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
Apr 8, 2014	2014_201167_0005	H-000135-14	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

MARILYN TONE (167), BERNADETTE SUSNIK (120), KATE MACNAMARA (540), MICHELLE WARRENER (107), VALERIE GOLDRUP (539)

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): February 4, 6, 7, 10, 11, 12, 13, 18, 19, 2014

Complaint inspection 2014_278539_004 related to Logs # H-000214-13 and H-000584-13 were completed simultaneously with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC),Director of Nursing (DON), Administrator, personal support workers (PSWs), registered staff, Physiotherapist, Program Manager, Registered Dietitian (RD), Nutrition Manager, Food Service Supervisor (FSS),recreation aides and the housekeeping lead.

During the course of the inspection, the inspector(s) reviewed relevant policies and procedures, health records for identified residents, minutes of meetings, investigation notes, staff schedules, financial reports, staff training records and audits, environmental policies and procedures, bed entrapment audit, conducted a tour of the home, observed resident care and bed systems, medication administration, dining, food production, recreation programming and testing of the door and window security systems.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing
Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

s. 6. (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).

Findings/Faits saillants :

1. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. 2007, c. 8, s. 6 (4)
A) The plan of care for resident #565 identified that the resident was to have 1 bed rail up when in bed for bed mobility. On an identified date in 2014, the resident was observed in bed with two half rails up at the head of the bed. Interviews with staff confirmed that the resident was using two half rails and that the care plan stated only one. Staff could not identify why two bed rails were being used.
Staff did not collaborate in their assessment of the resident's need for bed rails. [s. 6. (4) (a)]

2. Staff did not collaborate with each other in the assessment of resident #627 so that their assessments were integrated, consistent with and complemented each other.
A) Documentation in the progress notes by the nursing staff on an identified date in 2013 indicated that due to results of an x-ray for the resident that a weekly fleet would be prescribed to ensure the resident did not get obstructed. The notes also indicated that the order for (prn) Imodium would be discontinued and they would ensure that anti-diarrhea medication would never be ordered. Medication Administration Records reflected the same. The quarterly assessment completed by the Registered Dietitian on an identified date in 2013, stated that the resident was restarted on Imodium and another identified medication. The assessment was not consistent with documentation provided by the nursing staff and the Registered Dietitian confirmed an assessment of the resident in relation to the constipation/revised bowel medications was not completed. The Dietitian confirmed they were unaware of the documentation about

the constipation or the medication changes.
B) Documentation on a hospital report from an admission on an identified date in 2013, reflected a query of aspiration pneumonia and a request for a Speech Language Pathology assessment. Upon return to the long term care home, staff did not communicate and collaborate with the Registered Dietitian in relation to the diagnosis. The Registered Dietitian confirmed they were not aware of the report and the query of aspiration pneumonia and confirmed a nutritional assessment of the resident in relation to aspiration pneumonia did not occur. [s. 6. (4) (a)]

3. The licensee did not ensure that staff and others involved in different aspects of the care of residents collaborated with each other with regards to therapy services.
A) Resident #556, #564 and #579 were receiving physiotherapy prior to August 2013.
B) During an interview with the Physiotherapist at the home, they confirmed that due to a change in physiotherapy funding in Long Term Care Homes, a meeting was held on an identified date in August 2013 between physiotherapy and the home's staff related to residents that could be discharged from physiotherapy and could be followed by Nursing Restorative instead. Resident #556, #564 and #579 were discharged from physiotherapy and transferred to Nursing Restorative at that time.
C) The documentation in the Resident Assessment Protocols and the plans of care for these residents completed by the Physiotherapist confirmed that these residents had been transferred to the Nursing Restorative Program on an identified date in 2013.
D) During a review of the health files for these identified residents, it was noted that there were no nursing restorative plans of care in place for these residents and this was confirmed by staff interviewed.
E) It was also confirmed by staff interviewed that that the identified residents had not been receiving Nursing Restorative therapy since that time.
F) The Administrator and the Director of Care confirmed that the home had not yet implemented a Nursing Restorative Program although some training had been provided to staff. The home did have policies related to the program provided by their physiotherapy provider. [s. 6. (4) (b)]

4. Staff did not collaborate with each other in the development and implementation of the plan of care for resident #598 so that the different aspects of care were integrated, consistent with a complemented each other.
A) The plan of care for resident #598 identified Type 1 diabetes with interventions to address Type 1 diabetes. The resident did not have an order for insulin and was a Type 2 diabetic. The Registered Dietitian confirmed that the resident was a Type 2 diabetic. [s. 6. (4) (b)]

5. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. 2007, c. 8, s. 6(7)
A) The plan of care for resident #627 identified that one bed was to be elevated to assist resident with bed mobility and to prevent friction and shearing of skin. Observation of the resident on an identified date during this inspection revealed that no bed rail was elevated when the resident was in bed. Interview with PSW staff confirmed that the resident did not use a bed rail when in bed. [s. 6. (7)]

6. The care set out in the plan of care was not provided to the following residents as specified in their plans for afternoon snack pass on an identified date during this inspection.
A) Resident #107 had a plan requiring honey consistency thickened fluids. The resident was provided nectar consistency thickened fluids.
B) Resident #108 required a pureed menu, however, was provided regular textured cookies. The menu for the pureed texture identified pureed cookies were to be offered.
C) Resident #110 required nectar consistency thickened fluids, however, the resident was provided thin fluids.
D) Staff identified to the inspector who they were providing snacks to and what they were providing. [s. 6. (7)]

7. The care set out in the plan of care was not provided to residents as specified in their plan in relation to recreational programs.
A) Resident #555 had a plan of care that required staff to take the resident to programs, document refusals and attendance, and to provide one-to-one programming 1-3 times per week such as hand therapy, bedside music and friendly visits. Activation Participation Records for the identified month in 2014 were blank and did not reflect that programming was offered or refused. Staff interviewed stated they couldn't remember visiting the resident or providing one-to-one programming for the resident.
B) Resident #112 had a plan of care that required staff to assist the resident to and from programming, to document participation in programming and any refusals, and a goal for participation in 2-5 programs per week. Activation Participation Records for the identified month in 2014 did not reflect that programming was offered or refused.
C) Resident #113 had a plan of care that required staff to encourage the resident to participate in programs at least 1-3 times per week, staff to direct the resident to programs, and to document participation and refusals of programming. Activation

Participation Records for the identified month in 2014 were blank and did not reflect that programming was offered or refused. Staff interviewed stated the resident often refused.

D) Resident #114 had a plan of care that required staff to assist the resident to and from programming, to encourage spiritual programs, to document participation in programming and any refusals, and a goal for participation in 1-2 programs per week. Activation Participation Records for the identified month in 2014 did not reflect that programming was offered or refused. Staff interviewed stated the resident was often in bed during the day.

E) Resident #115 had a plan of care that required staff to assist the resident to and from programming, to encourage the resident to engage in activities and inform them of the programs available, to provide friendly discussion 1-3 times per week and to document participation and refusals of programming. Activation Participation Records for the identified month in 2014 did not reflect that programming was offered or refused. Staff interviewed stated the resident was refusing to attend programs.

F) On numerous days of the inspection multiple residents were lined up in their wheelchairs along the one side of the hallway for several hours per day. This was identified on all floors, however, one identified floor had a particularly large number of residents sitting in the hallways between breakfast and lunch and lunch and the dinner hour. Staff confirmed that programming was provided in the resident lounge and not routinely provided for residents in the hallways and also confirmed that one-to-one programming for residents in their rooms was not consistently provided. Staff confirmed that many residents refused the programs offered at the home. The programs provided for at the home did not consistently meet the needs of the residents and residents were not consistently offered programming as per their plans of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in 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 compliment each other; and 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 compliment each other, to be implemented voluntarily.

WN #2: 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 home's weight monitoring policy "Weight Change Management DTY-A-80" and the new weight policy "Weights - Monitoring of Resident Weights VII-G-40.50" was not followed by staff.
The policy stated that all residents were to be weighed on the first bath day of each month and no later than the 8th day of each month (first bath day on new policy), to re-weigh every resident with a questionable weight to verify the accuracy of the weight (immediately re-weigh residents with weight variance of +/- 2kg on the new policy), and to refer to the Registered Dietitian in a timely manner using the established referral procedure.
A) Not all residents had their weights recorded within the time frames specified in the policy. On an identified date in 2014, weights were not available on the paper copy or in the computer for residents #116, #117, #118, #119, #120. Staff reviewed the documentation with the inspector and confirmed the weights were not available.
B) As of an identified date in 2014 re-weighs (to verify the accuracy of the weight when there was a significant variance) were not completed for residents #108 - 12% loss, #121 - 10.6% loss, #122 - 2.2kg loss, #110 - 8.5% gain. Staff confirmed the re-weighs were not completed.
C) As of an identified date in 2014, re-weighs for the identified month were not completed for some residents (#565, #123). Interview with staff confirmed that several of the re-weighs were not completed by the required date. Staff stated the weights were not taken due to the computer not flagging the weight exceptions, however, a paper copy of all the weights was available to staff in addition to the computer system.
[s. 8. (1) (b)]

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. 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 did not ensure that when residents were using bed rails that those residents were assessed and their bed system evaluated in accordance with evidence based practices to minimize the risk to the residents.
A) During a review of the health files for residents #579, #547 and #603, it was noted that nursing assessments were not completed related to their risk of entrapment related to the use of the bed rails used on their beds.
B) Resident #547 was observed to be using one full bed rail with a bed rail pad in place. The document that the home referred to as the care plan for the resident indicated that this bed rail was used to assist the resident with their mobility and staff confirmed this. It was noted that the assessment of the resident's bed completed in February 2014 indicated that the resident's bed did not pass one or more entrapment zones.
C) Resident #579 was observed to have two half bed rails raised on their bed. Staff confirmed that the resident used two half rails when in bed to assist them with mobility. The care plan for the resident directed staff to put both half rails up when the resident was in bed. It was noted that the assessment of the resident's bed completed in February 2014 by the home indicated that the resident's bed did not pass one or more entrapment zones.
D) Resident #603's bed was observed to have one full bed rail raised. The care plan for the resident indicated that one full rail was used when the resident was in bed. Staff confirmed that one full bed rail was used when the resident was in bed. It was noted that the assessment of the resident's bed completed in February 2014 by the home indicated that the resident's bed did not pass one or more entrapment zones.
E) The Administrator and the Director of Care confirmed that staff at the home were not currently completing any type of nursing assessment related to entrapment risk for

residents who were using bed rails on their beds.
F) The Administrator confirmed that the home does have an assessment tool that could be used for this purpose but had not yet implemented the use of this tool within the home. [s. 15. (1) (a)]

2. On on identified date during this inspection, three residents were observed to be sleeping in beds with either one or more bed rails in the raised position. The beds were located in resident rooms for residents #550, #608 and #800. The beds were tested for entrapment zones on February 2014 by the Director of Care and confirmed that they had failed zones 2,3 and 4. Trained staff had also previously tested the beds and documentation was completed identifying that they had failed three zones of entrapment. However, no steps had been taken to prevent the potential for resident entrapment regarding any of the zones identified to be a risk. [s. 15. (1) (b)]

3. Where bed rails are used, other safety issues related to the use of bed rails were not addressed, specifically related to bed rail height.

An adult hospital bed located in an identified room was observed to be equipped with a very thick mattress, over three times the thickness that is required. The mattress did not fit the width of the bed and did not comply with recommendations provided by the manufacturer for the bed. The mattress was a pillow type coil style mattress and was higher than the bed rails which were found in the raised position. The rails could not be used and the mattress could not be raised and lowered adequately at the head or foot of the bed due to it's massive depth. Should the resident or staff require the the rails for repositioning, they would not be able to use them. Should the rails be required for falls prevention, the resident would be able to roll over the top of them onto the floor.
The bed system was not evaluated in accordance with evidenced-based practices to minimize risk to residents. [s. 15. (1) (c)]

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. 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. Weight changes were not assessed using an interdisciplinary approach with action taken and outcomes evaluated for resident #598 and #627.
A) Resident #598 fell below the goal weight identified on their plan of care in October 2013 with further weight loss in January 2014. Action was not taken and the plan of care was not revised in relation to the weight loss from October 2103 to February 2014.(the date when the resident's record was reviewed). At the January 2014 quarterly nutritional assessment the Registered Dietitian identified a further decline in nutritional intake, however, action was not taken and the plan of care was not revised to prevent further weight loss. The resident's intake went from 42% of their meals taken poorly in November 2013 to 83% of their meals taken poorly in January 2014. The Registered Dietitian documented they would consider further interventions in the quarter to prevent further weight loss, however, strategies had not been initiated as of February 2014 (the date when the chart was reviewed). The plan of care was not evaluated in relation to outcomes (less than goal weight range) and in relation to goals identified on the plan of care (weight gain to within the goal weight range over the quarter).
B) Resident #627 had a goal for prevention of weight loss identified on their plan of care in August 2013. At the nutritional assessment in August 2013, the Registered Dietitian stated that if the resident had a further decline in intake, supplements would be considered. The resident had further weight loss identified at the October 2013 quarterly review and again further weight loss below the resident's goal weight range in November and December 2013. At the January 2014 quarterly it was identified that the resident was below their identified goal weight range and further decline in dietary intake, however, action was not taken and the plan of care was not revised in relation to the goals for the prevention of weight loss identified on the plan of care. Outcomes

were not evaluated in relation to goals identified on the resident's plan of care and action was not taken to prevent further unintended weight loss. During interview with the Registered Dietitian in February 2014, they stated that the previous week some interventions were trialled with the resident, however, documentation did not reflect this. The resident was also not provided with sufficient assistance when observed in the dining room at the lunch meal on an identified date in February 2014 and did not eat well. [s. 69.]

2. Residents with weight changes were not assessed using an interdisciplinary approach.
A) Resident #123 had a documented 8.6% significant weight loss from January to February 2014. Documentation in the progress notes or Dietitian communication book did not reflect a multidisciplinary assessment of the weight loss or referral to the Registered Dietitian. Staff stated the home's process was to document resident weights on paper or in the computer, including re-weighs by the 7th of the month and refer to the Dietitian through the Dietitian communication book, including a nursing assessment of causal factors for the weight change. As of an identified date in February 2014 staff confirmed a multidisciplinary assessment of the weight change was not completed, however, staff stated the resident appeared as if they had lost weight and staff confirmed that a referral to the Dietitian had not yet been completed.
B) Resident #570 had a documented weight loss of 14% from January to February 2014 and staff confirmed a re-weigh had not been completed. As of February 2014, a multidisciplinary assessment of the significant weight change had not occurred and a referral to the Registered Dietitian was not completed as per staff interview/review of communication book. The resident had an identified wound, had fallen below their target weight range and was at nutrition risk.
C) Resident #122 had a 7.4% significant weight loss from November to December 2013 and in February 2014 had an 8.6% weight loss noted over 3 months. There was no assessment of the December 2013 significant weight loss until January 2014 at the nutritional quarterly review. Documentation did not reflect a multidisciplinary assessment of the February significant weight loss over 3 months. [s. 69.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. A process was not in place to ensure that nursing staff, who were distributing the afternoon snack pass on an identified date in February 2014 and assisting residents with eating, were aware of the residents' diets, special needs and preferences.

A) Information about what diet type and texture residents required was not available to staff providing the afternoon snack pass on the identified date. Errors were noted in diet type, texture and fluid consistency.
B) The Nutrition Manager confirmed the diet list was removed from the carts for updating and was not available for reference on the cart.
C) The revised diet list contained errors for resident #110 in relation to required consistency of thickened fluids. [s. 73. (1) 5.]

2. Not all food was served at a temperature that was palatable to the residents. The home's temperature monitoring records required foods to be served at a minimum of 140 degrees Fahrenheit (F), however, at the breakfast meal service on an identified date in February 2014, the hot cereal was probed at 119.3 degrees F after the last resident was served. Staff had portioned hot and cold cereal into bowls and stacked the bowls on a cart and took the cart around the dining room to deliver to all the residents in the dining room. By the time the last resident received their hot cereal, it was cold (0914 hours). Staff confirmed they had not followed the home's policy and were to serve only 1 tray of hot cereal at a time. [s. 73. (1) 6.]

3. Not all residents were provided with the required assistance and encouragement to safely eat and drink at the dinner meal on an identified dates in February 2014 and the lunch meal on an identified date in February 2014.
A) The plan of care for resident #104 required total assistance with eating and for staff to feed the resident slowly. The resident was not assisted with their lunch meal on the identified date in February 2014. The resident sat at the table in front of their food not eating from prior to 1215 until 1250 hours and the resident did not consume their meal. Staff interviewed stated the resident required a lot of encouragement to consume their meal, however, encouragement was not provided.
B) Resident #627 had a plan of care that required extensive assistance from staff and for staff to feed the meal to the resident. The resident sat at the table with their food in front of them from prior to 1215 hours to 1245 hours without assistance from staff. Verbal prompting was provided at 1235 hours and the resident attempted to eat but did not continue. Staff was assisting the resident sitting next to this resident, however, did not provide assistance for this resident. Staff confirmed the resident did not receive the assistance they required with the meal until the meal was almost over and the resident ate poorly.
C) The plan of care for resident #102 required extensive assistance with eating. Staff were to encourage the resident to continue to finish their meal. The resident was not encouraged or assisted during the observed meals. The resident ate 1/2 their meal at

the lunch meal on the identified date in February 2014 and was observed taking food off another resident's plate while the resident was sitting at the table. [s. 73. (1) 9.]

4. Not all residents who required assistance with eating were positioned safely at the dinner meal on an identified date in February 2014 and the lunch meal on an identified date in February 2014.
A) Resident #101 was sliding down in their wheelchair and had their head tilted back with their chin pointed towards the ceiling while being fed at both meals, creating a risk for choking. Registered staff confirmed the resident was not safely positioned during the meal and the resident was re-positioned. [s. 73. (1) 10.]

5. Residents that required assistance with eating and drinking were served a meal prior to assistance being available at the dinner meal on an identified date in February 2014 and lunch meal on an identified date in February 2014.
A) Meals were placed on the table for residents #102, #615, #111, prior to assistance being available at the dinner meal the identified date. Resident #615 sat sleeping at the table in front of their meal from 1705 to 1717 hours when staff came to provide the assistance.
Resident #102 sat in front of their meal not eating until staff came to sit at the table at 1717 hours.
Resident #111 had their meal placed on the table prior to assistance being available.
B) At the lunch meal the identified date in February 2014, residents #627, #104, #102, #555 had their meals placed on the table prior to assistance being available. The plan of care for these residents required assistance with eating.
Resident #555 had their meal covered and placed on the table for a significant amount of time prior to being assisted by the Speech Language Pathologist.
Residents #627, #104, and #102 did not receive the required level of assistance with eating at the meal and ate poorly. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences; food and fluids served at a temperature that is both safe and palatable to the residents; providing residents with any eating aides, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
The licensee will also ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Registered Dietitian confirmed that actions taken with respect to resident #627, under the nutrition and hydration program, including reassessments and interventions and the resident's responses to the interventions were not documented.
A) The Registered Dietitian stated that nutritional interventions were tried with the resident, however, documentation did not reflect this. Documentation did not reflect the resident's response to those interventions or a re-evaluation of the resident in relation to the nutritional interventions.
B) Documentation did not reflect an assessment of the resident's hydration in relation to the resident's assessed needs at the January 2014 quarterly nutritional assessment. According to the food and fluid intake records, the resident was not meeting their hydration requirement on most days in November and December 2013, however, documentation did not reflect an assessment of the poor hydration. Interview with the Registered Dietitian confirmed that the resident's hydration was reviewed, however, they were unconcerned as the resident was consuming fluids outside of meals that were not recorded in the resident's hydration records. [s. 30. (2)]

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. 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 :

1. Hazardous chemicals were accessible to residents in the treatment room on one floor on an identified date during the inspection. The door to the nursing station was left propped open and the door to the treatment room was left propped open. Residents had unrestricted access to this area and staff had left the area unsupervised (no staff around). A bottle of Virox disinfectant spray was identified under the sink in the treatment room. [s. 91.]

2. Maintenance staff left their maintenance room unlocked and accessible to residents on an identified date during the inspection. Staff confirmed that the room is left unlocked on a regular basis so that various staff members can access the room easily throughout the day. The room was found to contain a cabinet which was wide open containing various chemicals, some that were labeled "poisonous". Various objects were also left exposed such as sharp tools and cutters. [s. 91.]

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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee did not ensure that every window in the home that opens to the outdoors and is accessible to residents was restricted to an opening of 15 centimeters or less.

Large sliding windows were observed to be unrestricted in the main floor lounge, main floor dining room, an identified resident room and the 4th floor dining room. [s. 16.]

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 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 resident-staff communication and response system was not available in every area accessible by residents.

The activity room, main floor lounge, main floor dining room, the link, the exterior court yard, and lounges on 2nd, 3rd and 4th floor (next to the nurse's stations) were not provided. [s. 17. (1) (e)]

Additional Required Actions:

CO # - 009 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. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented for cleaning the walls and the floors throughout the home.

The home's flooring surfaces were observed to be discoloured, with wear patterns in many resident bedrooms on each floor. According to the home's various policies on floor care and maintenance, the floors are to be stripped and re-waxed annually in high traffic areas if well maintained and buffed regularly. Spray buffing procedures direct staff to use a machine once to three times weekly. The housekeeping staff were equipped with a new floor mopping system using microfiber pads which according to their policy, are to be used with a neutral floor cleaner.

The home's spray buffing machine has been out of service for an unknown period of time. No spray buffing was seen during the two day inspection. Staff confirmed that the floors were stripped and re-waxed approximately 2 years ago. The staff were using a microfiber mopping system using a disinfectant, causing the floors to be dull and sticky when slightly wet or when walking on the floor with wet shoes.

The home's housekeeping policy and procedure 06-01-06 regarding wall cleanliness requires staff to "spot clean walls on a daily basis". Visible wall matter was observed on walls in identified resident washrooms and resident bedrooms over a two-day period. [s. 87. (2) (a)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has not ensured that the furnishings and equipment were maintained in a safe condition and in a good state of repair.

Night tables observed in but not limited to identified resident rooms were not in a good state of repair and posed a potential safety issue. The top surfaces around the perimeter were exposed to a ragged particle board subsurface which may cause a skin injury.

Resident's beds were not in a good state of repair. Beds were randomly observed and many were identified to have loose head boards and/or foot boards. Beds located but not limited to identified rooms either had missing bolts or screws or loose screws. The boards moved back and forth substantially or were not attached to the bed frame on one side (both screws missing). Residents who use the boards for minor support in any way would not be stabilized adequately or could become injured if a board fell down on them. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 101(4)]
The licensee did not comply with the conditions to which the licence was subject.
A) Section 4.1 under Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration network (LHIN) under the Local Health System Integration Act, 2006, read, "The Health Service Provider shall use the funding allocated for an envelope for the use set out in the applicable policy". The Long-term Care Homes Funding Policy of July 1, 2010 for Eligible Expenditures for Long-Term Care Homes Program and Support Services (PSS) envelope Section 1. (a) and b) reads, "support services and programs are required under the Long-Term Care Homes Act, 2007, are in the schedule of recreation and social activities, or are assessed in a care plan or plan of care to benefit the maintenance or improvement of the level of functioning of residents with regard to the activities of daily living and/or improve the quality of life of residents' and "the time spent by PSS staff to assess, plan, provide, evaluate, and document the support services and programs being provided are included."
B) Recreation staff from the PSS envelope were required to staff the front desk during their duties as recreation staff. Those hours from 2012 were reconciled at a student rate of pay, however, staff confirmed they were not paid at a student rate during the hours worked at the front desk.
C) Staff working in the retirement home were paid from the Long-Term Care home funding envelope, according to the home's payroll information (Wage Distribution by G/L Account", "Wage Distribution by Employee" and "Payroll Register" reports) and staffing schedules for an eight month period in 2012, for 2013 and to date in 2014. Hours for the Recreation Manager were also charged to the nursing home, however, the staff attended meetings, planned, and completed scheduling/duties for the

retirement home Recreation programs. The CEO confirmed that reconciliation was completed for 2012 and the hours charged to the nursing home were reimbursed, however, review of the financial data provided by the home reflected:
i) The hours for recreation staff working split shifts in the nursing home/retirement home were reconciled for 2012 a lower rate of pay than the staff who worked the hours were paid. Staff and management confirmed that the rate of pay for 2012 during the reconciliation period did not differ from the employees' current rates of pay.
ii) The home did not have a system to record actual time worked for split shifts in both the nursing home and retirement homes. The staffing schedules were used to reconcile the retirement home recreation hours that were charged to the nursing home for an eight month period in 2012, however, staff working the split shifts confirmed that the scheduled hours for the retirement home did not consistently reflect actual hours worked in the retirement home. Staff confirmed that time on a split shift was often spent predominantly in the retirement home for a variety of reasons and did not consistently reflect the actual time allotted on the staffing schedules. The home had no way to verify actual hours spent working in the retirement home versus the nursing home on a split shift.
D) The nursing home was being charged for hours spent working in the retirement home and services provided to the nursing home residents were not consistently being offered/provided as per the residents' plans of care. On numerous days of the inspection multiple residents were lined up in their wheelchairs along the one side of the hallway for several hours per day. This was identified on all floors, however, one floor had a particularly large number of residents sitting in the hallways in their wheelchairs between the breakfast, lunch and and dinner meals. Recreation staff and residents confirmed that programming was provided in the resident lounge and not routinely provided for residents in the hallways. One-to-one programming for residents in their rooms was not consistently provided and goals related to minimum number of programs per month were not being met for residents at risk. Recreation staff confirmed they do not always have time to complete the one-to-one programming for residents in the nursing home. [s. 101. (4)]

Additional Required Actions:

CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #13: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. O. Reg. 79/10, s. 9. (1).
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. The licensee did not ensure that doors equipped with an access control system were kept on at all times, especially doors that lead to non residential areas such as a retirement home.

A door on the main floor that led from the long-term care home to a corridor called the "link" and further to the retirement home (non residential area) was identified to be unlocked or "not on at all times". The door is electronically controlled with a magnetic locking system that must be demagnetized by pressing a code on a key pad. The key pad was observed to be on by-pass on two identified occasions during the inspection. The administrator stated that the doors are normally unlocked during the day and locked at night when administrative staff go home. However, the staff are not adequately supervising the doors. The administrative staff were conducting duties such as answering phones, photocopying, speaking to visitors and stepping away from their desks periodically. The staff at the main desk do not have a direct line of vision from their desks to the door that was being used by residents, staff and visitors. [s. 9. (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 doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that resident do not have access to must be, ii) equipped with a door access control system that is kept on at all times., to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Not all residents were offered a between-meal beverage in the afternoon, at the snack pass on an identified date during the inspection.
A) Resident #570 was offered and assisted with a pureed snack, however, was not offered a beverage. Staff confirmed that a beverage was not offered and stated the resident takes a long time to eat and usually just gets the pureed snack.
B) Resident #109 was offered and assisted with a pureed snack however, was not offered a beverage. [s. 71. (3) (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 residents are offered a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #15: 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,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. Not all menu items were prepared according to the planned menu at the dinner meal on an identified date in February 2014.
A) The planned menu required chicken cacciatore to be prepared for all diet textures, however, the cook stated they prepared diced chicken with gravy for the minced and pureed textures, which was not consistent with the planned menu/recipes.
B) Insufficient quantities of squash were available so carrots were substituted.
C) Triple chocolate cake was on the planned menu, however, carrot cake was substituted. The Nutrition Manager stated the chocolate cake was ordered, however, was used on the weekend for unknown reason and carrot cake was substituted.

Not all menu items were prepared according to the planned menu at the breakfast meal on an identified date in February 2014.

A) The planned menu required pureed raisin bread, however, the cook confirmed this was not prepared.
B) The planned menu required papaya, however, insufficient quantities of papaya were available so diced pears were substituted for the second meal sitting.
C) Blackberries were required on the planned menu, however, these were not prepared and available for residents. The cook confirmed these were not prepared and available as per the menu.
D) Portion sizes listed on the therapeutic extension menus were not followed by staff preparing the meals. Smaller portions were served than what was identified on the planned menu (planned portions were #12 scoop for pureed bread, pureed papaya, however, #16 scoop was used).

Not all menu items were prepared according to the planned menu at the lunch meal on an identified date in February 2014.
A) The planned menu required beef noodle soup, however, beef stock was not available and a substitution was made.
B) The planned menu required tangerine jello or chocolate ripple ice cream. Vanilla ice cream, red jello or mandarin oranges or pureed mandarins were offered to residents.

Not all menu items were prepared according to the planned menu at the snack pass on an identified date in February 2014.
A) The planned menu required grape drink and dark chocolate omega 3 flax cookies, however, apple juice and social tea cookies were prepared and served to residents. The Nutrition Manager confirmed that the menu was not followed and cited difficulties obtaining the cookies from the supplier. The menu was not revised to reflect the change and not communicated to staff or residents. The Nutrition Manager confirmed that the items served on the snack rotation do not consistently reflect what is on the planned menu.
B) Honey thickened fluids were required by a resident on an identified floor, however, honey thickened fluids were not available on the snack cart. Staff mixed nectar and pudding thick fluids together to serve to the resident who required honey thick fluids. The Nutrition Manager confirmed that the snack cart usually had all consistencies that were required by residents on that floor. [s. 72. (2) (d)]

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 menu items are prepared according to the planned menu, to be implemented voluntarily.

WN #16: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. Not all staff were participating in the hand hygiene program. Staff delivering the snacks to residents were not consistently washing their hands between assisting residents and providing the snacks or clearing used dishes. One staff member was observed using their hands (versus napkin) to distribute the cookies and did not consistently sanitize their hands between assisting residents and distributing the snacks.
The licensee did not ensure that staff complied with the home's hand hygiene program in accordance with prevailing practices. Prevailing practices require that staff perform hand hygiene before and after handling food, handling dirty dishes or providing care. [s. 229. (9)]

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 there is a hand hygiene program in place in accordance with evidenced -based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents., to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 109.	CO #007	2013_191107_0005	167
O.Reg 79/10 s. 129. (1)	CO #016	2013_191107_0005	540
LTCHA, 2007 S.O. 2007, c.8 s. 20. (2)	CO #002	2013_191107_0005	539
O.Reg 79/10 s. 221. (1)	CO #015	2013_191107_0005	167
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2013_210169_0019	539
O.Reg 79/10 s. 26. (3)	CO #004	2013_191107_0005	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #017	2013_191107_0005	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2013_190159_0021	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #009	2013_191107_0005	167
O.Reg 79/10 s. 68. (2)	CO #013	2013_191107_0005	107
LTCHA, 2007 S.O. 2007, c.8 s. 84.	CO #010	2013_191107_0005	120

Issued on this 24th day of April, 2014

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

Marilyn Lozer

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARILYN TONE (167), BERNADETTE SUSNIK (120), KATE MACNAMARA (540), MICHELLE WARRENER (107), VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2014_201167_0005
Log No. / Registre no:	H-000135-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 8, 2014
Licensee / Titulaire de permis :	TYNDALL NURSING HOME LIMITED 1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3
LTC Home / Foyer de SLD :	TYNDALL NURSING HOME 1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patricia Bedord

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To TYNDALL NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant:
2013_191107_0005, CO #001;
2013_190159_0021, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that the care set out in the plan of care is provided to residents as specified in the plan, related to diet order at snack service and the provision of recreational programming and use of bed rails.

The plan is to be submitted by April 22, 2014 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O.2007. c.8, s.6(7)] previously issued as a CO on May 28, 2013 and again on July 31, 2013

The licensee did not ensure that the care set out in the plan of care for resident # 627 was provided to the resident as specified in the plan. 2007, c. 8, s. 6(7)
A) The plan of care for resident #627 identified that one rail was to be elevated to assist resident with bed mobility and to prevent friction and shearing of skin. Observation of the resident on an identified date during this inspection revealed that no bed rail was elevated when the resident was in bed. Interview with PSW staff confirmed that the resident did not use a bed rail when in bed.

The care set out in the plan of care was not provided to the following residents as specified in their plans for the afternoon snack pass on an identified date during this inspection.
A) Resident #107 had a plan requiring honey consistency thickened fluids. The resident was provided nectar consistency thickened fluids.

B) Resident #108 required a pureed menu, however, was provided regular textured cookies. The menu for the pureed texture identified pureed cookies were to be offered.
C) Resident #110 required nectar consistency thickened fluids, however, the resident was provided thin fluids.
D) Staff identified to the inspector who they were providing snacks to and what they were providing.

The care set out in the plan of care was not provided to residents as specified in their plan in relation to recreational programs.
A) Resident #555 had a plan of care that required staff to take the resident to programs, document refusals and attendance, and to provide one-to-one programming 1-3 times per week such as hand therapy, bedside music and friendly visits. Activation Participation Records for the identified month in 2014 were blank and did not reflect that programming was offered or refused. Staff interviewed stated they couldn't remember visiting the resident or providing one-to-one programming for the resident.
B) Resident #112 had a plan of care that required staff to assist the resident to and from programming, to document participation in programming and any refusals, and a goal for participation in 2-5 programs per week. Activation Participation Records for the identified month in 2014 did not reflect that programming was offered or refused.
C) Resident #113 had a plan of care that required staff to encourage the resident to participate in programs at least 1-3 times per week, staff to direct the resident to programs, and to document participation and refusals of programming. Activation Participation Records for the identified month in 2014 were blank and did not reflect that programming was offered or refused. Staff interviewed stated the resident often refused.
D) Resident #114 had a plan of care that required staff to assist the resident to and from programming, to encourage spiritual programs, to document participation in programming and any refusals, and a goal for participation in 1-2 programs per week. Activation Participation Records for the identified month in 2014 did not reflect that programming was offered or refused. Staff interviewed stated the resident was often in bed during the day.
E) Resident #115 had a plan of care that required staff to assist the resident to and from programming, to encourage the resident to engage in activities and inform them of the programs available, to provide friendly discussion 1-3 times per week and to document participation and refusals of programming. Activation Participation Records for the identified month in 2014 did not reflect that

programming was offered or refused. Staff interviewed stated the resident was refusing to attend programs.
F) On numerous days of the inspection multiple residents were lined up in their wheelchairs along the one side of the hallway for several hours per day. This was identified on all floors, however, one floor had a particularly large number of residents sitting in the hallways between breakfast and lunch and lunch and the dinner hour. Staff confirmed that programming was provided in the resident lounge and not routinely provided for residents in the hallways and also confirmed that one-to-one programming for residents in their rooms was not consistently provided. Staff confirmed that many residents refused the programs offered at the home. The programs provided for at the home did not consistently meet the needs of the residents and residents were not consistently offered programming as per their plans of care.
(540)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0005, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's policy and procedure related to weight monitoring is followed by staff.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 8(1)b] Previously issued as a VPC on March 14, 2011 and September 23, 2011 and as a CO on May 28, 2013.

The home's weight monitoring policy "Weight Change Management DTY-A-80" and the new weight policy "Weights - Monitoring of Resident Weights VII-G-40.50" was not followed by staff.
The policy stated that all residents were to be weighed on the first bath day of each month and no later than the 8th day of each month (first bath day on new policy), to re-weigh every resident with a questionable weight to verify the accuracy of the weight (immediately re-weigh residents with weight variance of +/- 2kg on the new policy), and to refer to the Registered Dietitian in a timely manner using the established referral procedure.
A) Not all residents had their weights recorded within the time frames specified in the policy. On an identified date in 2014, weights were not available on the paper copy or in the computer for residents #116, #117, #118, #119, #120. Staff reviewed the documentation with the inspector and confirmed the weights were not available.
B) As of an identified date in 2014, re-weighs (to verify the accuracy of the weight when there was a significant variance) were not completed for residents #108 - 12% loss, #121 - 10.6% loss, #122 - 2.2kg loss, #110 - 8.5% gain. Staff confirmed the re-weighs were not completed.
C) As of an identified date in 2014, re-weighs for the identified month were not completed for some residents (#565, #123). Interview with staff confirmed that several of the re-weighs were not completed by the required date. Staff stated the weights were not taken due to the computer not flagging the weight exceptions, however, a paper copy of all the weights was available to staff in addition to the computer system. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0005, CO #011;

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

Order / Ordre :

1. The licensee shall ensure that all residents including residents #800, #608, #550, #579, #547 and #603, who have been identified to require one or more bed rails while in bed and who currently reside in a bed that has failed one or more zones of entrapment shall have interventions instituted to mitigate the identified risk (i.e rail pad, gap filler, mattress keeper, alternative mattress, alternative rail, no rail, alternative bed frame or any combination of)
2. For bed systems that cannot be modified immediately to ensure entrapment zones are eliminated, monitor the interventions that were instituted and re-evaluate to determine if the interventions are effective for the resident.
3. Retest the bed systems when the bed systems have been changed or altered.

4. Update the residents' plans of care to reflect what directions staff require to ensure that the resident who resides in a bed that has failed one or more entrapment zones will have their specific risk mitigated.
5. Educate health care staff who provide care to residents on the risks associated with bed rail use and overall bed safety.
6. Maintain documentation of all bed audits so that it clearly identifies when the bed system was tested for entrapment zones, who completed the test and what follow up action is being proposed for the beds that failed one or more zones of entrapment.

Grounds / Motifs :

1. [O.Reg.79/10, s.15(1)] Previously issued as a CO on May 28, 2013.

The licensee did not ensure that when residents were using bed rails that those residents were assessed and their bed system evaluated in accordance with evidence based practices to minimize the risk to the residents.

A) During a review of the health files for residents #579, #547 and #603, it was noted that nursing assessments were not completed related to their risk of entrapment related to the use of the bed rails used on their beds.
B) Resident #547 was observed to be using one full bed rail with a bed rail pad in place. The document that the home referred to as the care plan for the resident indicated that this bed rail was used to assist the resident with their mobility and staff confirmed this. It was noted that the assessment of the resident's bed completed in February 2014 indicated that the resident's bed did not pass one or more entrapment zones.
C) Resident #579 was observed to have two half bed rails raised on their bed. Staff confirmed that the resident used two half rails when in bed to assist them

with mobility. The care plan for the resident directed staff to put both half rails up when the resident was in bed. It was noted that the assessment of the resident's bed completed in February 2014 by the home indicated that the resident's bed did not pass one or more entrapment zones.
D) Resident #603's bed was observed to have one full bed rail raised. The care plan for the resident indicated that one full rail was used when the resident was in bed. Staff confirmed that one full bed rail was used when the resident was in bed. It was noted that the assessment of the resident's bed completed in February 2014 by the home indicated that the resident's bed did not pass one or more entrapment Zones.
E) The Administrator and the Director of Care confirmed that staff at the home were not currently completing any type of nursing assessment related to entrapment risk for residents who were using bed rails on their beds.
F) The Administrator confirmed that the home does have an assessment tool that could be used for this purpose but had not yet implemented the use of this tool within the home. (167)

2. On an identified date during this inspection, three residents were observed to be sleeping in beds with either one or more bed rails in the raised position. The beds were located in identified rooms for residents #550, #608 and #800. The beds were tested for entrapment zones on February 2014 by the Director of Care and confirmed that they had failed zones 2,3 and 4. Trained staff had also previously tested the beds and documentation was completed identifying that they had failed 3 zones of entrapment. However, no steps had been taken to prevent the potential for resident entrapment regarding any of the zones identified to be a risk. (120)

3. Where bed rails are used, other safety issues related to the use of bed rails were not addressed, specifically related to bed rail height.

An adult hospital bed located in an identified resident room was observed to be equipped with a very thick mattress, over 3 times the thickness that is required. The mattress did not fit the width of the bed and did not comply with recommendations provided by the manufacturer for the bed. The mattress was a pillow type coil style mattress and was higher than the bed rails which were found in the raised position. The rails could not be used and the mattress could not be raised and lowered adequately at the head or foot of the bed due to it's massive depth. Should the resident or staff require the the rails for repositioning, they would not be able to use them. Should the rails be required

for falls prevention, the resident would be able to roll over the top of them onto the floor.
The bed system was not evaluated in accordance with evidenced-based practices to minimize risk to residents. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0005, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

The licensee shall ensure that residents with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, including residents

Grounds / Motifs :

1. [O.Reg. 79/10, s. 69.4] Previously issued as a CO on May 28, 2013.

Weight changes were not assessed using an interdisciplinary approach with action taken and outcomes evaluated for resident #598 and #627.
A) Resident #598 fell below the goal weight identified on their plan of care in October 2013 with further weight loss in January 2014. Action was not taken and the plan of care was not revised in relation to the weight loss from October 2013 to February 2014 (the date when the resident's record was reviewed). At the January 2014 quarterly nutritional assessment the Registered Dietitian identified a further decline in nutritional intake, however, action was not taken and the plan of care was not revised to prevent further weight loss. The resident's intake went from 42% of their meals taken poorly in November 2013 to 83% of their meals taken poorly in January 2014. The Registered Dietitian documented she would

consider further interventions in the quarter to prevent further weight loss, however, strategies had not been initiated as of February 2014 (the date when the chart was reviewed).The plan of care was not evaluated in relation to outcomes (less than goal weight range) and in relation to goals identified on the plan of care (weight gain to within the goal weight range over the quarter).
B) Resident #627 had a goal for prevention of weight loss identified on their plan of care in August 2013. At the nutritional assessment on August 2013, the Registered Dietitian stated that if the resident had a further decline in intake, supplements would be considered. The resident had further weight loss identified at the October 2013 quarterly review and again further weight loss below the resident's goal weight range in November and December 2013. At the January 2014 quarterly it was identified that the resident was below their identified goal weight range and further decline in dietary intake, however, action was not taken and the plan of care was not revised in relation to the goals for the prevention of weight loss identified on the plan of care. Outcomes were not evaluated in relation to goals identified on the resident's plan of care and action was not taken to prevent further unintended weight loss. During interview with the Registered Dietitian during the inspection, they stated that the previous week some interventions were trialled with the resident, however, documentation did not reflect this. The resident was also not provided with sufficient assistance when observed in the dining room at the lunch meal on an identified date in February 2014 and did not eat well.

Residents with weight changes were not assessed using an interdisciplinary approach.
A) Resident #123 had a documented 8.6% significant weight loss from January to February 2014. Documentation in the progress notes or Dietitian communication book did not reflect a multidisciplinary assessment of the weight loss or referral to the Registered Dietitian. Staff stated the home's process was to document resident weights on paper or in the computer, including re-weighs by the 7th of the month and refer to the Dietitian through the Dietitian communication book, including a nursing assessment of causal factors for the weight change. As of an identified date in February 2014 staff confirmed a multidisciplinary assessment of the weight change was not completed, however, staff stated the resident appeared as if they had lost weight and staff confirmed that a referral to the Dietitian had not yet been completed.
B) Resident #570 had a documented weight loss of 14% from January to February 2014 and staff confirmed a re-weigh had not been completed. As of February 2014, a multidisciplinary assessment of the significant weight change

had not occurred and a referral to the Registered Dietitian was not completed as per staff interview/review of communication book. The resident had a wound, had fallen below their target weight range and was at nutrition risk.
C) Resident #122 had a 7.4% significant weight loss from November to December 2013 and in February had an 8.6% weight loss noted over 3 months. There was no assessment of the December 2013 significant weight loss until January 2014 at the nutritional quarterly review. Documentation did not reflect a multidisciplinary assessment of the February significant weight loss over 3 months.
(107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0005, CO #014;

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance. This includes resident #101.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)10] Previously issued as a CO on May 28, 2013.

Not all residents who required assistance with eating were positioned safely at the dinner meal on an identified date in February 2014 and the lunch meal on an identified date in February 2014.

A) Resident #101 was sliding down in their wheelchair and had their head tilted back with their chin pointed towards the ceiling while being fed at both meals, creating a risk for choking. Registered staff confirmed the resident was not safely positioned during the meal and the resident was re-positioned.[O.Reg. s.73(1)10] (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0005, CO #012;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall ensure that any actions taken with respect to a resident under the nutrition and hydration program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Grounds / Motifs :

1. [O.Reg. 79/10, s..30(2)] Previously issued as a CO on May 28, 2013.

The Registered Dietitian confirmed that actions taken with respect to resident #627, under the nutrition and hydration program, including reassessments and interventions and the resident's responses to the interventions were not documented.

A) The Registered Dietitian stated that nutritional interventions were tried with the resident, however, documentation did not reflect this. Documentation did not reflect the resident's response to those interventions or a re-evaluation of the resident in relation to the nutritional interventions.
B) Documentation did not reflect an assessment of the resident's hydration in relation to the resident's assessed needs at the January 2014 quarterly nutritional assessment. According to the food and fluid intake records, the resident was not meeting their hydration requirement on most days in November and December 2013, however, documentation did not reflect an assessment of the poor hydration. Interview with the Registered Dietitian confirmed that the resident's hydration was reviewed, however, they were unconcerned as the resident was consuming fluids outside of meals that were not recorded in the resident's hydration records. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0005, CO #006;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall;
1. Ensure that the maintenance room is always kept locked when unoccupied by staff.
2. Ensure that all hazardous substances are kept inaccessible to residents, specifically Virox disinfectant

Grounds / Motifs :

1. Maintenance staff left their maintenance room unlocked and accessible to residents on an identified date during this inspection. Staff confirmed that the room is left unlocked on a regular basis so that various staff members can access the room easily throughout the day. The room was found to contain a cabinet which was wide open containing various chemicals, some that were labeled "poisonous". Various objects were also left exposed such as sharp tools and cutters. (120)

2. Hazardous chemicals were accessible to residents in the treatment room on one floor on an identified date during this inspection. The door to the nursing station was left propped open and the door to the treatment room was left propped open. Residents had unrestricted access to this area and staff had left the area unsupervised (no staff around). A bottle of Virox disinfectant spray was identified under the sink in the treatment room. (107)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 008

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee shall ensure that all windows to which residents have access and that open to an outdoor space are restricted to 15 cm or less, beginning with the windows located in the main floor lounge, main floor dining room, the identified resident's room and the fourth floor dining room.

Grounds / Motifs :

1. The licensee did not ensure that every window in the home that opens to the outdoors and is accessible to residents was restricted to an opening of 15 centimeters or less.

Large sliding windows were observed to be unrestricted in the main floor lounge, main floor dining room, an identified resident room and 4th floor dining room. (120)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 08, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 009

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall;
1.Have the current resident-staff communication and response system assessed by March 31, 2014 to determine if additional activation stations can be added to the system. If the current system is not capable of supporting activation stations for all of the resident accessible areas on the main floor along with 1 additional station per floor in accordance with legislative requirements, alternative solutions must be sought.
2. When alterations are to be made, complete the Operator's Guide to the Process of Alterations, Renovations or Additions to Existing Long Term Care Homes and submit any proposed amendments to the resident-staff communication and response system to the Planning and Renewal Branch for approval prior to starting any amendments by April 30, 2014.
3. The approved plan shall be implemented by August 30, 2014.

Grounds / Motifs :

1. The resident-staff communication and response system was not available in every area accessible by residents.

The activity room, main floor lounge, main floor dining room, the link, the exterior court yard, and lounges on 2nd, 3rd and 4th floor (next to the nurse's stations) were not provided.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 010

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall develop and implement a plan that:
1. Describes who and by when an audit will be completed of all the flooring surfaces within the home to ensure that they are maintained according to the home's floor care policies 06-02-04, 06-02-05 and 06-02-07;
2. Describes who will be responsible for stripping, re-waxing and buffing the floor surfaces in the home once the audit has been completed;
3. Describes the long term action plans to keep the floors within the home maintained according to the home's floor care policies.
The plan shall be emailed to Bernadette.Susnik@ontario.ca or faxed to Bernadette Susnik at 905-546-8255 by April 30, 2014. The plan shall be implemented by May 30, 2014.
The above work is to be completed by May 30, 2014.

Grounds / Motifs :

1. The licensee did not ensure that procedures were implemented for cleaning the walls and the floors throughout the home.

The home's flooring surfaces were observed to be discoloured, with wear patterns in many resident bedrooms on each floor. According to the home's various policies on floor care and maintenance, the floors are to be stripped and re-waxed annually in high traffic areas if well maintained and buffed regularly. Spray buffing procedures direct staff to use a machine once to three times weekly. The housekeeping staff were equipped with a new floor mopping system using microfiber pads which according to their policy, are to be used with a neutral floor cleaner.

The home's spray buffing machine has been out of service for an unknown period of time. No spray buffing was seen during the two day inspection. Staff confirmed that the floors were stripped and re-waxed approximately 2 years ago. The staff were using a microfiber mopping system using a disinfectant, causing the floors to be dull and sticky when slightly wet or when walking on the floor with wet shoes.

The home's housekeeping policy and procedure 06-01-06 regarding wall cleanliness requires staff to "spot clean walls on a daily basis". Visible wall matter was observed on walls identified resident washrooms and identified resident bedrooms over a two-day period. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 011

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall:
1. Complete a full maintenance check of all beds in the home to ensure that head boards and foot boards are in good condition and tight fitting to the frame.
2. Replace or repair night tables in identified resident rooms rooms so that surfaces are smooth, tight-fitting and impervious to moisture.

Grounds / Motifs :

1. The licensee has not ensured that the furnishings and equipment were maintained in a safe condition and in a good state of repair.

Night tables observed in but not limited to identified resident rooms were not in a good state of repair and posed a potential safety issue. The top surfaces around the perimeter were exposed to a ragged particle board subsurface which may cause a skin injury.

Resident's beds were not in a good state of repair. Beds were randomly observed and many were identified to have loose head boards and/or foot boards. Beds located but not limited to identified rooms either had missing bolts or screws or loose screws. The boards moved back and forth substantially or were not attached to the bed frame on one side (both screws missing). Residents who use the boards for minor support in any way would not be stabilized adequately or could become injured if a board fell down on them. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 012

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Order / Ordre :

The licensee shall comply with Section 4.1 under Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Network (LHIN) under the Local Health Integration Act, 2006, read, " The Health Service Provider shall use the funding allocated for an envelope for the use set out in the applicable policy".

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 101(4)]
The licensee did not comply with the conditions to which the licence was subject.

A) Section 4.1 under Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration network (LHIN) under the Local Health System Integration Act, 2006, read, "The Health Service Provider shall use the funding allocated for an envelope for the use set out in the applicable policy". The Long-term Care Homes Funding Policy of July 1, 2010 for Eligible Expenditures for Long-Term Care Homes Program and Support Services (PSS) envelope Section 1. (a) and b) reads, "support services and programs are required under the Long-Term Care Homes Act, 2007, are in the schedule of recreation and social activities, or are assessed in a care plan or plan of care to benefit the maintenance or improvement of the level of functioning of residents with regard to the activities of daily living and/or improve the quality of life of residents' and "the time spent by PSS staff to assess, plan, provide, evaluate, and document the support services and programs being provided are included."
B) Recreation staff from the PSS envelope were required to staff the front desk during their duties as recreation staff. Those hours from 2012 were reconciled at a student rate of pay, however, staff confirmed they were not paid at a student rate during the hours worked at the front desk.

C) Staff working in the retirement home were paid from the Long-Term Care home funding envelope, according to the home's payroll information (Wage Distribution by G/L Account", "Wage Distribution by Employee" and "Payroll Register" reports) and staffing schedules for an eight month period in 2012, for 2013 and to date in 2014. Hours for the Recreation Manager were also charged to the nursing home, however, the staff attended meetings, planned, and completed scheduling/duties for the retirement home Recreation programs. The CEO confirmed that reconciliation was completed for 2012 and the hours charged to the nursing home were reimbursed, however, review of the financial data provided by the home reflected:

i) The hours for recreation staff working split shifts in the nursing home/retirement home were reconciled for 2012 a lower rate of pay than the staff who worked the hours were paid. Staff and management confirmed that the rate of pay for 2012 during the reconciliation period did not differ from the employees' current rates of pay.

ii) The home did not have a system to record actual time worked for split shifts in both the nursing home and retirement homes. The staffing schedules were used to reconcile the retirement home recreation hours that were charged to the nursing home for an eight month period in 2012, however, staff working the split shifts confirmed that the scheduled hours for the retirement home did not consistently reflect actual hours worked in the retirement home. Staff confirmed that time on a split shift was often spent predominantly in the retirement home for a variety of reasons and did not consistently reflect the actual time allotted on the staffing schedules. The home had no way to verify actual hours spent working in the retirement home versus the nursing home on a split shift.

D) The nursing home was being charged for hours spent working in the retirement home and services provided to the nursing home residents were not consistently being offered/provided as per the residents' plans of care. On numerous days of the inspection multiple residents were lined up in their wheelchairs along the one side of the hallway for several hours per day. This was identified on all floors, however, 2nd floor had a particularly large number of residents sitting in the hallways in their wheelchairs between the breakfast, lunch and dinner meals. Recreation staff and residents confirmed that programming was provided in the resident lounge and not routinely provided for residents in the hallways. One-to-one programming for residents in their rooms was not consistently provided and goals related to minimum number of programs per month were not being met for residents at risk. Recreation staff confirmed they do not always have time to complete the one-to-one programming for residents in the nursing home. (107)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Marilyn Tone

Name of Inspector / Nom de l'inspecteur : MARILYN TONE

Service Area Office / Bureau régional de services : Hamilton Service Area Office