Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 2, 2015	2015_275536_0011	H-002690-15	Resident Quality Inspection

Licensee/Titulaire de permis

PEEL HOUSING CORPORATION
10 Peel Centre Drive, Suite A BRAMPTON ON L6T 4B9

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

VERA M. DAVIS NURSING HOME
80 Allan Drive Bolton ON L7E 1P7

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

CATHIE ROBITAILLE (536), KATHLEEN MILLAR (527), MICHELLE WARRENER (107), SUSAN PORTEOUS (560)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 15, 16, 17, 18, 19, 22, 23, 24 and 25, 2015.

During the course of this Resident Quality Inspection the following Critical Incident System (CIS) inspections were conducted concurrently: H-000678-14 and H-002773-15. There were findings on non-compliance in both CIS's.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s)spoke with residents, family members, Dietary staff, Supervisor of Dietary Service, Registered Dietitian (RD), Personal Support Workers(PSW),Registered Nurses (RN) and Registered Practical Nurses(RPN), Supervisor of Care, Supervisor of Activation, Maintenance Staff, housekeeping staff,Program Support Nurse, Supervisor of Business Services, Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed meal and snack services, observed the provision of care and services provided on all home areas,interviewed staff, residents and families, and reviewed relevant documents including, health care records,investigation reports, training records, meeting minutes, menus, health care records, resident billing and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **15 WN(s)**
- **8 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #032 set out clear directions to staff and others who provided direct care to the resident.

A) On an identified date in 2015, the residents' plan of care was reviewed by the Long Term Care (LTC) Inspector. The resident's Kardex provided direction to the Personal Support Workers (PSW's). The residents' plan of care which the home refers to as the care plan dated on an identified date in 2015; and in place on an identified date in 2015, identified the bathing focus as different that the practice currently in place. The PSW staff interviewed during the inspection reported the current practice that was in place was not what the Kardex directed.

B) During the review of the plan of care by the LTC Inspector, it was noted that a focus in resident #032's care plan stated: Ineffective coping and identified behaviours. On an identified date and time in 2015, the progress notes documented identified information. On an identified date in 2015, the Care Plan did not contain the intervention of the current plan of care in place.

During an interview with the registered staff and the Director of Care (DOC), they both confirmed that the Care Plan and Kardex directed that resident #032 was still to receive the previous plan of care in place. The DOC also confirmed the directions for staff providing direct care to the resident were not clear in the written plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #004 so that their assessments were integrated, consistent with and complemented each other.

A skin assessment was completed on the resident's pressure area on an identified date in 2015. The assessment indicated the area was an identified size, and was an identified stage. A skin assessment was completed by a different staff who stated they were unaware of the other skin assessment the day prior when completing the assessment on an identified date in 2015. The skin assessment on an identified date in 2015, identified the same area was an identified size, and was an identified stage. The assessments were not consistent with each other in the assessment of the resident's wound. The staff completing the assessment on an identified date in 2015, stated they did not agree with the assessment completed on the identified date; however, documentation did not reflect the disagreement, or an explanation of the difference between the two skin assessments. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #035 as specified in the plan.

The resident had a plan of care that required an identified thickened fluids, and also required a nutritional supplement (Great Shake) to be provided at snacks. On an identified date in 2015, the resident was provided a Great Shake that was not thickened to the identified consistency. The Personal Support Worker (PSW) who provided the snack confirmed the supplement did not have thickener added to it. The Supervisor of Dietary Services confirmed that thickener was available on the snack cart and staff were to thicken the supplement to identified consistency prior to giving it to the resident. The diet list available on the snack cart identified the resident required an identified consistency of their thickened fluids. The resident received regular consistency fluids which was not consistent with the plan of care which required honey consistency thickened fluids. [s. 6. (7)]

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 and ensuring that staff collaborate with each other in the plan of care and that care is provided to residents as specified in the plan. This VPC is for 6(4)(a) and 6 (7), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #042, who was identified to have an identified size pressure area on an identified area, received a skin assessment by a

member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Progress notes on an specified date in 2015, identified a pressure area on an identified area. An assessment of the area using a clinically appropriate assessment instrument specifically designed for skin and wound assessment was not completed. The registered staff confirmed that the area was not assessed using a clinically appropriate assessment instrument and stated that skin assessments were not completed unless the area was open. The progress note on an identified date in 2015 only mention the pressure area and it was unclear if the area was being monitored. On an identified date in 2015, registered staff confirmed the area remained reddened. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #004, who had a pressure area identified on a specific date in 2015, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A progress note dated on identified date in 2015, identified the resident had developed a pressure area. A clinically appropriate skin assessment of the area was not completed until an identified date in 2015, when the wound had deteriorated and progressed to an identified stage. Registered nursing staff confirmed an assessment of the area was not completed using a clinically appropriate assessment instrument, until an identified date in 2015. The home's policy, "LTC9-05.09.02 Skin and Wound Care Program", effective date May 28, 2014, stated, "Upon discovery of a pressure ulcer, initiate a weekly wound assessment utilizing the Bates-Jensen Assessment Tool on Point Click Care (PCC)." [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that resident #004, who exhibited altered skin integrity, including skin breakdown, had been assessed by a Registered Dietitian in relation to the skin breakdown.

Skin breakdown was identified in the progress notes on an identified date on resident #004. A referral to the Registered Dietitian was not completed until the area progressed to an identified stage at the assessment completed on an identified date in 2015. Staff confirmed a referral was not completed initially when the area was first identified. [s. 50. (2) (b) (iii)]

4. The licensee has failed to ensure that resident #004, who had identified altered skin

integrity, including skin breakdown and wounds, was reassessed at least weekly by a member of the registered nursing staff.

A) The resident was noted to have an identified stage open area on an identified date in 2015 when the initial skin assessment was completed by registered staff. The next weekly wound assessment was completed on an identified date in 2015, and another eleven to twelve days after the initial assessment. The next weekly assessment was nine or ten days after. The Physician wrote a progress note on an identified date in 2015 that identified the area was deteriorating, a Care Conference note on an identified date in 2015 stated the wound had not been healing; however, the skin assessment completed on an identified date in 2015 identified the wound was decreasing in size with current interventions. An order was not initiated on the Treatment Administration Record (TAR) for weekly wound assessments for the area until an identified date in 2015, despite the area being noted on an identified date in 2015.

B) Progress notes on an identified date in 2015, identified that the resident had developed a pressure area on an identified area on an identified date in 2015. An assessment of the area was not completed until 9 days later, when the area had significantly deteriorated and was identified as an identified stage. The TAR identified weekly wound assessments starting on an identified date in 2015 despite the area being identified on a specified date in 2015. [s. 50. (2) (b) (iv)]

5. The licensee has failed to ensure that resident #004 who was dependent on staff for repositioning every two hours was repositioned.

The written plan of care for resident #004 specified that the resident was to be turned and positioned every 2 hours to offload pressure to the wound which was initiated on an identified date in 2015. Point of Care (POC) turning and repositioning documentation was reviewed for an identified month in 2015. Between identified dates in 2015, there were nineteen separate incidents, where the documentation identified a range of hours, between turning and repositioning times for resident #004. The resident's wound was documented as deteriorating and the documentation did not reflect that repositioning was occurring every 2 hours as per the plan of care. This was confirmed by registered nursing staff. [s. 50. (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 and ensuring skin assessments using a clinically appropriate assessment instrument, resident is assessed by a Registered Dietitian, completion of weekly assessments and repositioning every two hours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A) Resident #015 was hospitalized on an identified date in 2014, and their health status had changed. In addition, Minimum Data Set (MDS) assessment completed on an identified date in 2015 stated that the resident was occasionally incontinent for bowel, and in an identified month in 2015 the MDS identified the resident's bowel incontinence had worsened to frequently incontinent. The clinical record was reviewed and the last Bladder and Bowel Assessment for resident #015 was completed in an identified month

in 2013. The Registered Nurse (RN) confirmed they have not completed a Bladder and Bowel assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence for the resident since they were admitted in an identified month in 2013.

B) The Minimum Data Set (MDS) assessment completed in an identified month in 2015 identified that resident #016 was continent for bowel, and in another identified month in 2015 the MDS identified the resident's bowel continence had worsened to frequently incontinent of bowel. The clinical record was reviewed and the last Bladder and Bowel Assessment for resident #016 was completed in an identified month in 2012. The RN confirmed they have not completed a Bladder and Bowel assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence for the resident since an identified month in 2012.

C) The Minimum Data Set (MDS) assessment completed in an identified month in 2015, stated that resident #019 was frequently incontinent for bowel, and in an identified month in 2015 the MDS identified the resident's bowel continence had worsened to incontinent of bowel. The clinical record was reviewed and the last Bladder and Bowel Assessment for resident #019 was completed in an identified month in 2013. The RN confirmed they have not completed a Bladder and Bowel assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence for the resident since an identified month in 2013.

The home's policy called "Continence Care and Bowel Management Program", number LTC9-05.09.05, and revised May 2014 directed RNs and RPNs that "Quarterly the MDS assessment shall be completed including a bowel and bladder assessment (according to the RAI-MDS schedule), and after any change in health status that may affect bladder or bowel continence". The DOC was interviewed and confirmed that when there was a change in the MDS assessment in bowel or bladder continence, or a change in health status that RNs and RPNs were expected to complete a Bladder and Bowel Assessment using the home's assessment tool in Point Click Care (PCC). [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring each resident who has a change in continence receives an assessment with a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #032's medical records from identified dates and years, were reviewed by the Long Term Care (LTC) Inspector and provided the following information:

i) Resident #032 had a history of inappropriate behaviours. The resident was referred to an identified center in an identified year and to another identified center in another identified year for assessment and followed up by psychiatrists.

ii)In an identified year, behaviours were documented as occurring. In an identified year, referrals were made to Behavioural Support Ontario (BSO) because the resident was exhibiting identified behaviours. Physical, Intellectual, Emotional, Capabilities, Environment, Social & Cultural (P.I.E.C.E.S.) assessments were completed by the Psychogeriatric Research Consultant (PRC).

iii)In 2015 between identified dates, there were a total of 5 documented incident.

iv)According to the documentation received by the inspector, the next referral to BSO was made on an identified date in 2015. The resident was referred for identified behaviours. Daily Observation Study (DOS) charting was initiated on an identified date in 2015.

v)On an identified date in 2015 the resident once again had identified behaviours.

vi)On an identified date in 2015(different than the above date)the resident once again had identified behaviours.

vii)On an identified date in 2015 (different than the above date) the resident once again had identified behaviours.

viii)The home's policy "Prevention and Management of Responsive Behaviour Program" policy no. LTC-05.09.03, revised May 5, 2014. The Policy directs registered staff (on page 5) to initiate a Direct Observation Study (DOS) for seven days if 2 or more episodes occur within 7 days, refer to the Behavioural Supports Ontario (BSO) consultant and complete a P.I.E.C.E.S. review. DOS charting was not initiated after the two behaviour incidents on an identified date in 2015. DOS charting and a referral to BSO for the resident were not initiated until an identified 2015, after the incident involving the female resident. On an identified date in 2015, neither a P.I.E.C.E.S. assessment in relation to the resident's behaviours or a referral to the PRC had been completed. The P.I.E.C.E.S. assessment for the resident was to be completed by the PRC. This information was confirmed by the BSO nurse during an interview on an identified date in 2015.

On an identified date in 2015 the Director of Care (DOC) confirmed during an interview that the Policy was in effect and directs registered staff to initiate DOS charting after 2 episodes of behaviour within 7 days; make a referral to the BSO nurse, and complete a P.I.E.C.E.S. assessment for the resident. On an identified date in 2015, during an

interview the Supervisor of Care confirmed that a referral to the PRC was made on an identified date in 2015. The licensee did not ensure that procedures and interventions including DOS charting, referral to BSO and a P.I.E.C.E.S. assessment were implemented as directed by the home's Policy on responsive behaviours to assist residents and staff who were at risk of harm as a result of the residents' responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring procedures and interventions are implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident's behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition and hydration programs included, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

A) The home's hydration program directed registered nursing staff to notify the Registered Dietitian if a resident did not consume all or almost all liquids (1500 ml) provided during the last three days if the care plan did not indicate a fluid restricted diet, and to follow up with the Dietitian to ensure the resident has been assessed. The Corporate Dietitian clarified that the policy was 1500 ml each day over three days. The policy also directed the Registered Dietitian to provide recommendations/interventions for the resident to address the fluid intake in collaboration with registered nursing staff and the resident/SDM.

B) The home's Registered Dietitian stated that interventions related to hydration were not implemented until the resident consumed an average fluid intake that was less than 75% of their assessed hydration target if the resident was eating well, which was not

consistent with the home's policy.

C) Resident #041 was assessed as requiring 1550-1850 mL of fluids per day, on the RAI-MDS assessment completed in an identified month in 2015. The Registered Dietitian identified the resident was consuming less than their assessed hydration target. The Dietitian confirmed a referral related to hydration was not received for the resident (consistently less than 1500 mL). Interventions related to hydration were not revised at that assessment. The RAI-MDS assessment completed in an identified month in 2015, the resident was assessed as requiring 1600-1850 mL per day. The resident's fluid intake decreased to an average below their assessed hydration target. The Dietitian confirmed a referral related to the resident's hydration was not received and interventions related to hydration were not revised. The resident had a further decrease in their hydration to less than their assessed hydration target, in an identified month in 2015 due to illness. Staff confirmed a referral to the Registered Dietitian for assessment of hydration was not completed. The resident was re-assessed by the Registered Dietitian with hydration strategies implemented after discussion with the Long Term Care (LTC) Inspector.

Staff did not follow the home's policy of referral to the Registered Dietitian for fluid intake of 1500 mL or less each day for three days or a reduction in hydration and the parameters the Registered Dietitian was following were not consistent with the home's hydration policy. [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the nutrition and hydration programs include development and implementation in consultation with a Registered Dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that action was taken and outcomes were evaluated after significant and ongoing unplanned weight loss for resident #042.

Resident #042 had a goal for weight maintenance between their target weight range. The resident had been declining in weight with a significant weight loss warning triggered in an identified month in 2015 (5.8% loss in one month, 8.6% loss over three months, 11.7% loss over six months). The resident dropped below their target weight range in an identified month. The Registered Dietitian reviewed the resident in relation to the triggered weight warning in an identified month in 2015; however, action was not taken and interventions were not revised in relation to the significant weight loss at that time. Nutritional interventions had not been revised as of an identified date in 2015 when the inspector spoke with the Registered Dietitian. [s. 69.]

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 and ensuring that action is taken and outcomes are evaluated after a significant and ongoing unplanned weigh loss, to be implemented voluntarily.

WN #7: 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, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a snack, in addition to a beverage, at the afternoon snack pass on June 24, 2015. Only part of the snack pass was observed (six residents).

Resident #014 required a identified texture menu. The resident was offered a labeled beverage (cranberry juice) but was not offered a snack. The Personal Support Worker (PSW) confirmed that the resident was on a identified texture menu and was not offered a snack. The PSW confirmed they should have offered a snack in addition to the beverage.

Resident #045 required an identified texture menu. The resident was offered a beverage, however, was not offered a snack. The PSW confirmed that the resident required an identified texture snack and was not offered a snack. The PSW voiced concerns over the close proximity between the lunch meal and snack pass (lunch often finished at 1330 hours and the afternoon snack pass which begins at 1400-1430 hours). [s. 71. (3) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that each resident is offered a snack in addition to a beverage during afternoon and evening distribution times, to be implemented voluntarily.

WN #8: 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: 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,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

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. The licensee has failed to ensure that proper techniques were used to assist residents.

A) A Personal Support Worker(PSW) was assisting resident #046 at the lunch meal on an identified date in 2015, and was standing to assist the resident with eating and was not at eye level with the resident. The staff member stated they had finished assisting at one table and had moved to that table to assist with feeding resident #046. The PSW confirmed that staff were to be seated while assisting residents with eating. The home's policy, "LTC 09-05.06.03 Meal Service - Dining Room Responsibilities - Personal Support Workers", effective date May 3, 2013, directed staff to be seated at eye level with the resident while assisting with feeding.

B) A PSW assisting resident #035 with eating their lunch meal on an identified date in 2015, was using the spoon to scrape food from the resident's mouth, instead of using a napkin.

C) Staff were not consistently informing the residents being assisted with eating of what they were feeding to the resident prior to putting the food into the resident's mouth at the breakfast and lunch meals on an identified date in 2015. The home's policy, "LTC 09-05.06.03 Meal Service - Dining Room Responsibilities - Personal Support Workers",

effective date May 3, 2013, directed staff to tell the resident what he/she was eating. [s. 73. (1) 10.]

2. The licensee has failed to ensure that staff members assisted only one or two residents at the same time who required total assistance with eating or drinking.

A) At the breakfast meal on an identified date in 2015, three residents (#022, #044, #045) at an identified table required extensive assistance with eating. Two of the resident were able to drink independently; however, required total assistance with eating. One staff member was assisting the residents at this table.(107)

B) At the lunch meal on an identified date in 2015, three residents (#036, #003, #043) at an identified table required total assistance with eating. Staff was observed feeding two of the residents and then moved to the other side of the table to assist the third resident. The third resident sat with their soup in-front of them until the PSW was finished feeding the other two residents. An additional PSW came intermittently during the meal; however, for most of the meal one PSW was required to assist three residents who required full assistance with eating.(107)

C) At the lunch meal on an identified date in 2015, three residents (#008, #035, #039) at an identified table required total assistance with eating. Staff was observed feeding resident #039. Residents #008 and #035 sat with their food in-front of them not eating until total assistance was provided. Staff was observed moving between the three residents at the table throughout the meal. Staff confirmed the residents required full assistance with eating at that meal.(107)

D) At the breakfast meal on an identified date in 2015, a Personal Support Worker (PSW) was observed feeding resident #13, #25, #33, and #37 from 0830 hours(hrs) to 0905 hrs moving from one side of the table to the other at quick intervals. The plan of care for these residents identified they could require limited assistance; assistance with eating if unable, or extensive assistance. At that time all residents required extensive assistance with eating. At 0905 hrs a registered staff sat down to assist however, at 0915 hrs the PSW was called away leaving the registered staff to feed 3 residents that had not completed their meal. The PSW and the registered staff both confirmed that they were to assist only 2 resident at a time; however, both also stated there were not enough staff available to assist with all the residents requiring feeding. At the time of the observation the PSW who was feeding was on modified and was an extra staff. (536)

The home's policy, "LTC9-05.06.01", effective date, April 5, 2011, confirmed that staff were not to assist more than two residents at a time for residents who required assistance with eating. [s. 73. (2) (a)]

3. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

A) At the breakfast meal on an identified date in 2015, staff were seated on the right side of resident #042. Resident #046 was sitting in-front of their meal until the Personal Support Worker (PSW) had finished assisting resident #042 and then moved across the table to assist resident #046. The resident's meal (hot cereal and entree) had been placed in-front of the resident prior to assistance being provided.

B) Meals, including hot entrees/cereals, were placed on the table for residents prior to assistance being provided at the lunch meal on an identified date in 2015, and at the breakfast meal on an identified date in 2015. The meals sat on the table while staff assisted other residents at the table. Residents were observed sleeping at the table until the assistance was provided.Beverages were placed on tables for all residents, including those who required full assistance with eating, prior to assistance being available or provided at the lunch meals on identified dates in 2015. The Supervisor of Dietary Services confirmed that meals were not to be placed on the tables for residents until the assistance was available/provided.(107)

C) On an identified date and time in 2015, resident #032 was observed to be sitting at an identified table in the dining room with 3 other residents and one staff member. According to their plan of care, resident #032 and two other residents at the same table required full staff assistance during meals. Resident #032 was served a hot meal approximately ten minutes before a staff member was available to provide assistance. The only staff member at the table was feeding two other residents during this time. During an interview with the Long Term Care(LTC)Inspector on an identified date in 2015, the Director of Care (DOC) confirmed that her expectation is that a residents meal only be served when someone is available to provide the assistance required by the resident. (560)

The home's policy, "LTC9-05.06.01", effective date, April 5, 2011, directed staff not to serve meals to residents who required assistance with eating and drinking until someone was available to provide the assistance required by the resident. (107) [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure only two residents are fed at a time and that someone is available to feed residents once food is placed on the table. This VPC is for 73 (2) (a) and (b), to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy, "Skin and Wound Care Program", Policy No: LTC9-05.09.02, effective date, May 28, 2014, was in compliance with and implemented in accordance with all applicable requirements under the Act. Regulation O.Reg. 79/10, s. 50(2)(b)(i) and (iii), states, "Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented".

A) The home's policy was not consistent with the legislative requirement in relation to a

referral to the Registered Dietitian for assessment of altered skin integrity. On page 6 of the home's policy it directed staff to refer to the Registered Dietitian for stage 2-4 and un-stageable ulcers only. Two registered staff members confirmed that a referral to the Registered Dietitian was only completed for stage 2-4 pressure areas. The policy was not consistent with the legislative requirement for all residents exhibiting altered skin integrity to be assessed by the Registered Dietitian.

B) The home's policy was not consistent throughout the document and was not consistent with legislative requirements related to assessment of altered skin integrity using a clinically appropriate assessment instrument that was specifically designed for the assessment of skin and wound assessment. Page 19 of the home's policy did not direct staff to complete a skin assessment using a clinically appropriate assessment tool for stage I pressure areas. Page seven of the policy directed staff to complete the Bates-Jensen weekly wound assessment (on Point Click Care) for all altered skin integrity, i.e. pressure ulcers, skin tears or wounds and document in the wound note. Two Registered staff members confirmed that they do a progress note for stage one pressure areas and do not complete a formal assessment of the area until it progressed to a stage II pressure area. [s. 8. (1) (a)]

2. The licensee has failed to ensure that the policy is complied with.

Resident #045 had falls on identified dates in 2014. The homes policy "Falls Prevention and Management Program" Policy No: LTC9-05.09.08; Effective Date: April 5, 2011 which was the policy in place when resident #047 had fallen stated: Initiate Head Injury Routine for all un-witnessed falls. Six of the eight falls for resident #045 were un-witnessed. The Head Injury Routine form states: to Monitor every hour for the first 4 hours and then every 4 hours for 24 hours post fall for signs of neurological changes. A review of resident #047's Head Injury Routine(HIR) records identified that five of six required HIR's for un-witnessed falls were completed. The review of the HIR records identified the following:

i) two of the forms did not contain the dates they were initiated

ii) one of the forms that was not dated, did not have any temperature readings for the entire twenty eight hours of the recording

iii) two of the forms did not do vitals for either the 1 hour or 4 hour checks, indicating resident was "sleeping"

iv) one of the forms did not have the hourly vitals done between 1600 and 1800 hours stating "supper"

v) one of the forms did not have every 4 hour vitals done between 0500 hrs and 1900 hrs due to breakfast at 0900 hrs followed by a Leave of Absence at 1300 hrs

vi) one of the forms had no vitals identified for the last 4 hours of the 28 hour recording

vii)one of the forms that was not dated, indicated for the first 2 hours the HIR was in place "sleeping" beside each of the following: glasgow coma scale, level of consciousness, pupils, grip strength, arm/leg movement or change in behaviour [s. 8. (1) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system is calibrated so that the level of sound is audible to staff.

During stage one room observations; on an identified date and time in 2015, the Long Term Care (LTC) Inspector was testing call bells in what the home refers to as Pod One. A call bell light for an identified room was ringing; however, it was barely audible. A Personal Support Worker (PSW) was noted to be doing documentation at a Point of Care monitor located two doors down from the identified room, and they did not hear it ringing. The Personal Support Worker (PSW) confirmed she could not hear it with the noise in the background. The Registered Nurse (RN) on duty walked down from the nurse's station to answer the call bell. The LTC Inspector kept testing call bells in Pod One however, the sound remained barely audible until she walked back towards the nursing station. The LTC Inspector then went into an identified room and rang the bell. Once again the inspector had to walk towards the nursing station to hear the bell. It was later discovered that the communication and response system was on what was called "Night Mode". However, even with "Day Mode" on in an identified room with the door closed, the call bell ringing was not audible in the room unless you stood silently directly behind the closed door. The Director of Care(DOC)confirmed that the sound was not loud when in the room behind the closed door. The DOC took action to put their pager system back into service that same day. [s. 17. (1) (g)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized skin and wound care program, required under section 48 of this Regulation, was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices for the year 2014/2015.

The program evaluations for the Skin and Wound Care Program that the home provided to the Long Term Care (LTC) Inspector, dated February 24, 2014, and February 25, 2015, did not include an evaluation of home specific indicators and the effectiveness of the program. The Director of Care confirmed that the information was not included on the evaluation form. [s. 30. (1) 3.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Administrator and staff attend Residents' Council meetings only when invited.

The Administrator confirmed that they attended all of the Residents' Council meetings and stayed for the entire Council meeting - not just what was on the agenda for the Administrator to address. The Administrator confirmed that when staff are identified on the agenda they stay for the entire Council meeting. Documentation in the Residents' Council meeting minutes and agendas did not reflect that the Administrator was an invited guest. The President of the Residents' Council confirmed the Administrator attended every Council meeting and stayed for the entire meeting. The presence of the Administrator and staff at all Residents' Council meetings is contrary to the legislative requirements and does not allow the Council to function independently. [s. 64.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that all foods were prepared, stored and served using methods which prevents contamination.

During observation of the lunch meal on an identified date in 2015, the dietary staff where observed applying condiments from bottles, then using their fingers when picking up the hamburger bun that was being placed on top of the hamburger and condiments. Also noted during the same lunch service, the other dietary staff was observed turning the pages of the book containing the resident's diet list, and then picking up the sandwiches, cutting them and placing them on the plates. At no time during this observation did hand washing occur. The food service manager confirmed that these items should have been served using utensils. [s. 72. (3) (b)]

2. The licensee has failed to ensure that there were policies and procedures for the safe operation and cleaning of equipment for the food production system and the dining and snack service.

The Supervisor of Dietary Services confirmed a procedure was in place for the meat slicer; however, the other equipment did not have safe operation and cleaning direction for staff to follow. The Supervisor of Dietary Services also confirmed, that a policy was not in place that covered the safe operation and cleaning of equipment for the food production system. [s. 72. (7) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the director was informed no later than one business day after resident #047 had a significant change in condition for which the resident was taken to the hospital.

On an identified date and time in 2014, resident #047 had a fall. At the time the resident complained of pain. The pain continued and at an identified time the same day, the resident was sent to the hospital for an x-ray. At an identified date and time, the home was notified the resident had suffered an injury, and would be returning to the home. A Critical Incident System (CIS) was not submitted by the home until an identified date and time in 2014, two days after the incident occurred. This was confirmed by the Administrator on an identified date in 2015. [s. 107. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided training in skin and wound care for the year 2014.

The Education Coordinator confirmed that 100 % direct care staff had not received training on skin and wound management for the year 2014. Non-compliance was identified during this inspection in relation to skin and wound management. [s. 221. (1) 2.]

Issued on this 17th day of July, 2015

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

Original report signed by the inspector.