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
Mar 15, Apr 30, 2013	2013_105130_0007	H-000112-13	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

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

GILLIAN TRACEY (130), BERNADETTE SUSNIK (120), LISA VINK (168), TAMMY SZYMANOWSKI (165)

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 26, 27, 28, March 1, 5, 6, 7, 8, 12, 13, 2013

This inspection report contains findings of non-compliance identified during a Complaint Inspection, log #H-000106-13, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Resident Care (DRC), Associate Director of Care (ADOC), Manager of Food Services, Manager of Recreation Services, Manager of Environmental Services, Manager of Education, Physiotherapist, Physiotherapist Assistant, Registered Staff, personal support workers (PSW), dietary staff, housekeeping staff, Residents' Council President, Family Council president, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care & services, toured the home, reviewed relevant documents, including but not limited to policies & procedures, clinical records and meeting minutes.

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

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Quality Improvement
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing
Trust Accounts

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee did not ensure the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening or cleaning of dentures.

a) On two identified dates in 2013, an identified resident was noted to have halitosis. The resident's oral hygiene supplies and equipment were monitored from 10:30 hours to 14:00 hours on these dates. On both occasions the toothbrush belonging to the resident remained in the same position from the beginning of the monitoring period until the end of the monitoring period. The resident stated on both dates that oral care was not provided and two different staff members responsible for providing care to the resident on these dates admitted that oral care was not provided to the resident.

b) An identified resident was interviewed on a specific date in 2013 and stated that staff provided specific dental care only in the evening. The resident was re-interviewed on another date in 2013 and stated that staff had not provided specific dental care in the morning and had not assisted with oral care. Staff interviewed on this date confirmed that mouth care was "never" provided to this resident.

c) On two identified dates in 2013, an identified resident did not have a toothbrush with their personal care supplies on both observed days and staff confirmed that oral care was not provided.

d) Another identified resident was interviewed and they stated they required assistance from staff for oral hygiene and that staff had not assisted with oral hygiene for weeks. The resident's family was also interviewed and stated they had requested the resident receive assistance with oral hygiene. A progress note written on a specific date in 2013, confirmed this request. The oral care supplies and equipment provided in the resident's bathroom, were monitored from 09:30 hours until at least 16:00 hours on four specific dates in 2013. The resident was re-interviewed on a second date in 2013, at 15:30 hours and stated that staff had not yet assisted with oral care. It was noted that the resident had broken pieces of wooden dental sticks, provided by family, on the bed and night table. According to the resident, they had been attempting to remove debris that was stuck in their teeth. Staff interviewed on this same date confirmed they had not assisted the resident with oral hygiene.

e) An identified resident was observed on a specific date in 2013, to have excessive plaque on their teeth. The resident was not provided oral care with the supplies and

equipment available in the bathroom on an observed date in 2013. Front line staff confirmed that they did not provide oral care to the resident on the shift they were interviewed and that the resident did not receive oral care as part of care needs. The daily documentation record for two identified months in 2013, identified that the resident did not receive oral care on a number of dates.

f) An identified resident was observed on several specific dates in 2013, to have halitosis and dry lips and tongue. The resident was not provided oral care with the supplies and equipment available in the bathroom from approximately 09:30 hours until at least 16:00 hours over the course of a number of days. Two front line staff interviewed confirmed that the resident previously was independent in oral care, however was no longer able to brush own teeth. The staff confirmed that they did not provide oral care to the resident on the shift they were interviewed and that when they work they did not provide oral care as a part of routine care needs. The daily documentation record for an identified month in 2013, identified that the resident only received oral care a total of 15 times during the month, each time completed by the resident. The plan of care identified that the resident had an oral care deficit and that staff "provide oral hygiene", however no frequency of care or other interventions to provide the necessary care have been identified. [s. 34. (1) (a)]

2. The licensee did not ensure that residents who could not brush their own teeth received physical assistance or cueing.

a) According to statements made by an identified resident on two identified dates in 2013, the resident did not receive assistance with specific dental care needs, nor did they receive assistance with oral care. This information was verified by staff.

b) A specific resident was identified on three identified dates in 2013, to have halitosis and dry lips and tongue. The plan of care identified that staff "provide oral hygiene" for the resident. Interview with staff confirmed that the resident was unable to complete oral care independently and that they did not provide oral care to the resident on the shift they were interviewed. The Daily Documentation Record for a specific month in 2013, identified that the resident only received oral care a total of 15 times during the month, each time completed by the resident.

c) An identified resident did not receive physical assistance or cueing required for oral care on a specific date in, 2013. The staff confirmed oral care was not provided and

indicated the resident did not receive oral care as part routine care needs. The plan of care indicated that the resident required total dependence of staff for physical assistance to complete personal hygiene.

d) An identified resident did not receive assistance to complete oral care on four identified dates in 2013, despite documentation which indicated the resident's family had requested assistance be provided and the resident's requests for assistance.

e) An identified resident did not receive physical assistance or cueing required for oral care on two identified dates in 2013. The resident did not have a toothbrush and staff confirmed oral care was not provided. The plan of care indicated that the resident required assistance from staff for physical assistance to complete personal hygiene. [s. 34. (1) (b)]

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 the residents receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening or cleaning of dentures, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out the planned care for the resident, the goals the care was intended to achieve and clear directions to staff and others who provided direct care to the resident.

a) According to assessments completed for an identified resident, the resident was frequently bladder incontinent and wore a brief, had some or all of own teeth and was high risk for falls. One staff interviewed in 2013, indicated the resident wore a brief, was incontinent and required routine toileting; required rails up in bed, and could not get out of bed without assistance; had own teeth and needed staff to provide oral care. A second staff interviewed in 2013, stated the resident was frequently incontinent, but was not on a routine toileting schedule, as was able to ring for help. The second staff was not sure why the resident required bed rails up when in bed but thought they may be for safety; as was able to get out of bed without assistance; and was not sure whether or not the resident wore dentures, because they brushed their own teeth. The nutritional plan of care directed staff to ensure dentures were in place before each meal, however, the minimum data assessment (MDS) completed on admission made no mention of dentures. The plan of care did not provide direction regarding oral hygiene,a toileting routine, nor identify the need for bed rails.

b) An identified resident was assessed by a pain management consultant in 2013. This assessment suggested specific nursing measures to be implemented to assist the resident. The clinical record notes that this information was recorded in the communication book for a specific shift however was not included as an intervention on the plan, which provided direction to staff.

c) Assessments completed in 2012, for an identified resident indicated "Daily cleaning of teeth or dentures or daily mouth care - by resident or staff." The assessment findings were not identified on the record known in the home as the "care plan". There were no goals developed nor directions to staff, specifying, the level of assistance required and the frequency for which care was to be provided.

d) The home's dietitian made changes to an identified resident's nourishment plan in 2012, by discontinuing an intervention at bedtime and initiating another intervention for the afternoon nourishment. The food and fluid tracking for meals and snacks, used by staff during the provision of care, were reviewed. Direction provided to staff was not clear as the information on the plan was different from the food and fluid tracking

information.

e) An identified resident had a physician's order effective in 2013, for glucometer readings at specific times. The Medication Administration Record (MAR) for a specific month in 2013, identified times for blood sugar reading to be completed at 08:15, 12:15, 17:15 and 21:15 hours. Management staff have identified that meal times begin at 08:00, 12:00 and 17:00 hours. Residents were observed having capillary blood glucose testing completed in the dining room as late as 13:00 hours on a specific date in 2013.

f) An identified resident was observed to have bed rails in the raised position when in bed during the course of the inspection. Interview with staff confirmed that this is the planned care for the resident. The resident's plan of care identified to "encourage to help (with bed mobility) by holding on to bed rail when repositioning." The plan did not identify how many rails are in use or the purpose of the rails. [s. 6. (1)]

2. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complimented each other.

a) An identified resident was identified to be at risk for falls according to an assessment completed in 2012. The resident sustained a subsequent fall in 2012. Assessments completed by the PT during this period indicated the resident was high risk for falls. The Minimum Data Set (MDS) Annual Assessment completed after the fall, did not include a non-triggered falls resident assessment protocol (RAP).

b) An identified resident had a SALT assessment (lift and transfer status) completed in 2013, on return from the hospital post surgery. This assessment indicated that the residents skin was intact, however, a skin assessment completed during the same time period identified that the resident had impaired skin integrity that required attention. Interview with the Restorative Care Aide identified that the information recorded on the SALT assessment regarding the condition of the residents skin was based on information provided by registered staff at the home and not on a visual assessment. Staff did not collaborate with each other and the assessments conducted were not consistent.

c) An identified resident was identified on admission to be experiencing pain and was

assessed using a pain assessment tool. During this assessment it was identified that the resident was not able to verbalize pain however identified specific behaviours which the resident would display when experiencing pain. The admission MDS assessment completed in 2013, identified that the resident experienced "no pain" although progress notes and observation records (for the observation period) reviewed identified that the resident received one dose of as needed analgesic and demonstrated behaviours characteristic of pain. The MDS assessment completed was not consistent with and did not complement the assessments recorded by other staff.

d) An identified resident had a Quarterly Review Assessment conducted 2012. This assessment identified that the resident had no change in mood status or behavioural symptoms as compared to the status of 90 days ago. The RAP completed for the same assessment identified that the resident had fewer mood indicators, a reduction in responsive behaviours and a decrease in the Depression Rating Scale. The review assessment conducted was not consistent with and did not complement the RAP completed for the same time period.

e) Progress notes for an identified resident completed on an identified date in 2013, identified that the resident picked a scab off on an identified area. The head to toe skin assessment conducted around the same time period noted only areas on altered skin integrity on other identified parts of the resident's body, not the other identified area. The resident was assessed by the physician on a specific date in 2013, and a treatment to the affected area, caused by the resident, was ordered. The assessments conducted on two identified dates 2013, were not consistent and did not complement each other. [s. 6. (4)]

3. The licensee did not ensure that the care set out in the plan was provided as specified in the plan.

a) The plan of care for an identified resident identified the requirement to be toileted before and after meals with the assistance of two staff. The resident was observed on a specific date in 2013 and was not toileted after the breakfast or noon meal. Interview conducted with PSW staff, responsible to provide care on the observed day confirmed that the resident was only toileted once on the day shift.

b) The plan of care for an identified resident indicated that they were incontinent and

staff were to check for wetness before and after meals, bedtime and on rounds during the night. Staff and the ADOC stated that the resident was to be checked every two hours. It was observed and staff confirmed that the resident was not checked from 10:30 hours until 15:45 hours on the observed day. Staff confirmed that the resident was not checked from 11:15 hours until 15:45 hours on a second observed day. Staff confirmed that the resident was usually only checked once per shift occasionally twice per shift, for wetness.

c) An identified resident's plan of care indicated the resident was to receive specific dietary items at meals however; these interventions were not provided at the lunch meal on an identified date in 2013.

d) The plan of care for an identified resident identified "staff to assist with toileting routinely and when resident requests to reduce risk of falls due to attempts to self transfer/stand related to need for toileting". In 2013, it was identified that the resident was bathed, dressed, an incontinent brief applied and then positioned into the wheelchair at approximately 11:00 hours. The resident was returned to bed following the noon meal. At approximately 14:30 hours the resident was noted with the same incontinent product on as applied following bathing. Staff interviewed confirmed that the resident was not changed/toileted since the incontinent brief was applied at 11:00 hours. [s. 6. (7)]

4. The licensee did not ensure that staff and others who provided direct care to the resident were aware of the contents of the resident's plan of care and had convenient and immediate access to it.

a) An identified resident had a non-triggered RAP completed for pain 2013. The electronic plan of care for this identified need was created in 2013 and modified a day later. The hard copy of the plan, in the residents record, was reviewed sometime later in 2013. The hard copy was the plan which would direct front line staff, who do not have computer access. This version of the plan had a print date prior to the creation of the non triggered pain RAP and did not include the focus statement regarding alteration in comfort level. Not all direct care staff have convenient or immediate access to the plan.

b) In 2013, two staff were interviewed regarding an identified resident's need for and use of bed rails. One staff interviewed stated the resident had both rails down when in

bed; the second staff stated the resident had one bed rail up and one down while in bed. According to the plan, the resident was to have "both rails up".

5. The licensee did not ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

a) An identified resident was identified as a high risk for falls and sustained falls with and without injury on four identified dates from 2012 to 2013. According to the plan of care, the resident was identified as high risk for falls, however, the interventions in place to mitigate fall risk and injury were not updated or revised after any of the identified falls.

b) The plan of care for an identified resident, identified that staff are to "use a mechanical lift to transfer resident on/off toilet" and " is continent of bowels". The resident was not toileted during the day shift on an observed date in 2013 and PSW staff interviewed confirmed that the resident was incontinent of bowels and no longer toileted due to a change in needs.

c) According to the SDM of an identified resident, the resident had been unwell in bed, on three identified dates in 2013. The SDM reported they had taken very little by mouth during those days because the resident had experienced choking spells. The SDM reported the resident had a diagnosis and regularly experienced exacerbations as a result, which resulted in prolonged bed rest during these periods. The SDM reported that the resident's condition was worse than normal, which had caused concern. Staff interviewed confirmed that they were updated of the resident's condition by the SDM. Staff stated they normally document changes in resident's conditions in progress notes, however, there were no progress notes recorded on two of the identified dates, regarding the resident's condition, monitoring activities or actions taken in response to the resident's change.

d) An identified resident was identified to have an open area on an identified area in 2013; the physician ordered a dressing to the area. The plan of care was not revised with the changes in the resident's skin integrity. The plan noted only the potential of altered skin integrity due to inability to move independently and incontinence and not the actual area of breakdown or the location and orders of the physician.

e) An identified resident was identified to have an area of altered skin integrity. The plan of care identified that the resident had the potential for skin breakdown due to decreased ability to move independently; however was not revised with the changes in the resident's care needs and does not reference the actual need of the resident which was previously identified.

f) An identified resident returned from hospital in 2013, with a physician's order for a specific textured diet; however the plan of care reviewed in the resident's clinical health record after the resident's return indicated staff provide a different diet. The plan of care indicated the resident required limited assistance with eating however; during meal observation in 2013 the resident required total feeding. Staff confirmed that since the resident returned to the home, total feeding by staff was required. [s. 6. (10) (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 there is a written plan of care for each resident that sets out, the planned care for the resident, the goals the plan is intended to achieve; and clear directions to staff and others who provide direct care to the resident; that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complimented each other; that residents are reassessed and their plans of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system implemented was complied with.

a) The home's policy LTC-G-05 Administration of Medication: No. 13, indicated: "For oral medication, remain with each resident until the medication has been swallowed; otherwise, it cannot be considered administered". In 2013, during the 12:00 hour medication pass, the inspector observed the medication nurse place medication on the dining room table in front of two identified residents. The nurse returned to the medication cart without observing that residents had consumed their medications.

b) The home's bowel protocol indicated that after day three with no bowel movement staff were to provide a laxative in the evening, day four with no bowel movement staff were to provide a laxative in the evening, day five with no bowel movement staff were to provide a suppository and on day six staff were to provide an enema. The bowel records for an identified resident indicated that the resident did not have a bowel movement a number of days in 2013. The clinical health record indicated the resident received a laxative on one of these dates however, registered staff were unable to demonstrate that the resident received interventions on the two subsequent dates, as indicated in their bowel protocol.

c) The procedure "Admissions, Transfers, Discharges and Death LTC-B-80", identified that "appropriate assessments will be completed by the interdisciplinary team" on return from hospital. An identified resident with a known history of pain returned from the hospital in 2013, with changes to ordered analgesia. The resident was not formally assessed for pain on the return from hospital. Interview with registered staff confirmed that this assessment should have been completed based on the known history of pain and change in orders for analgesic on return from the hospital.

d) The procedure "Admissions, Transfers, Discharges and Death LTC-B-80", identified that "appropriate assessments will be completed by the interdisciplinary team" on return from hospital. An identified resident returned from the hospital 2013, with orders for analgesic. The resident was known to experience pain prior to hospitalization. The resident was not formally assessed for pain on return from hospital. Interview with registered staff confirmed that this assessment should have been completed based on the known history of pain, recent injury and treatment and orders for analgesic on return from the hospital.

e) The home used a "Pain Monitoring Sheet" to monitor residents who were experiencing pain, the interventions used and effectiveness. The guidelines for use of this record indicated that staff were to "initiate the pain monitoring sheet when: as needed (prn) pain medication is used for three consecutive days". An identified resident was administered medication for pain on specific dates without the initiation of the monitoring sheet. The pain champion nurse confirmed that the resident did not have a pain monitoring record in place.

f) An identified resident used bed rails as a PASD when in bed as confirmed by staff interview. The procedure "Least Restraints - LTC-K-10" included a process flow titled "Restraint/PASD Algorithm". This flow indicated when a PSAD was in use staff were to obtain a consent, an order, have monitoring and positioning forms in place and care plan the need. This information was confirmed with the ADOC. The ADOC indicated that although the process flow refers to consent/order and required documentation the home had not been completing this portion of the procedure for bed rails as PASD's. When reviewing the clinical record there was no evidence of an order or consent for the bed rails nor monitoring sheets in place. The policy indicated that when a PASD was in place a valid physician's order was required. Review of the three month physician medication review in 2013, for an identified resident, that there was no physician's order for the use of the PASD (table top) prior to hospitalization in 2013. Staff confirmed that the restraining device was a PASD prior to hospitalization.

g) The licensee provided "Clinical Documentation Guidelines" to the registered staff to direct documentation requirements. "Documentation Requirements" page 5, reads "chart promptly after delivery of care and chart only the care you provided". Interview with two registered staff confirmed that they have delegated the responsibility to administer some topical treatments to PSW's. Staff confirmed that although the PSW administered the treatments it was the registered staff who sign the Treatment Administration Record (TAR) to indicate the application had been completed. Registered staff have been signing for care that they have not provided on the TAR.

h) The home's weight management policy LTC-G-60 indicated that a resident would be re-weighed immediately if the preceding month's weight was greater than a 2kg variance. A nutrition referral to the home's registered dietitian would be completed and the information documented in the interdisciplinary progress notes for significant variances of 7.5% over three months and 10% over six months. An identified resident had a weight variance for a period of time in 2012; however, there was no

indication that a re-weigh was taken and documented during that time period in 2012. The Food Services Manager (FSM) confirmed that a nutrition referral was not completed for the homes registered dietitian for a significant change of 8% over three months and 11.2% over six months during that time period in 2012. [s. 8. (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 any plan policy, protocol, procedure, strategy or system implemented is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :