Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2013	2013_191107_0005	H-000159-13	Resident Quality Inspection

Licensee/Titulaire de permis

TYNDALL NURSING HOME LIMITED
1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3

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

TYNDALL NURSING HOME
1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3

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

MICHELLE WARRENER (107), BERNADETTE SUSNIK (120), LALEH NEWELL (147), SHARLEE MCNALLY (141)

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): March 21, 22, 25, 26, 27, April 2, 3, 5, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 2013

During the course of the inspection, the inspector(s) spoke with Residents, families, the Owner, Administrator, Director of Care (DOC), Minimum Data Set - Resident Assessment Instrument (RAI-MDS) Coordinator/Behaviour Support Ontario (BSO) Lead, Wellness Coordinator, Registered Nursing Staff (RN/RPN), front line nursing (Personal Support Workers (PSW))and Dietary staff, Registered Dietitian (RD), Nutrition Managers (NM), Housekeeping staff, Laundry staff, Activity Coordinator and Recreation Aides, Continuous Quality Initiative (CQI)/RM Coordinator, Maintenance staff

During the course of the inspection, the inspector(s) Toured the home, observed meal service, reviewed food production, clinical health records of identified residents, relevant policies and procedures, observed care of residents, observed the laundry, housekeeping, and maintenance areas,

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Quality Improvement

Recreation and Social Activities

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Snack Observation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) 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. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

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

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The plan of care for resident #2144 did not set out clear directions for staff and others who provided direct care to the resident.
A) Clear direction was not provided for the cleaning of teeth. The resident was observed on March 26, 2013 with odourous breath, and on April 12, 2013 at 1045 hours with build up of food debris between their teeth. The resident's RAP in 2012 stated debris was present in their mouth after meals. Oral hygiene was not recorded as being completed on two of eight shifts over a four day period. The Home's policy and procedure Oral Hygiene (#0-2012-01) last revised February 3, 2013, stated "All residents will received or be provided with oral hygiene at a minimum of twice daily (morning and night). This oral hygiene will be individualized to meet the preferences and the abilities of each resident based on an assessment". The written plan of care, kardex, and Resident Assessment Protocol (RAP) did not identify the frequency of oral care to be provided for the resident to maintain appropriate oral hygiene. (141)
B) The plan did not provide clear direction related to protein powder served at the breakfast meal. The resident was changed from hot cereal to cold cereal and the plan directed staff to put protein powder in the cereal at breakfast. During interview April 15, 2013, the Dietitian stated that staff were to mix the protein powder into the milk and then pour the milk onto the cereal. Staff who add the protein powder at the breakfast meal stated they put the powder on top of the cereal and then add the milk. The dietary aide stated that the protein powder did not mix well with the cold cereal and did not dissolve well. Direction was not provided to staff in the home's policy or in the resident's plan of care on how to administer the protein powder in the cold cereal. (107)
C)The written plan of care did not set out clear directions related to the level of pressure to be used for a specialized mattress the resident required to promote skin integrity. The mattress had the ability to adjust the level of firmness from low to high. The plan of care did not identify the required level of firmness to ensure the resident's comfort needs, skin integrity, and pain reduction were maintained. Review of the plan of care and interview with the Director of Care (DOC) confirmed that clear direction to staff, related to the need for and use of the specialize mattress, was not provided. (147)
D) The plan of care did not provide clear direction related to recreation and social activities. The resident required one to one programming to reduce the risk of isolation, however, direction as to the type or frequency of one to one programming was not provided. Activation participation records reflected one 1:1 program was provided one month, two the next month, three in the next two months, and two the

following month. The resident's group participation was low (two programs, including 1:1 for one month, five the next month, 11 in the following month, seven the next month and six the following month), however, the resident was identified as low risk on the 1:1 list. Direction was not provided as to the frequency of one to one programming to meet the goal of preventing social isolation. During interview, staff confirmed direction was not provided as to the frequency of one to one programming and that they provide one to one programs when they can. (107)

The plan of care for resident #4592 did not set out clear directions for staff and others who provided direct care to the resident.
A) The plan of care did not provide clear direction related to the use of bed rails when in bed. The resident was observed to be in bed with one quarter bed rail raised on two occasions during the review. Staff stated they put the side rail up for safety. The resident's plan of care identified the resident was at risk for falls and rest needs but did not include the use of a bed rail as a strategy. (141)
B)The plan of care did not provide clear direction related to activation and one to one programming. The plan of care directed staff to provide one to one interventions when participation in group programs decreased. The resident had a decrease in group programming, however, the plan did not direct staff as to the frequency and type of one to one programming to provide to the resident. (107)
C) The Nutrition Risk focused section of the resident's plan of care directed staff to refer to the "Eating" focus on the plan of care, however, an "Eating" focus was not included in the plan of care. Direction was not provided to staff related to the type or quantity of assistance required for eating during meals and snacks. (107)

The plan of care for resident #8509 did not set out clear directions for staff and others who provided direct care to the resident.
A) The plan of care did not provide clear direction to staff related to the use of bed rails. The resident was observed during the inspection to have one half bed rail in place when in bed. Staff confirmed the resident used one half bed rail for turning in bed. Strategies in the resident's plan of care for falls included direction to encourage the resident to use bed rails. The plan did not specify the number or length of bed rails to be used. (141)

The plan of care for resident #1004 did not set out clear directions for staff and others who provided direct care to the resident.
A) The plan of care did not set out clear direction to staff for the use of two full length

bed rails as a restraint. The current plan of care for risk of falls identified the use of bed rails for safety when in bed, however, did not specify the equipment as a restraint and did not include specific strategies required when a restraint was in place.(141)

The plan of care for resident #8610 did not provide clear direction for staff and others who provided direct care to the resident.
A) The "Eating" focus of the resident's plan of care directed staff to provide a nutritional supplement, however, the "Nutrition Status" focus of the plan of care directed staff to provide a different nutritional supplement. The different sections of the plan of care were not consistent in relation to the type of supplement required for the resident. (107)[s. 6. (1) (c)]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(2)]
The plan of care for resident #8610 was not based on an assessment for use of bed rails. The resident was observed to have two half bed rails in place when in bed. The plan of care for risk of falls identified the use of the bed rails but did not specify if the rails were used as a restraint or a Personal Assistance Services Device (PASD). Staff stated the resident was unable to get out of bed on their own and two staff were required for extensive assistance in transferring. There was no consent by their Power of Attorney to identify the purpose of the bed rails. There was no documentation to identify the resident had an assessment completed to determine if the bed rails were in place as a PASD or physical restraint. The DOC stated the home did not assess bed rails to determine if they were in place as a PASD or restraint. [s. 6. (2)]

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(a)]
Staff did not collaborate with each other in the assessment of resident #8608 so that their assessments were integrated, consistent with and complemented each other in relation to recreation and activation. The resident's Index of Social Engagement (ISE) score (which was supposed to highly correlate with actual time spent in activities) reflected a decline from three to zero, however, activation participation records reflected that the resident was actively participating with only a slight change from the previous quarter (27 programs actively participated in one month, 29 the next month, 21 the following month, 18 the subsequent month, 23 the next month, and 23 the next month). The ISE reflected no to very little recreation participation which was not consistent with the resident's actual participation levels according to participation records. [s. 6. (4) (a)]

4. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
Care was not provided according to residents' plans of care at the afternoon snack pass April 16, 2013.
A) Thickened fluids were not available as required on the snack cart when the snack service began. A jug of one consistency of thickened fluids was obtained from the nursing cart and used for the snack pass, however, residents requiring different consistencies of thickened fluids were not offered the correct consistency of thickened fluids. Staff confirmed that there were residents on that floor that required a different consistency of thickened fluids than what was provided on the snack cart.
i) Residents #1012, #5581, and #1013 required thickened fluids, however, were provided a different consistency of thickened fluids than what was indicated on their prescribed diet order.
ii) Resident #1014 required thickened fluids, however, was provided thin fluids.
iii) Resident #1015 required thickened fluids and was provided thin fluids.
B) Sugar instead of sweetener was provided for two residents with diabetes (not requested or indicated as a preference in their plans of care): Residents #1016, #1014
C) Resident # 2144 did not require thickened fluids, however, thickened fluids were provided in addition to a glass of thin fluids. Staff stated that sometimes they take thick fluids and sometimes they take thin fluids so I gave them both. The resident did not take more than two teaspoons (tsp) of the thickened fluids before refusing.
D) Resident #9951 required a straw for fluids, however, a straw was not provided.

5. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
Resident #8509 did not receive care as specified in their plan related to the administration of protein powder for skin integrity. On March 25, 2013 at 1315 hours the resident received one scoop of protein powder in their soup. The dietary aide serving the protein powder confirmed the diet list indicated the resident was to receive protein powder. The resident's current written plan of care did not identify the need for protein powder or current skin breakdown. The resident's progress notes included documentation by the dietitian the month prior that protein powder was discontinued as skin breakdowns were healed. [s. 6. (7)]

6. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)]
Residents were not reassessed and their plans of care reviewed and revised when the residents' care needs changed or care set out in the plan was no longer necessary.

A) The plan of care for resident #4592 was not revised when their care needs changed in relation to activation/recreation. The resident had a significant change in status in 2012, which resulted in some changes to the resident's participation levels. The recreation plan of care was not revised in relation to the change in condition. Staff stated the resident was participating more passively than they used to with a change from moderate participation to low participation. The resident's Index of Social Engagement (ISE) score decreased from two, to one two months later, and zero, three months after that. Review of the resident's recreation participation records also reflected a decline in participation without revision to the resident's plan of care. The resident participated 16 times one month, 11 times the next month, 11 times the subsequent month, 8 times the next month and 4 times the following month. Coding and Resident Assessment Protocols (RAPS) for the RAI-MDS quarterly review did not reflect a change in participation levels or in the type of activities the resident was participating in and interventions were not revised in relation to the changes noted by staff. The resident had a goal for weekly religious services. The resident was participating in weekly services the first two months reviewed, however, participation dropped to once a month in subsequent months without an evaluation of the decline. (107)

B) Resident #1005 was not reassessed quarterly for the use of two full length bed rails as a restraint. The resident was observed in bed with the bed rails raised. The MDS coding identified the use of two full bed rails daily. The RAP for restraints was not triggered and not completed. (141)

C) Resident #1004 was not reassessed and the plan of care reviewed quarterly for the use of two full length bed rails as a restraint. The resident was observed in bed with the bed rails raised. The Minimal Data Set (MDS) coding identified the use of two full bed rails daily. The RAP for restraints was not triggered and not completed. The resident's current plan of care was not reviewed by staff and the bed rails were not identified as a restraint. (141)

D) Resident #2144 was not re-assessed in relation to changes that occurred in the resident's recreation participation levels at their quarterly review. The resident's participation records reflected that participation improved over a two month period, and staff confirmed that the resident was participating more frequently. An assessment of the change did not occur and the coding and RAP summary did not reflect a change in the resident's participation levels. (107)

E) The plan of care for resident #8593 was not reviewed and revised when the resident's care needs changed in relation to continence. The resident's room had a strong odour of urine on two occasions during the inspection. The resident's quarterly

assessment (RAP) documented that the resident was: occasionally incontinent of bladder; at risk for infection and falls and those would be addressed in the care plan; and that the floor should be clean and dry due to urine dribbling. Staff confirmed the resident was incontinent at times and did dribble urine. Staff stated the resident remained independent in toileting but sometimes missed the toilet causing urine to splash on the bathroom floor. Staff also confirmed the odour of urine in the room was from resident #8593. The resident's current plan of care did not address that the resident dribbled or missed the toilet when voiding and there were no strategies in place to address the dribbling of urine or urine on the floor, including monitoring for keeping the floor clean and dry as identified in the assessment.(141)
F) Resident #8593 was not reassessed and the plan of care reviewed and revised when care needs changed in relation to pain. Documentation in the resident's progress notes and Medication Administration Records (MARs) identified the resident as having pain over a 10 day period for which they received pain medication 14 times. Documentation in the resident's MDS coding identified the resident had mild pain, less than daily, for which they received pain medication. The resident did not have a completed RAP for pain at this time. The resident's plan of care identified the resident had pain, however, did not include all sources of pain. (141) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 009, 017 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the written plan of care sets out clear direction to staff and others providing direct care to residents, s. 6(1)(c), and that the care set out in the plan of care for residents is based on an assessment of the resident and the needs and preferences of that resident, s. 6(2), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The policy to promote zero tolerance of abuse and neglect of residents, at a minimum, did not comply with requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulations.

Review of the home's "Abuse" policy with an original date of 1996, current issue date of December 15, 2006, and last reviewed on March, 2008, and interview with the DOC, confirmed that the current policy did not comply with requirements respecting the matters provided for in clauses (a) through (f) that were provided for in the regulation.

The policy did not clearly set out: what constituted sexual abuse; a program that complied with the regulation for preventing abuse and neglect; any explanation of the duty under section 24 to make mandatory reports; and did not set out the consequences for those who abused or neglected residents. [s. 20. (2) (g)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 8(1)(a)]
The nursing and nutrition and hydration programs did not include systems to ensure the home's policies and procedures were current and relevant. Many of the home's policies had not been reviewed since 2005, 2008, and/or not revised since the 1990's, and were not revised to reflect legislative changes with the LTCHA, 2007 in 2010. The home was purchased by a new licensee one year prior, however, policies that reflected the new owner's practices were not implemented by the home. Direction through policy was not clearly provided to staff providing care to residents.

Nursing examples:

Review of the home's Infection Control Manual interview with the Director of Care confirmed that the home's policy and procedures were not in compliance with and implemented in accordance with applicable requirements under the Act.
A) The Infection Control Policies were dated back to Original Date of June 1st, 1987 with Current Issue Dates of January 15, 2007 and Original Date of May 2008 with Current Issue Date of May 30, 2008.
Interview with the infection control lead and review of the current policy in use confirmed that the policy did not require time frames for screening for tuberculosis on admission and that the program was not being evaluated and updated at least annually.
B) Review of the current policies in use and interview with the Skin and Wound lead confirmed that the policies did not direct the registered staff regarding: weekly wound assessments; referral to physiotherapy as required; assessment and documentation of pain interventions; and strategies to promote healing and prevent infections, which are all required under the LTCHA. (147)

Dietary examples:
A) Different policies for the same topics were in the policy binder (e.g. hydration, supplements, weights, nutrition assessment) and they were not consistent with each other in direction for staff.
B) Nutrition policies available did not identify the requirement of the Registered Dietitian (RD) to complete the admission nutrition assessment and whenever there was a significant change in status, which is required under the LTCHA.
B) The "diet change policy" did not reference the Dietitan's role in diet changes, only the Nutrition Manager (NM).
C) The "Changes in Weight" policy did not reflect the requirement to assess significant

weight changes of 5% in one month, 7.5% in 3 months and 10% over 6 months. The policy required assessment of only a 5 pound (lb) change in 1 month or a 10 lb change in 3 months. This practice would miss many of the significant changes in small stature residents and over trigger for larger residents and did not address significant changes over a 6 month period. The "Weight" policy referenced only a 5% change in one month or 10% over 3-6 months and did not require the RD to assess significant weight changes. These policies were not consistent with requirements under the Act.
D) the "Nutritional Documentation" policy did not reference the RD's role in nutritional assessments, only the NM.
E) The "change in hydration" policy indicated that a referral to the RD would occur for all residents taking less than 2000ml/day, initiate a separate "intake" form for the individual, check at least every two hours as to the intake status, document on nurses notes every shift, however, this was not consistent with the Hydration Assessment & Management policy.
F) The policy "Resource Instant Protein Powder", created in 1993 and reviewed (no changes) in 2005, 2008, and 2012, did not provide direction to staff related to how to record or monitor the intake of the intervention and the policy was approved by the "Nursing Director". There is no evidence that a Registered Dietitian approved this policy. The policy reflected a protein requirement factor that would be inappropriate for most residents with skin integrity issues.
G) Dietary Aide and Cook job descriptions, created 1999, reviewed 2005, did not include the educational requirements identified in the regulations. (107)
H) The Tyndall employee phone list was not revised. Eleven of 20 staff on the list were not currently working at the home, including the Nutrition Manager. [s. 8. (1)]

2. [O.Reg. 79/10, s. 8(1)(b)]
The policy and procedure for Responsive Behaviours, last reviewed December 2011, was not complied with for resident #8578 related to monitoring the resident's responsive behaviours. The policy defined the resident's behaviour as a responsive behaviour. Further it identified Dementia Observation Screening (DOS) charting was to be completed to track specific behaviours and time to assist staff with evaluating preventative strategies which may be effective in minimizing and/or eliminating the behaviour. The physician progress notes identified the resident presented with responsive behavious and was commenced on medication. There was no documentation of the resident having DOS monitoring completed at any time from the initial identification of the responsive behaviour until the period of inspection.[s. 8. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 26(3)5]
Residents' plans of care were not based on an interdisciplinary assessment of mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
A) The responsive behaviour plan of care for resident #1007 was not based on an interdisciplinary assessment of the resident. Interview with staff and documentation in the clinical health records indicated that the resident became agitated and as a result, exhibited certain behaviours. The resident was started on a medication for these behaviours. There was no evidence that an interdisciplinary assessment related to the behaviours had been conducted. Triggers and variations in functioning at different times of the day had not been identified. The plan of care had not been developed and implemented to manage the responsive behaviours. (147)
B) An interdisciplinary assessment was not completed for resident #1006, related to responsive behaviours and physical aggression, including potential behavioural triggers. The resident's progress notes identified five incidents of physical aggression towards other residents and staff in 2012 and three incidents to date in 2013. The staff confirmed the incidents did occur and an outside agency was called into the home on each occasion. The resident's RAPS, completed over a five month period, did not identify resident incidents of physical aggression. The RAP for behaviours was not completed in 2013, although the Multidisciplinary Review of Resident's Assessments, prior to MDS coding, identified the resident had episodes of physical aggression in the past quarter. An interdisciplinary assessment of the resident's risk of physical aggression was not completed.
C) The plan of care for resident #1006 did not identify potential behavioural triggers for physical aggression towards others. The resident's progress notes identified the resident was involved in physical aggression towards other residents resulting in an outside agency being called to the home five times in 2012 and three times in 2013. Staff were able to identify triggers indicating the resident may become physically aggressive, however, the resident's current plan of care did not include the identified triggers for physical aggression (141)[s. 26. (3) 5.]

2. [O.Reg. 79/10, s. 26(3)21]
The plan of care for resident #2144 did not identify the resident's sleep patterns or preferences. The resident was unable to articulate their preferences due to cognitive impairment. [s. 26. (3) 21.]

3. [O.Reg. 79/10, s. 26(4)(a)(b)]
The registered dietitian did not assess a change in resident #2144's hydration status over a three month period. The resident required a minimum of 1500ml fluids daily, however, they met this requirement on only six days over a two month period(food and fluid intake records were reviewed). The resident was assessed as consuming approximately 1300ml of fluids daily at the beginning of the three month period and supplements were initiated. At the nutritional assessment at the end of the three month period the resident was noted to be consuming approximately 1000ml/day. An assessment of the resident's fluid consumption in relation to the assessed fluid requirement was not documented and action was not taken to address the poor hydration at the nutritional assessment. The dietitian confirmed during interview that a hydration assessment and evaluation was missed. [s. 26. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the registered dietitian completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition and assesses the matters referred to in paragraphs 13 and 14 of subsection (3), s. 26(4)(a)(b), to be implemented voluntarily.

WN #5: 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. [O.Reg. 79/10, s. 69.1]
A) Resident #8607 was not re-assessed after a 9.7% significant weight loss over one month. Progress notes indicated the resident: was eating poorly on numerous days over two months; had an area of skin breakdown; ongoing weight loss in addition to the significant weight loss noted over one month (18.6% loss in 6 months); and the Power of Attorney (POA) requested a nutritional assessment by the Dietitian for concerns about weight loss and poor appetite. The Dietitian reviewed the resident after the significant weight loss and clarified the resident's diet order, however, there was no re-assessment of the resident in relation to intake and weight loss, and interventions that had been implemented two months prior were not evaluated for effectiveness at that time. The resident was not assessed by the Dietitian in relation to the significant weight loss until the regularly scheduled quarterly review the next month. At the quarterly review the Dietitian used an incorrect weight for the assessment. Interventions were revised at the quarterly review, however, the supplement initiated provided 90kcals less than the previous intervention without a documented explanation for the reduction in calories or a documented assessment of the resident's requirements in relation to current intake.
B) A "weight warning" notification was triggered for resident #8607, however, action was not taken related to the weight loss and outcomes were not evaluated in relation to the goal for weight maintenance within their goal weight range noted at the quarterly review. The resident's weight was noted to be below their goal weight range with no change to the nutritional interventions identified on the resident's plan of care. [s. 69.]

2. [O.Reg. 79/10, s. 69.2]
The licensee did not ensure that action was taken and outcomes were evaluated for resident #2144 after further significant weight loss over a three month period. Interventions to prevent further weight loss were initiated previously, however, action was not taken and outcomes were not evaluated after the continued significant weight loss. The resident had a 13.6% significant weight loss over three months, however, the plan was to continue with the current interventions. The Dietitian reduced the resident's goal weight range by 9kg the first month, to a further reduction of six kg the next month and stated that the current interventions were effective. The resident had a goal for the prevention of further weight loss, however, when further weight loss occurred strategies were not revised. The resident was noted to be consuming mainly liquids and often refusing solid foods (as per progress notes and nursing staff interview). The resident continued to lose weight over the three months and interview

with the Registered Dietitian confirmed that further action was not taken to address the three month weight loss.[s. 69.]

3. [O.Reg. 79/10, s. 69.3]
The licensee did not ensure that action was taken and outcomes were evaluated for resident #7804 after a significant 11% weight loss over 6 months. The resident had a goal for the prevention of further weight loss and weight maintenance within their goal weight range, however, the resident continued to lose weight below the goal weight range over a five month period, with only 1 change to nutritional interventions. The plan was to continue with the current plan and the resident's goal weight range was reduced. Nutritional interventions were not evaluated for effectiveness in relation to the goal for the prevention of further weight loss. At the nutritional assessment, the Dietitian used the previous month's weight, despite the current month's weight/re-weight being available which indicated a significant weight loss.[s. 69.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

Hazardous substances were not kept inaccessible to residents at all times. Disinfectant products, which contain ingredients that are harmful when ingested, were found accessible to residents on numerous occasions throughout the inspection period by all inspectors.

* A spray bottle of disinfectant (Virox) was left in a resident's bathroom on April 2, 2013. A staff member was informed immediately.

* A spray bottle of Virox was found in an unlocked cabinet in the dining room on April 2, 10, 2013 after the noon time meal.

* A door to the furnace room located in the corridor on the main floor was found to be unlocked on April 2, 2013 at 1018 hours. Inside the room was an unlocked housekeeping cart with several cleaning solutions and a bottle of disinfectant inside of the cart. A door was also left wide open to a chemical storage room. The inspector locked the room upon exit. At 1148 hours, the door handle to the furnace room had a key in it and at 1233 hours, the door was found unlocked again. The door was locked by the inspector at 1233 hours.

* At 1011 hours on April 5, 2013, the door to the furnace room was found unlocked, with an unlocked housekeeping cart inside. The cart contained disinfectants. The room was locked upon exit by the inspector. The door was found unlocked again at 1147 hours.

* On April 19, 2013, at 1209 hours the tub and shower room on a home area was propped wide open with the key left in the door. A bottle of Virox was accessible on the counter behind the toilet.

* April 19, 2013 at 1219 hours the tub and shower room on a different home area was found unlocked and a bottle of Virox was accessible on the counter behind the toilet.

* On March 22 1232 hours and April 12 1143 hours, the door to a tub room was found unlocked with 1-2 bottles of Virox accessible. The door was locked immediately and staff informed.

* On March 25 at 1014 hours, April 2 at 1030 hours, and April 11 at 1320 hours, a janitor's closet was found unlocked and accessible with multiple bottles of cleaning

solutions and disinfectant accessible. Staff were notified and the door was locked by the inspector.

* On March 25, 2013 at 1500 hours, a janitor's closet was found unlocked and accessible with multiple bottles of cleaning solutions and disinfectant accessible. On March 26, 2013 at 1009 hours, the janitor's closet was again found unlocked and accessible and the shower/tub room was also found unlocked and unattended with hazardous chemicals accessible on the back of the toilet.

* On March 21 at 945 hours, during a tour of the home a tub room and janitor's closet were found unlocked and accessible to residents. The tub room contained a bottle of Virox and the janitor's room had a housekeeping cart with multiple bottles of disinfectant and cleaning solutions. On a different floor, the janitor's room was also found unlocked and unattended with cleaning fluids and disinfectants in unlocked housekeeping cart.

Management was informed of the inspector's concerns on numerous occasions with continued non-compliance with keeping chemicals inaccessible to residents.

(120)(147)(107)(141)[s. 91.]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.

Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,

(a) use of physical devices; O. Reg. 79/10, s. 109.

(b) duties and responsibilities of staff, including,

(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,

(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.

(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.

(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.

(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.

(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.

(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The home's policy for Restraints, last reviewed April 2008, did not include procedures for the use of Personal Assistance Services Devices (PASD) and bed rails.
A) The Restraint policy defined PASDs. A policy was not in place to direct staff in the requirements for PASDs including assessment, inclusion in the individual's plan of care, approval and consent. Multiple residents on all home areas were identified as using two half and quarter bed rails when in bed. The DOC confirmed that PASDs were not assessed prior to implementation and there was no policy related to PASDs specifically.
B) The Restraint policy stated bed rails for the purpose of this document were not classified as a restraint. The policy did not include requirements for assessment of bed rails to identify if they were a restraint. Two residents were identified in the home as requiring full length bed rails when in bed. The DOC stated that the use of two full bed rails were considered restraints. [s. 109. (a)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

Procedures were not developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

Review of all the resident mattresses for two floors, and interview with staff on each floor, indicated that procedures were not implemented to ensure that all the mattresses in the home were kept in good repair. Fourteen of the mattresses identified had broken mattress cover zippers and/or tears/significant wear in the mattress covers exposing the mattress foam. There were approximately three to seven centimeter (cm) divots in the middle of the mattresses and the protective surfaces on top of the mattresses were worn, exposing rips in the fabric which posed a risk for contamination and infection to the residents. Three examples from the 14 mattresses noted to be in poor repair:
A) Resident #8448's mattress was found to have severe sagging in the middle with extensive wear of the water proof cover exposing porous material underneath. The resident was not able to articulate comfort of mattress due to level of cognitive impairment. Resident currently had multiple areas of skin breakdown.
B) Resident #1011's mattress had a 6 cm divot in the centre. The resident had a significant area of skin breakdown.
C) Resident #1009's mattress had the surface worn away, with white worn patches covering the surface, and a 5 cm divot in the middle of the mattress. The resident had a significant area of skin breakdown.[s. 90. (2) (b)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The home had developed a quality improvement system, however, they had not included action plans to address the areas with deficiencies and not all programs had been included in the quality monitoring system. Staff confirmed that action plans were not currently in place to improve the quality of the accommodation, care, services, programs and goods provided to residents. Numerous areas of non-compliance were identified during this inspection. Staff were unaware of some of the identified concerns and were unable to provide evidence of action taken to improve the areas of concern identified through their system. [s. 84.]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: 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. Steps have not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment where bed rails are used.

The home commissioned an external contractor to complete a bed entrapment zone audit of all the resident bed systems in October and November 2012. The contractor used the Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", 2008) as a guide to determine which beds passed or failed the specified parameters. The results of the audit concluded that over 60% of the beds failed one or more zones of entrapment which could potentially cause injury to the resident. Since that time, the management of the home have not instituted any measures to minimize or mitigate potential risk to the residents.

During a tour of the home, some gaps between head boards and mattresses and bed rails and mattresses were observed. These are areas that failed bed safety parameters during the audit. The home has a mix of bed models and mattresses of different ages. The older the mattresses, the more likely they will fail one of the entrapment zone parameters. According to the home administrator, many of the mattresses are older than seven years, which would decrease their ability to resist compression. Another parameter where beds are likely to fail is with the type and design of the bed rail. Some beds are furnished with quarter length assist bed rails and others with full length rails. Bed mattresses were noted to be either too long or too short for the bed frames. Mattresses that are too short create excessive gaps at the head or foot of the bed (entrapment zone 7). Mattresses that are too long can bunch in the center and may not lie flat. A number of bed frames had missing mattress keepers to keep the mattresses from sliding side to side. When beds without mattress keepers were tested, the mattresses easily slid off the frame of the bed.

Therapeutic surfaces were also noted on bed frames. These surfaces have inherent entrapment risks based on their design (soft edges, height and compressible nature). The therapeutic surface in one room was not attached to the deck of the bed as required by the manufacturer.

At the time of this inspection, many of the failed beds continue to be used by residents who use bed rails. Since the audit, some new mattresses have been purchased, however the management did not identify or document which bed frames they were applied to. The beds that received a new mattress also did not receive a post

entrapment zone assessment to determine if the new mattresses were adequate for the specific bed frame. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 30(1)4]
The written record relating to each required program evaluation did not include the specific date the evaluation occurred (only stated the month and year), the names of the persons who participated, a summary of the changes made, and the date that changes were implemented. Annual program evaluations were shared for the Infection Prevention & Control program, the Skin & Wound Care program, and the Training & Orientation programs, however, the required information was not included in the written records provided to the inspector. [s. 30. (1) 4.]

2. [O. Reg. 79/10, s. 30(2)]
Actions taken with respect to residents #2144, #8607, and #8610, under the nutrition and hydration program, including assessments, reassessments, interventions and the resident's response to interventions were not documented.
A) Action taken with respect to resident #2144, including the administration of protein powder and nutritional supplement interventions, for the treatment of impaired skin integrity/wounds, was not documented.
i) Resident #2144 required protein powder at multiple meals, however, documentation did not include a record of the administration of the protein powder or the resident's consumption of the protein powder. The Dietitian and Registered Nursing staff confirmed that an evaluation of the effectiveness of the protein powder could not be completed with the available information. The resident's wounds were not healing. Registered Nursing staff confirmed that a system was not in place to record or evaluate the consumption of protein powder being provided by dietary staff.
ii) The resident required a nutritional supplement for the prevention of weight loss and for skin integrity concerns, however, documentation did not include the consumption of the supplement and interventions could not be evaluated for effectiveness. The resident had ongoing weight loss and skin integrity concerns. (107)
iii) The resident was observed by the inspector in the dining room and protein powder was placed in their soup by the dietary aide. The resident consumed half of their soup. Nursing staff assisting the resident with feeding confirmed the resident only consumed half of the soup. The resident had multiple areas of poor skin integrity. There was no documentation identified to monitor the residents intake of the protein powder and soup. (141)
B) Action taken with respect to resident #8607, including the administration of protein powder for the treatment of impaired skin integrity/wounds, was not documented. Resident #8607 required protein powder at meals, however, documentation did not include a record of the administration of the protein powder or the resident's

consumption of the protein powder. The Dietitian and Registered Nursing staff confirmed that an evaluation of the effectiveness of the protein powder could not be completed with the available information. Registered Nursing staff confirmed that a system was not in place to record or evaluate the consumption of protein powder being provided by dietary staff. (107)
C) Action taken with respect to resident #8610, including the administration of protein powder for the treatment of impaired skin integrity/wounds, was not documented. Resident #8610 required protein powder at multiple meals, however, documentation did not include a record of the administration of the protein powder or the resident's consumption of the protein powder. The Dietitian and Registered Nursing staff confirmed that an evaluation of the effectiveness of the protein powder could not be completed with the available information. The resident's wound had worsened and was not healing. Registered Nursing staff confirmed that a system was not in place to record or evaluate the consumption of protein powder being provided by dietary staff. (107)
D) Resident #4592 was observed in the dining room and protein powder was placed in their soup by the dietary aide. The resident refused the soup and the refusal of soup was confirmed by the nursing staff assisting the resident. The resident had multiple significant pressure ulcers. Documentation did not include the resident's refusal of the protein powder and soup and the resident's response to the intervention of protein powder could not be evaluated by the Dietitian without documentation to support the refusal. (141)
E) Resident #1009 was observed in the dining room and protein powder was placed in their soup by the dietary aide. The resident consumed the soup with the protein powder, however, documentation did not include a record of the resident's consumption of the intervention. The resident had multiple areas of poor skin integrity. There was no documentation identified to monitor the residents intake of the protein powder. (141)[s. 30. (2)]

3. [O. Reg. 79/10, s. 30(2)]
Resident #2144 did not have all interventions and responses to interventions documented related to catheter care.
A) Urine output by catheter was not consistently documented in the progress notes or Point of Care (POC) at the end of each shift. The resident's written plan of care included specific directions for staff on monitoring urine output. The DOC confirmed that documentation of urinary output should be recorded at the end of each shift in the POC and progress notes.

B) Documentation in the progress notes at the time of catheter change did not include all actions taken. The home's policy and procedure "Urinary Catheterization", last reviewed April 2008, stated when changing an indwelling catheter document in progress notes and care plan the type, size and inflation of catheter; appearance and amount of urine obtained; change date on care plan, type and size of catheter and amount inflated; residents response to procedure. Documentation in the progress notes at the time of catheter change did not include the type, size and inflation of catheter; appearance and amount of urine obtained; change date on care plan, type and sized of catheter and amount inflated; residents response to procedure. [s. 30. (2)]

Additional Required Actions:

CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring a written record is kept relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, s. 30(1)4, to be implemented voluntarily.

WN #12: 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. [O.Reg. 79/10, s. 68(2)(d)]
A system to monitor and evaluate the food intake of residents who were at nutrition risk was not in place.
A) Resident #8610, who was at high nutrition risk, did not have their food intake consistently monitored. There were 58 missing entries for the afternoon snack consumption on the Point of Care (POC) nutrition documentation over a two month period. Staff confirmed that the afternoon snack pass was not always recorded for residents due to computer system set up concerns.
B) A system to monitor the food and fluid intake was not consistently in place for resident #7804, who was identified with nutritional risks. Documentation on the POC nutrition monitoring records identified nine missing snacks entries and 14 missing meals between over a 1.5 month period. The resident had a significant weight loss of 10.9% over 6 months.
C) A system to monitor and evaluate resident #2144's food and fluid intake was not in place. The resident was identified as high nutrition risk, however, consumption of meals and snacks was not consistently documented in the resident's clinical record. There were 76 missing entries for snacks over a two month period (mainly afternoon and evening snacks) and 11 missing records for the supper meal. The resident's food and fluid intake could not be effectively evaluated with the amount of missing data. [s. 68. (2) (d)]

2. [O.Reg. 79/10, s. 68(2)(e)(i)]
A weight monitoring system was not in place to measure and record resident #2144's weight on admission and monthly thereafter.
A) The resident was admitted to the home, however, an admission weight was not recorded until 18 days after admission. The resident was in the home for ten days prior to admission to hospital, however, a weight was not taken or recorded during that time. The Registered Dietitian was not able to complete their assessment due to the unavailable weight and height. Staff stated that the resident's weight was to be taken within 24 hours of admission. Progress notes and staff interview did not identify rationale for not taking the resident's weight.
B) The resident did not have their weight taken or recorded for one month. Staff interview and documentation did not identify rationale for not weighing the resident and staff confirmed that the resident was required to have their weight taken and recorded monthly. [s. 68. (2) (e) (i)]

Additional Required Actions:

CO # - 013 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring a system is in place that measures and records each resident's weight on admission and monthly thereafter, s. 68(2)(e) (i), to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

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

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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)5]
A system was not in place to ensure that other staff assisting residents were aware of residents' diets, special needs and preferences.
A) At the afternoon snack services April 16, 18, 2013, the resident diet list that was attached to the cart did not contain all the resident names and required special snacks. Staff confirmed that the information was not available for staff portioning snacks. Errors in diet type and texture were noted at the observed afternoon snack pass April 16, 2013. A therapeutic extension menu was also not available on the snack cart to identify which snacks were appropriate for each diet type. Staff confirmed that direction was not provided in relation to appropriate items for each diet type. (107)
B) A system was not in place to ensure dietary staff providing protein powder to resident #8509 was aware of the resident's current special needs related to skin integrity. On March 25, 2013 at 1315 hours the resident received protein powder in their soup. The resident's current written plan of care did not identify the need for protein powder or evidence of current skin breakdown. The resident's progress notes included documentation by the dietitian that protein powder was discontinued one month prior as skin breakdowns were healed. The dietary aide serving the protein powder confirmed their diet list had not been updated and still indicated the resident was to receive protein powder. (141)
C) Staff assisting residents at the supper meal April 16, 2013, were not aware of residents' diets, special needs and preferences when asked by the inspector. Several staff were not aware of what the foods were that they were feeding to residents requiring texture modified menus. (141) [s. 73. (1) 5.]

2. [O.Reg. 79/10, s. 73(1)6]
Not all food and fluids were served at a temperature that was palatable to the residents. At the lunch meal March 21, 2013, staff portioned the soup and stacked the bowls (3 layers high) and then delivered the soup from the cart as it was pushed around the dining room. Several residents identified concerns with food temperatures and the Nutrition Manager (NM) confirmed that there were concerns about the temperature of the soup as it was not always maintained when stacked on the carts. A concern about cold soup was voiced by residents in the food committee meeting minutes of March 1, 2013. [s. 73. (1) 6.]

3. [O.Reg. 79/10, s. 73(1)9]
Resident #1025 was not provided the level of personal assistance they required to

safely eat and drink as comfortably and independently as possible at the supper meal April 16, 2013. The resident required extensive to total assistance with eating, however, the resident was observed sleeping at the table. The resident barely touched their meal and did not receive the required level of assistance until the inspector went to the table to inquire about the resident. [s. 73. (1) 9.]

4. [O.Reg. 79/10, s. 73(1)10]
Proper techniques, including safe positioning, were not used to assist residents with eating.
A) During the 3rd floor afternoon snack pass on April 16, 2013, resident #1023/#1024 was being fed by staff while in a reclined chair and not in an upright position. Staff feeding the resident did not reposition the resident prior to feeding and the resident yelled, "Wait, Wait". The resident was slightly repositioned after that, however, they remained in a reclined position and staff proceeded to feed the resident again.
B) Proper techniques were not used to assist resident #5106 with eating at the lunch meal March 21, 2013. The resident was reclined in their wheelchair and had their chin pointed towards the ceiling (not tucked for safe swallowing) while being fed by staff. The resident was being fed by a staff member and was noted to be coughing while being fed. The resident's plan of care stated dysphagia with risk for coughing/choking/aspiration and to position the resident in an upright position. The inspector asked for the resident to be repositioned.
C) Proper techniques were not used to assist resident #1025 at the supper meal April 16, 2013. Staff were observed standing to feed the resident and were not at eye level when assisting the resident. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 014 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, s. 73(1)5; that food and fluids are being served at a temperature that is both safe and palatable to the residents, s. 73(1)6; and that residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #14: 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).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. For the purposes of paragraph 6 of subsection 76 (7) of the Act, the other areas in which training was not provided to all staff who provide direct care to residents included:
A) Falls Prevention and Management
B) Skin and wound care
C) Continence care and bowel management
D) Training in the application, use and potential dangers of physical devices for staff who apply physical devices or who monitor residents restrained by physical devices
E) Training in the application, use and potential dangers of the PASDs, for staff who apply PASDs or monitor residents with PASDs.

Review of the home's training schedule for 2012/2013 and interview with the DOC and registered staff confirmed the required training was not provided to staff. [s. 221. (1)]

Additional Required Actions:

CO # - 015 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #15: 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. [O.Reg. 79/10, s. 129(1)(a)(iv)]
On April 10, 2013, during inspection of two medications carts, residents #5581, #1010 and #0812 had prescribed, opened eye drops stored in the medication cart without the date documented when the drops were initially opened. The home's policy Auto-Refill (Eye Preparation) stated the date the eye preparation is opened should be recorded in the appropriate place on the label of the container in order to avoid confusion and as part of risk management. A blank label was attached to the containers for provision of the information. [s. 129. (1) (a)]

2. [O.Reg. 79/10, s. 129(1)(a)(ii)]
Drugs were not consistently stored in a medication cart that was secure and locked.
A) On April 16, 2013 at 1530 hours two medication carts were left unlocked and unattended by staff. The carts were in-front of the nursing station facing the elevators and staff left the carts unattended while they went to the nursing room to get supplies. Staff interview confirmed that the staff were aware the carts were to be locked when unattended. (107)
B) On April 16, 2013 at 1620 hours a medication cart was left unlocked and unattended while the RPN was providing care in a resident's room. The medication cart was left in the hallway and was not visible from the room that the care was being provided. When the staff returned to the cart they asked the inspector, "Do I really have to lock the cart every time?". (107)
C) On April 10, 2013, during observation of morning medication administration, two medication carts were stationed outside the nursing station with the cart drawers facing the elevator. Two RPNs were administering medication from the carts. One RPN went down in the elevator and the second RPN went behind the nursing station, where the medication carts were out of visual view, to speak with the inspector. Approximately five minutes later the inspector walked out of the nursing station and both medication carts were unlocked and had been unattended. This observation was identified with the second RPN, who confirmed the carts should of been locked. (141)
D) On April 22, 2013 at 1536 hours an inspector observed a RPN administering medication from the medication cart situated outside a nursing station. On two occasions the nurse administered medication to residents in the lounge area which was out of visual view of the cart and the cart was left unlocked. On one occasion the nurse administered medication to a resident in the hallway out of visual view of the cart and the cart was left unlocked. (141)[s. 129. (1) (a) (ii)]

Additional Required Actions:

CO # - 016 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)4]
Resident #2144 was not cared for in a manner consistent with their needs.
Documentation in the resident's progress notes identified hematuria in the resident's urine and a urine sample was obtained for laboratory testing. The laboratory results for urine culture and sensitivity were received by the home and identified two organism growths with possible antibiotic treatment. The home's policy "Laboratory Services", last reviewed April 2008, stated lab results returned to the Home will be reviewed by the receiving RN/RPN and results outside of the therapeutic range would be called into the physician. The laboratory report was initialed by the physician but no date of review was identified.
The progress notes four days later stated, "the urine culture and sensitivity report indicated a urinary tract infection, the resident had no symptoms. The physician was informed of the result. No new orders. Staff to monitor for symptoms and inform the physician". At 2122 hours documentation in the progress notes stated, "the resident was afebrile but crying in pain occasionally, had hematuria last week but resolved. Placed on antibiotic treatment".
There was no documentation in the resident records related to the negative urine results between the four days. The DOC confirmed that the negative urine result should have been reported to the physician when it was received in the home.
Review of the Medication Administration Record (MARs) indicated antibiotic therapy was commenced five days after the resident's abnormal laboratory results were received by the home. The resident was not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)8]
Resident #8610 was not afforded privacy in treatment and in caring for their personal needs.
A) On Mar 25, 2013 at 1332 hours, the Inspector entered the resident's room and a PSW was changing the resident's bed and sheets. The resident was uncovered with legs bare and their nightwear pulled up exposing their incontinent brief. The roommate could visually see resident from their bed and the privacy curtain was not closed. The PSW apologized and acknowledged the privacy curtain should have been closed.
B) On Mar 25, 2013 at 1233 hours the inspector entered the resident's room, and the resident was having a treatment completed and was uncovered with their nightclothes pushed up and their incontinence brief showing. The privacy curtain around the resident's bed was not pulled and the resident was in full view of the roommate