirmed that the resident has requested not to be addressed that way. This information was not shared with all staff involved in the different aspects of the resident care, and was not included in the plan of care. [s. 6. (4) (b)]

3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Record review indicated that staff should conduct a pain assessment weekly and every quarter and with any change of resident #377's health status related to the possibility of pain. Record review and staff interview confirmed that pain assessments for identified weeks were not completed. [s. 6. (7)]

4. Record review revealed that resident #430's plan of care indicated a preference to have only female staff members assist him/her with activities of daily living. Progress notes revealed that on an identified day, resident #430's visitor stated she/he told the staff that the resident would rather receive care from female staff members. Interview with registered staff and an identified PCA confirmed that the resident's continence care was provided by male staff members at times. [s. 6. (7)]

5. Record review of the plan of care indicated that resident #452 is totally dependent at night. The plan of care indicates that the resident is to wear two briefs during the night and one staff member should change the continent brief when the brief is soiled and provide hygiene care to the resident. During the day, the resident wears one brief and is to be changed in the morning, before or after meals, and when the brief is soiled assisted by one staff.

Record review revealed that a family member found resident #452 wearing two incontinent briefs on identified dates.

Staff interview confirmed that the resident was wearing two briefs on both identified days and this should not have occurred. [s. 6. (7)]

6. The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the content of the resident's plan of care and have convenient and immediate access to it.

Record review and staff interview indicated that it is the practice of the home to have a

printed version of the written plan of care called "Care Plan" available for PCAs' use. They (PCAs) do not have access to the entire residents' plans of care, but only to the printed version "care plan".

Record review revealed that resident #337 had responsive behaviours. Interview with an identified PCA and an registered nurse confirmed that they were aware of resident's behaviours. Record review and interview with the nurse manager confirmed that the printed version of the responsive behaviours section in the plan of care for resident #337 was not available to direct care staff.

Record review indicated that resident #430 requests to be assisted by a female staff member for activities of daily living. Interview with an identified registered staff and PCA confirmed that she/he was not aware of the plan of care related to the resident's care preference. [s. 6. (8)]

7. Record review revealed that there was a post fall assessment huddle completed on an identified date, for resident #352. It was recommended to put a mattress on the floor next to the resident's bed as a preventive measure. Interview with registered staff confirmed that the PCAs have only access of the printed version of the plan of care and the preventive measure was not included in it. [s. 6. (8)]

8. Record review revealed that resident #502 was admitted to the home on an identified day and was placed on isolation precautions. Two days after admission, the inspector observed that isolation precaution signage was place on the resident's door. Interview with the registered staff revealed that the isolation precautions were not included in the resident's printed version of the plan of care available to the PCAs. Interview with the nurse manager confirmed that isolation precautions should have been included in the printed version of the resident's plan of care as the PCAs have access only to the printed version of the plan of care. [s. 6. (8)]

9. Record review revealed that the physician made an order that resident #371 was to start having a wander guard bracelet applied on an identified day. Three days after the order, interview with an identified PCA revealed that she/he was not aware of this intervention as the printed version of the "care plan" had not been updated and he/she was unsure of how and when to apply this device. Interview with registered staff confirmed that the electronic and printed versions of the "care plan" had not been updated.

Record review and staff interview confirmed that resident #488 returned from a leave and was reassessed by the RD on an identified day. The RD recommended that resident #488 not be served certain food. Interview with an identified PCA revealed that he/she was unaware of the resident's new diet restrictions and registered staff confirmed that the printed version of the resident's plan of care does not include this intervention. [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:
1. There is a written plan of care for each resident that sets out clear directions to staff who provide direct care to the resident.
2. 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 consistent with and complement each other.
3. The care set out in the plan of care is provided to the resident as specified in the plan and,
4. The staff and others who provide direct care to a resident are kept aware of the content of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #3: 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 failed to ensure that any home's plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or the Regulation to put in place is complied with.

On an identified day, the inspector observed that an identified registered staff member was wearing an isolation mask when at the nursing station. Interview with the registered staff member revealed that she/he was in resident #500's isolation room and forgot to remove the mask after leaving the room. Review of the home's personal protective equipment (PPE) policy revised December 1, 2011, stated that all PPE should be discarded in the appropriate receptacle before leaving the resident's room or care area. Interview with the nurse manager confirmed that the isolation mask should have been discarded before leaving the resident's room. [s. 8. (1) (b)]

2. On an identified day, the inspector observed an identified PCA cleaning resident #601's mouth without wearing gloves. After the resident cleared his/her throat and spit mucous out into the face cloth, the PCA used the same face cloth to clean around the resident's mouth. The PCA left the resident's room and went to the nursing station to take additional supplies without washing or sanitizing his/her hands.

Review of the home's policy titled Routine Practices, revised December 1, 2012, indicated that staff should use clean, non-sterile gloves when there is a risk of hand contact with residents' body fluids, excretion, secretion, non-intact skin, or mucous membranes.

Interview with the infection prevention and control co-ordinator confirmed that staff are required to wear gloves while handling body fluids.

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

Review of the home's policy titled Dining Room-Point of Service Tools, revised September 1, 2013, stated staff should serve meals using the information documented on the diet information sheet.

Interview with the identified FSW confirmed that he/she did not refer to the diet list because the unit is his/her assigned unit and he/she is aware of all the residents and their diets and preferences. Interview with the nutrition manager confirmed that staff should refer to the diet list during meal service. [s. 8. (1) (b)]

3. On an identified day, the inspector observed an identified PCA wiping resident #601's mouth with the clothing protector and a face cloth while assisting with feeding.

Review of the home's policy titled Assistance at Mealtime, revised September 1, 2014, states that staff should encourage residents to wipe their mouths with a damp cloth or napkin throughout the meal, assist as required, and not to use the clothing protector to wipe the residents' mouths. [s. 8. (1) (b)]

4. On an identified day, the inspector observed three unlabelled containers containing fish in dill sauce, cooked sausage, and gravy respectively in the dairy fridge.

A review of the home's policy titled Storage in Food and Nutrition Service, revised September 1, 2013, indicated that all food items should be kept in closed containers and labelled properly.

Dietary staff interview confirmed that the food should have been labelled and dated. [s. 8. (1) (b)]

5. On an identified day, the inspector observed that thermometers used to take food temperatures were not calibrated; the temperature recorded at lunch on the same day was not within the home's standard temperature for hot food which is 140 to 170 degrees Fahrenheit, and cold food which is less than 40 degree Fahrenheit.

A review of the home's policy titled Thermometer Calibration and Cleaning, revised September 1, 2013, indicates that thermometers should be calibrated on regular basis. Interview with the nutrition manager confirmed staff should calibrate the thermometers weekly. Record review of the home's temperature logs revealed that the thermometers were not calibrated weekly in March and April 2014.

The inspector and nutrition manager calibrated the thermometer used by the dietary staff in the kitchen, on the first floor, and on the third floor, which read 40 degrees Fahrenheit, which is 8 degrees higher than the standard temperature for calibration. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any home's plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or the Regulation to put in place is complied with, to be implemented voluntarily.

WN #4: 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 failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On April 15, 2014, inspector #502 observed the plastic elevated toilet seat in resident #430's bathroom was dirty. On April 23, 2014, at 2:30 pm, inspector #507 observed the plastic elevated toilet seat was dirty in resident #430's bathroom. Interview with the supervisor of building services confirmed that residents' rooms were cleaned by 2:30 pm daily and resident #430's toilet seat was not clean.

On April 25, 2014, the inspector observed the electrical outlet by resident #352's bedroom door was dirty and four sofas in the common area at the end of the hallway on the fourth floor of the west wing were stained and unclean. Interview with the supervisor of building services confirmed that these items were not clean.

On April 25, 2014, the inspector observed there was dust gathered on the floor and baseboard in the area between the bed and the night table in resident #437's room.

Interview with the supervisor of building services confirmed that the housekeeping staff had not cleaned resident #437's room properly. [s. 15. (2) (a)]

2. On April 14, 2014 the inspector observed on the second floor of the east wing that dining room chairs were stained, the base and foot rest of three feeding stools were dirty and one table had dried food at the edge.

Interview with housekeeping staff confirmed that some dining room chairs and tables were dirty and stained. Interview with the supervisor of building services confirmed that the dining room chairs were dirty and stained and the dining room chairs should be wiped after each meal.

On April 14, 2014, the inspector observed resident #333 and #430's wheelchairs were dirty. Record review and interview with the supervisor of building services confirmed that according to a monthly cleaning schedule for wheelchairs, not all wheelchairs were cleaned in March 2014. [s. 15. (2) (a)]

3. The licensee failed to ensure that the home, furnishings and equipment are maintained in a good state of repair.

Observations conducted by inspector #507 on April 11, 14 and 15, 2014, revealed the following:
1. Scratch marks, a hole and a dent on the walls in the spa room on the first floor of the east wing,
2. Patches of paint that were peeled off from the wall facing the nursing station on the second floor of the east wing,
3. Chipped walls in the hallway on the third floor of the east wing,
4. Scratch marks on the walls throughout the building , and
5. Scratch marks on the walls and door frames of most utility rooms throughout the building.

Observations conducted by inspector #502 on April 11, 14 and 15, 2014, revealed the following:
1. In the dining room of the second floor of the east wing, the floor had scratch marks, the pillar had scrapes and holes and the wall in the servery area was chipped and scrapped,
2. Scratch marks on the wall in resident #333's bathroom, and
3. Chipped wall behind resident #430's lazy boy chair.

On April 14, 2014, inspector #211 observed a hole in the wall behind the headboard of resident #437's bed.

Interview with the supervisor of building services confirmed that many the home's furnishings are not in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Record review revealed that resident #430, #218, and #452 were assessed for the use of the bed rails for transferring and repositioning. Record review and interview with the supervisor of building services confirmed that these residents' bed systems were not evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents prior to the use of bed rails. [s. 15. (1) (a)]

2. Record review revealed that resident #377 requires extensive assistance by two staff and bed rails for repositioning in bed. Interview with resident #377 confirmed he/she needs bed rails for repositioning. Interview with the physiotherapist confirmed that resident #377 received an assessment for the use of bed rails but the bed system was not evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (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 to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident and family interviews revealed concerns with staffing and care standards in the home.

Record review revealed and interview with the DOC confirmed that the staffing plan is not evaluated and updated at least annually in accordance with evidence-based practices or in accordance with prevailing practices. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes the communication of the seven-day and daily menus to residents.

On April 28, 2014, the inspector observed that on the third floor of the west wing, the weekly menu differed from the daily menu posted. An identified FSW confirmed that the weekly menu had not been changed. The menu should have been changed the previous evening and he/she should have checked to ensure of it. [s. 73. (1) 1.]

2. The licensee failed to ensure that food is served at a temperature that is palatable to the residents.

Interview with residents #377 and #423 revealed that hot food items are often served cold.

Record review indicated that the home's standard temperature for hot food is 140 to 170 degrees Fahrenheit. The inspector observed that the temperature recorded at lunch on April 17, 2014, at the point of service on the first floor for baked Pollock was only 107.7 degrees Fahrenheit, for poached fish Newburg was only 118 degrees Fahrenheit and on the third floor the temperature for the baked Pollock was only 126 degrees Fahrenheit.

Interview with the nutrition manager, FSW and the cook confirmed that the temperatures were not within their standard range and the food was not served at a temperature that is palatable to the residents. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes the communication of the seven-day and daily menus to residents and that food is served at a temperature that is palatable to the residents, to be implemented voluntarily.

WN #8: 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 failed to ensure that all staff at the home receive retraining in infection prevention and control annually.

Record review and interview with the infection prevention and control co-ordinator confirmed that only 34 per cent of staff received retraining in infection prevention and control in 2013. [s. 76. (4)]

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

Record review and staff interview indicated that 83 per cent of staff who provides direct care to residents received training in behavior management in 2013. [s. 76. (7) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff at the home receive retraining in infection prevention and control and all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, receive training in behaviour management annually, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provides direct care to residents receive, as a condition of continuing to have contact with residents, training in fall prevention and continence care and bowel management.

Record review and interview with the nurse manager indicated that only 41 per cent of staff who provided direct care to residents received training in fall prevention and management and only 30 per cent received training in continence care and bowel management in 2013. [s. 221. (1) 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 all staff who provides direct care to residents receive, as a condition of continuing to have contact with residents, training in fall prevention and management and continence care and bowel management, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 22, 2014, the inspector observed an identified registered staff not performing hand hygiene prior to and post medication administration to an identified resident. The registered staff used his/her fingers to open a capsule and pour the powder into the medication cup.

Record review of the home's policy #IC-0501-00 titled Routine Practices in the Infection Control Manual revised December 1, 2012 indicates the use of alcohol based hand rub is recommended when hands are not visibly soiled before/after any direct contact with a resident and between residents. [s. 229. (4)]

2. On April 11, 2014, the inspector observed an identified PCA cleaning resident #601's mouth without wearing gloves. The resident cleared his/her throat and spit mucous out into the face cloth, and the PCA used the face cloth to clean around resident's mouth. The PCA left the resident's room and went to the nursing station to take additional supplies without washing or sanitizing his/her hands.

Staff interview confirmed that staff are required to wear gloves while handling body fluids. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: 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 failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents.

On April 11, 2014, the inspector observed the door to the electrical room on the fifth floor of the west wing unlocked. Interview with an identified registered staff revealed that he/she did not know why the door was unlocked at that time and it should be locked at all times. The registered staff attempted to find the key to lock the electrical room but he/she was not able to find it. On April 22, 2014, the electrical room on the fifth floor of the west wing was observed locked.

On April 11, 2014, the inspector observed the door to the laundry storage on the first floor of the east wing unlocked with a washer and dryer in the room. Interview with an identified housekeeping aide revealed that the laundry room is available for the family and private sitters upon request and it is supposed to be locked when not in use. The housekeeping aide locked the laundry room. On April 22, 2014, the inspector observed the laundry storage on the first floor east wing locked. [s. 9. (1) 2.]

WN #12: 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 failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed and used by residents, staff and visitors at all times.

On April 15, 2014, the inspector observed the call bell in an identified room not functioning. Interview with an identified PCA revealed that he/she was not aware of the non-functioning call bell. Interview with the supervisor of building services confirmed that the contracted technician was called to come in to repair the call bell on the same day. On April 22, 2014, the inspector observed the call bell in that room functioning. [s. 17. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident of the home has his or her personal items labeled within 48 hours of admission and of acquiring, in the case of new items.

On April 15, 2014, the inspector observed a set of dirty nail clippers that were not labelled and were stored in the spa room on third floor of the west wing. Staff interviews revealed they could not identify the owner of these nail clippers. Interview with the nurse manager confirmed that all nail clippers should be kept in a labelled container or individual drawers in the residents' bathrooms. [s. 37. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to ensure that supplies are readily available at the home to meet the nursing and personal care needs of residents.

Interview with resident #477 revealed that he/she did not receive a disposable soaked pad after having asked for one on an identified day. Interview with the nurse manager confirmed that the resident had asked for a soaked pad on an identified day and an identified PCA could not find any available in the unit and failed to check with another unit. Resident #477 did receive a soaked pad the next day. [s. 44.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and dietary services program includes a weight monitoring system to measure and record weight on admission and monthly thereafter.

Record review revealed that resident #371 was not weighed in an identified month. Record review and staff interviews confirmed that this resident was away during an identified period of time. Staff interviews confirmed that all residents are weighed the first week of the month but there is no policy to ensure that residents who are absent during this week are weighed upon their return. [s. 68. (2) (e)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 10 per cent of body weight, or more, over 6 months are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Record review revealed that resident #371's weight loss of 12.1 per cent over six months was not assessed. Staff interviews revealed that because the resident is on a weight loss program, nursing staff did not make a referral to the RD. Interview with the RD confirmed that this weight loss was not on his/her list of significant weight changes to address in an identified month. [s. 69. 3.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there are standardized recipes and production sheets for all menus.

On April 17, 2014, the inspector observed an identified cook slicing in-house oven roasted turkey breast after removing the skin and without referring to the recipe binder.

Record review revealed and interview with the nutrition manager confirmed that a cooked turkey breast was substituted with a raw turkey breast with skin and a standardized recipe for the the substitution was not available. [s. 72. (2) (c)]

2. The licensee failed to ensure that all food is stored using methods which preserve taste, nutritive value, appearance and food quality.

On identified dates, the inspector observed cold menu items placed on the counter during lunch service.

Interview with the nutrition manager indicated that cold food should be stored on ice during meal service to preserve the food quality. [s. 72. (3) (a)]

3. The licensee failed to ensure that staff comply with the home's policies and procedures for the safe operation and cleaning of equipment related to the food production system, dining and snack service.

On identified dates, the inspector observed an identified FSW using a thermometer to check and document food temperatures and the FSW did not wipe the food from the thermometer after each item.

The home's policy titled Thermometer Calibration and Cleaning, revised September 1, 2013, indicates that when using a probe thermometer to check temperatures on multiple food items one after another, the FSW should wipe the food from the thermometer with a clean paper towel to remove the food before testing the next item.

Interview with the nutrition manager confirmed that FSWs are not following the policies for using thermometers. [s. 72. (7) (a)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the

consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

On April 15, 2014, the inspector observed the following inspection reports:
2012_162109_0008 from December 11, 2012
2012_162109_0010 from December 13, 2012
2012_162109_0011 from December 17, 2012
2013_102116_0003 from January 28, 2013
2013_158101_0036 from July 25, 2013
in a locked notice board facing the first floor of the east wing in the lobby. A table and a chair were placed in front of the notice board.
Interview with the administrator confirmed that inspection report 2012_162109_0009 was posted but completely covered by another inspection report in the locked notice board, and the location posting the inspection reports is not easily accessible.

On April 28, 2014, the inspector observed the inspection reports being removed from the locked notice board and placed in a clip board with rings installed on the wall next to the locked notice board. The table and the chair were removed. [s. 79. (1)]

2. The licensee failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home.

On April 15, 2014, the inspector observed the inspection reports 2012_108110_0021 from October 4, 2012 and 2012_162109_0009 from December 12, 2012, were not posted in the home.

Interview with the administrator confirmed that inspection report 2012_162109_0009 was posted but completely covered by another inspection report, and the inspection report 2012_108110_0021 was not posted. [s. 79. (3) (k)]

WN #19: 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,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair.

Record review revealed and interview with the supervisor of building services confirmed that maintenance services in the home are not available on weekends and holidays. [s. 90. (1) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Interview with resident #477 revealed that he/she experiences pain in certain areas and uses a mild topical pain reliever. Record review revealed and staff interview confirmed that this mild topical pain reliever was not prescribed for resident #477. [s. 131. (1)]

Issued on this 12th day of May, 2014

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

S. Someredy
J. Taillefer
J. Ngo Nlogo

Stella Ng