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 being restrained by a physical device are released from the device and repositioned at least once every two hours; and including documentation regarding the effectiveness, resident's response, repositioning and the removal of the device, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that every resident was afforded privacy in treatment and when caring for his or her personal needs.

a) During observation of the noon meal on an identified date in 2013, a number of known diabetics had their capillary blood glucose levels (CBGs) monitored at the dining room table. A number of known diabetics received their required dose of insulin while seated at dining room tables. The nursing staff interviewed stated that it was their normal practice to check CBGs and administer insulin in the dining room, in an open area, in the presence of other residents, visitors etc. [s. 3. (1) 8.]

WN #15: 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 of the long-term care home has not ensured 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.

a) Several resident washrooms were equipped with a resident-staff communication and response system, however the cord attached to the receptacle could not activate the system when tested on two identified dates in 2013. The receptacle in these washrooms and a few others was located behind the toilet as opposed to the side. In order for the cord to be reached, the home maintenance staff threaded the cord between eye hooks attached to the walls behind the toilet to bring the cording around from behind the toilet to the side of the toilet. The length of the cord and the 90 degree angle of the cord could not activate the station and therefore was not easily used by the residents or staff.

b) Resident washrooms located in 301, 304, 321 and 312 had the cord detached from the receptacle over the course of several days. Staff did not report the issue to the maintenance manager. The cords in rooms 423 and 326 were tied and wrapped around the grab bar making it difficult to use. A resident in an identified room,who was in bed, was not able to access their call bell on an identified date. The push button at the end of the cord was behind the wheel of the bed. [s. 17. (1) (e)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table.

Findings/Faits saillants :

1. The licensee of the long-term care home has not ensured that the lighting requirements set out in the Table to this section are maintained.

a) Resident bathrooms and corridors were measured and do not meet minimum requirements. Other areas of the home may also be deficient but were not tested.

b) Random resident washrooms were measured with a light meter on March 5, 2013. Lights were turned on and allowed to burn until completely illuminated (approx. 5 minutes). The resident washrooms in the home all have lights mounted to the wall above the sink. These lights are all shielded with a wood valence which prevents the room from being adequately illuminated. Depending on the age of the light bulbs, various washrooms produced different lux levels. Toilet areas were measured to be between 10-30 lux (furthest point from the sink area), sink areas were adequate and measured between 300-600 lux and the centre of the rooms were between 40-100 lux. The minimum required level for the room is 215.28 lux.

c) The lounge area directly in front of the nurse's station, which is a pass through area and also considered a corridor is illuminated with pot lights, which produce a cone of light down to the floor. The lights do not adequately illuminate the space. The illumination level below the bulbs was measured to be 400 lux and only 80-90 lux between each pot light. The pot lights are spaced six feet apart. The requirement is 215.28 of continuous consistent lighting.

d) The corridors in the home are illuminated with fluorescent tubes, spaced 10-12 feet apart. The illumination level below the lights was 800 lux and only 65-70 between the lights. The measurement was taken four feet above the floor or between waist and chest height, with the light source in front of the meter. Resident bedroom doors were closed to minimize the amount of natural light coming from the windows in the bedrooms. The lighting level required is 215.28 lux of continuous consistent lighting. [s. 18.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee did not ensure that the 24-hour admission care plan included, at a minimum, any risks the resident may pose to himself or herself, including any behavioural triggers and safety measures to mitigate those risks, and the type and level of assistance required related to activities of daily living.

a) The care plan for an identified resident which was in place, reviewed and provided direction to front line staff on an identified date in 2013, was called the "Resident Admission Assessment/Plan of Care". This plan did not identify any level of assistance for the following daily activities: dressing, hygiene and oral care. The plan identified that the resident had a number of behaviours including physical and verbal aggression, anger, suspicious, sad/depressed and resistive to care however; there were no interventions recorded to manage the identified needs. Interview with the staff confirmed that the plan was not finalized as the resident was under a period of observation, and for that reason the plan which was initiated in the computer, in Point Click Care (PCC), had not been printed and made available to front line staff for reference. Interview with the PSW confirmed that they do not have access to the computer care plan and that they would refer to the resident's chart for the care plan. [s. 24. (2)]

2. The licensee did not ensure that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change.

a) The care plan for an identified resident which was in place, reviewed and provided direction to front line staff on an identified date in 2013, was called the "Resident Admission Assessment/Plan of Care". This plan was not revised with changes in the resident needs. The resident sustained a fall and fractures on an identified date in 2013. The resident returned to the home from the hospital and had a change in care needs. The plan in place before the hospitalization, identified the resident as requiring one staff for supervision for transfers, a walker for walking/locomotion limited assistance of staff for toilet use, did not include any concerns regarding skin and mentioned only bed rails for safety devices in use. Staff interview and progress notes indicated that the resident now required a higher level of assistance for all aspects of care, had specific care needs related to skin and required specific safety interventions. The plan of care was not revised with changes in the resident's needs. Interview with staff confirmed that the plan was not finalized as the resident was under a period of observation and for that reason the plan which was initiated in the computer, in PCC, had not been printed and available to front line staff for reference. Interview with the

PSW confirmed that they do not have access to the computer care plan and that they would refer to the resident's chart for the care plan. [s. 24. (9)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

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Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

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

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

Findings/Faits saillants :

1. The plan of care is not based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

a) An identified resident was observed to be in bed, sleeping during the breakfast meal and was not offered tray room service, for a number of days during the course of the inspection. Interview with PSW and Registered staff confirmed that it was a resident/family request to have the resident sleep in. The medication administration times had also been adjusted to allow the resident to sleep in. The plan of care does not include the desired preference for the resident to sleep in or sleep pattern.

b) An identified resident was observed to be in bed, sleeping during the breakfast meal and was not offered tray room service, for a number of days during the course of the inspection. Interview with PSW and Registered staff confirmed that it was a resident/family request to have the resident sleep in. Documentation reviewed from 2012, identified the resident's increased time in bed and behaviours associated when not in bed if desired. The plan of care, which provided direction to staff regarding the daily routine of the resident does not include the desired preference to sleep in or sleep pattern.

c) Interview with a specific resident identified a preference to sleep in, which was confirmed by PSW staff. The "Resident/Family Questionnaire" completed on admission was incomplete for section titled "Sleeping/Napping/Routine". Interview with the staff confirmed that there was no other "formal assessment" conducted regarding sleep patters and preferences, although this would be discussed at care conferences. An assessment of the residents sleep patterns or preferences was not completed and the plan of care did not include the desire to sleep in.

d) According to statements made by an identified resident, staff were waking the resident early in the morning and getting the resident dressed. Although the resident stated being an early riser, the time staff were entering the room was earlier than the resident preferred. The resident's plan of care did not identify the resident's desired wake and sleep times. [s. 26. (3)]

2. The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment with respect to the resident's disease diagnosis.

a) The plan of care for an identified resident did not include specific interventions

related to the management of the resident's disease diagnosis and the specific symptoms that was experienced on a frequent basis. [s. 26. (3) 9.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a care conference of the interdisciplinary team providing care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

a) An identified resident was admitted to the home in 2012. The resident's family stated they were not invited to attend a six week post admission conference and staff interviewed and documentation confirmed a post admission conference was not held. [s. 27. (1) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee had not ensured that the following was complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the regulation: Not every program included written descriptions of the program that included goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources.

a) Management confirmed that the home did not have a policy, procedure or protocol in place related to the management of hyperglycemia. [s. 30. (1) 1.]

2. The licensee had not ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

a) An identified resident was noted to be ungroomed during the inspection. Staff interviewed and the plan of care identified that the resident was resistive to the care provided. The Daily Documentation Records reviewed for two months in 2013, indicated that the resident refused specific care on at least six occasions; however there was no documentation of the interventions tried and the resident's response to interventions. [s. 30. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. Not every resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

a) An identified resident was observed on a specific date in 2013, at 10:08 hours in the hallway outside of the spa room. The resident was expressing frustration and voiced concerns regarding wearing a thin hospital gown, to breakfast with only a knitted blanket over the shoulder area for warmth, and that the resident still had not received a bath. The resident indicated that they were not given a choice as to what to wear to breakfast and that they were not comfortable in this attire.
On a specific date another identified resident was observed eating lunch in the dining room wearing nightwear clothing backwards. This resident was then observed following lunch enter the spa area with a staff member and once exited the room was fully clothed in day clothing. [s. 40.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the skin and wound care program was developed and implemented in the home that promoted skin integrity, prevented the development of wounds and pressure ulcers and provided effective skin and wound care interventions. The home's skin and wound policy [LTC-E-90] indicated : National Operating Procedures:Prevention of Skin breakdown
"1. A Pressure Ulcer Risk Scale (PURS) score is obtained from MDS upon admission, quarterly and with any significant status change assessments".

a) According to the plan of care for an identified resident, a PURS assessment had not been completed since 2011. This information was verified by staff. [s. 48. (1) 2.]

WN #23: 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 :