Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 28, 29, 30, Dec 1, 2, 5, 6, 7, 8, 9, 13, 14, 19, 21, 2011; Jan 4, 2012	2011_087128_0029	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

ROSE GARDEN VILLA
350 DOUGALL AVENUE, WINDSOR, ON, N9A-4P4

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

RUTH HILDEBRAND (128), JOAN WOODLEY (172), KARIN MUSSART (145), MARIAN MACDONALD (137), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, 2 Associate Directors of Care, Registered Dietitian, 2 Food Services Managers, Environmental Services Manager, Corporate Nova Representative, Programs Manager, Human Resources Manager, Office Manager, Resident Services Coordinator, Pharmacist, Physiotherapist, 2 Physiotherapy Assistants, Kinesiologist, Occupational Therapist, 6 Registered Nurses, 11 Registered Practical Nurses, 27 Personal Support Workers/Health Care Aides, 4 Dietary Aides, 3 Activation Aides, 2 Housekeeping Aides, 1 Maintenance Worker, 1 Volunteer, 48 residents and 8 family members.

During the course of the inspection, the inspector(s) conducted a tour of all resident areas and common areas, observed residents and the care provided to them, and observed meal service. Medication administration was observed and the clinical records for identified residents were reviewed. The inspectors reviewed admission and resident charges records, policies and procedures, as well as minutes of meetings pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

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

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. A tour of the basement was conducted on November 28, 2011. It was noted in the physio/storage area that there was a large unlocked plastic container containing an estimated 100 wheelchair foot rests, as well as a piece of wooden 2 x 4, approximately 18 inches in length, sitting on one of the wheelchairs.
A staff interview with the Executive Director confirmed that the safety concerns would be taken care of immediately.
2. On December 6, 2011 an opened, unattended tool box near the North elevator was observed.
The Executive Director was informed and she spoke to the elevator repairman, who immediately removed the tools.
A staff interview with the Executive Director confirmed that the home's expectation is that tools are not left unattended.

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 the home is a safe environment for residents, to be implemented voluntarily.

WN #2: 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 subsections:

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

Findings/Faits saillants :

1. The following housekeeping concerns were observed on November 28, 2011:
a) old dried food debris was noted on baseboard heaters in the main floor dining room; and
b) plastic table cloths in the main floor dining room were stained and soiled with black coloured debris embedded in the raised pattern.
A staff interview with the Nutrition Manager revealed she was concerned about the soiled condition of the tablecloths and this did not meet the home's expectations related to cleanliness. (128)
Ongoing observations throughout the inspection revealed that the outside of the home is not kept clean of debris, including cigarette butts and garbage. (128)
A staff interview, December 5, 2011, with the Human Resources Manager and Resident Services Coordinator revealed clean up of the exterior of the home, including the cigarette butts has not been happening on an ongoing basis. (172)
A staff interview with the Executive Director confirmed that the home needed to look at other ways of ensuring the ongoing issue, with cigarette butts and garbage around the exterior of the building, was addressed.
[LTCHA, 2007, S.O. 2007, c.8, s.15(2)(a)]
2. On December 6, 2011, the following housekeeping concerns were observed in a tub room:
a) the underside seat of the Arjo lift and the surface directly under the water controls both have a buildup of residue; and
b) the shower enclosure and the care caddy were dirty.
A staff interview on December 6, 2011 with the Environmental Services Manager and Nova Representative confirmed the expectation is that all areas of the home are kept clean and sanitary.
[LTCHA, 2007,S.O.2007,c.8, s.15(2)(a)]
3. On December 6 and 7, 2011 the following maintenance concerns were observed:
a) in a tub room, the wall coverings are marked, corners are damaged, sections of the corner guard are missing, and paint is chipped on the walls, door and door frame;
b) in the main dining room the table legs are scraped and the wooden divider at the entrance to the dining room is damaged;
c) in another tub room, the wall protective covers are marked/scraped and in one spot across from the tub it is damaged with a deep depression, the door and door frame have rough surfaces, the paint is chipped off the handle of the commode shower chair and there is a broken surface in the ceiling above the toilet; and
d) in an additional tub room, the door and door frame have chipped paint and are very rough with damage visible under the paint, and holes were observed in the wall from where a towel bar previously sat.
A staff interview with the Environmental Services Manager and Nova Representative confirmed that the home's expectation is that all areas of the home are kept in good repair.
[LTCHA, 2007, S.O. 2007, c.8, s.15(2)(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 to ensure that the home's furnishings are kept clean and sanitary; and the home, furnishings and equipment are maintained in a safe condition and a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3);
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The Quality Improvement binder was reviewed on December 8, 2011 and it was noted that there is no documented evidence to support that the licensee ensures that:
a) the results of the satisfaction survey are documented and made available to the Residents' Council and the Family Council;
b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council; and
c) the documented satisfaction survey results and actions taken to improve the home are made available to residents and their families.
An interview, on December 7, 2011, with the President of the Family Council revealed that the licensee has not made the results of satisfaction surveys available to the Family Council.
A staff interview with the Executive Director confirmed that the licensee has not ensured that:
a) the results of the satisfaction survey are documented and made available to the Residents' Council and the Family Council;
b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and Family Council; and
c) the documented satisfaction survey results and actions taken to improve the home are made available to residents and their families.
[LTCHA, 2007, S.O. 2007, c.8, s. 85(4)(a)(b)(c)]
2. A review of the Family Council minutes on December 7, 2011 did not reveal any evidence to support that the home seeks the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.
An interview with the President of the Family Council revealed that the Family Council was not involved in developing or carrying out the survey or in acting on the results.
A staff interview with the Executive Director confirmed the home has not sought the advice of the Family Council in developing and carrying out the survey, and in acting on its results. Currently, the survey is developed, distributed and analyzed at a Corporate level.
[LTCHA, 2007, S.O. 2007, c.8, s. 85(3)]
3. A resident interview on December 5, 2011 revealed the Residents' Council knows the home completes surveys but does not get the results or know about any actions being taken as a result.
A staff interview with the Executive Director revealed that the satisfaction survey is a corporate survey that is sent out and input from the residents or Residents' Council in this home is not sought in developing, carrying out the satisfaction survey or in acting on the results.
[LTCHA, 2007, S.O. 2007, c.8, s. 85(3)]

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 the licensee seeks the advice of the Residents' Council and the Family Council in developing and carrying out the satisfaction survey and acting on its results. The written plan of correction should also ensure that the results of the survey are documented and made available to the Residents' Council and the Family Council; that actions taken to improve the home, care, services and programs are documented and made available to the Residents' Council and the Family Council; and that the documentation is also made available to residents and their families, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

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

Findings/Faits saillants :

1. The temperature of the soup at the first seating of a lunch meal, in the main dining room, was probed after a resident complained that the soup was cold. The temperature of the soup was 38 degrees Celsius. Dietary staff reported to the kitchen that the soup was cold but approximately 12 minutes later another resident complained that the soup being served was only "luke warm".
A staff interview with the Nutrition Manager confirmed that the home's expectation is that hot food is served to residents at a minimum of 63 degrees Celsius. She acknowledged that the soup was not hot enough at the lunch meal, November 28, 2011.
[O.Reg. 79/10, s. 73(1)6]
2. During a lunch meal, in the main dining room, ten residents were not provided with the assistance that they required to eat their meals independently and were placed at a potential choking risk. These residents were served full sausages which they were unable to cut and had to chew pieces off the full sausages using their fingers or forks, as staff did not cut up the sausages.
A staff interview with the Nutrition Manager confirmed that all residents who require their meat cut up were expected to be provided the assistance they required at each meal from either a Dietary Aide or a Personal Support Worker/Health Care Aide.
[O.Reg. 79/10, s. 73(1)9]
3. A resident was observed to be left unattended with food and fluids in front of them, at the end of a lunch meal. This resident was identified as being at risk for choking and needed a longer period of time to eat to prevent choking.
[O.Reg. 79/10, s. 73(1)4]
4. The Nutrition Manager stated in a staff interview that "all residents who are at choking risk should never be left unattended nor should their food or fluids be left in front of them if they are unattended." She confirmed the home's expectation is that residents are monitored during meals in all dining locations.
[O.Reg. 79/10, s. 73(1)4]

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 a monitoring system is in place for residents during meals; food is served at a temperature that is palatable to the residents; and residents are provided with the personal assistance required to safely eat and drink as independently as possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. A strong, lingering urine odour was detected in the washroom, of an identified room, on December 6 and 7, 2011.
A staff interview with the Environmental Services Manager and the NOVA Representative confirmed that the home's expectation is that all resident areas are to be kept clean and odour free.
[O.Reg. 79/10, s. 87(2)(d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all resident areas are kept odour free, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Linen, which was not in a good state of repair, was found in 3 identified rooms and included a bottom fitted sheet with holes in at least 4 places, 2 torn bottom fitted sheets and a worn soaker pad. A worn soaker pad was also found on the linen cart outside of the dining room.
A staff interview with the Executive Director revealed that the home's expectation is that all linens are maintained in a good state of repair.
[O.Reg. 79/10, s. 89(1)(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 to ensure that all linen is maintained in a good state of repair, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. A staff interview with the Infection Control Coordinator/Associate Director of Care on December 6, 2011 revealed that tetanus and diptheria immunization is not offered to the residents residing in the home.
A review of the home's Immunization Program policies revealed that Policy #LTC-I-380-10, dated November 2009 and RHA Immunization Policy #LTC-I-380-20, dated February 2008 did not reference offering tetanus or diphtheria immunizations to residents.
[O.Reg. 79/10, s. 229(10)3]
2. A staff interview with the Infection Control Coordinator/Associate Director of Care on December 6, 2011 revealed that the home did not have any pets in-house or visiting other than the home's Bunny.
A family interview on December 9, 2011 revealed they visit 3 times per week, bring their dog with them each time and confirmed they have never been asked by the home to provide veterinarian records for immunization shots for the dog.
Another staff interview with the Infection Control Coordinator/Associate Director of Care confirmed she was not aware that this dog was visiting the home 3 times a week.
[O.Reg. 79/10, s. 229(12)]
3. During a lunch meal, in the main dining room, it was observed that an Activity Aide did not wash or sanitize her hands between removing dirty dishes from the table and feeding/assisting residents.
[O.Reg. 79/10, s. 229(4)]
4. At the end of a lunch meal a housekeeping aide was observed offering a resident a quarter sandwich with her bare hands after sweeping the dining room floor and not hand washing/sanitizing prior to touching the sandwich. Additionally, Nursing staff were observed wiping all tables in the dining room after the dishes were cleared using a white facecloth like cloth with water from the tap and no disinfectant.
The same day, trays were observed being taken to residents' rooms without the fluids or food covered except for a serviette over the main course.
On November 30, 2011, 2 plastic syringes used for irrigation or medication administration were observed lying on the bare bathroom counter.
A staff interview with the Infection Control Coordinator/Associate Director of Care confirmed the following expectations:
a) both Registered and non-registered staff must wash their hands or use hand sanitizer at all times while administering medications and feeding/assisting residents with eating;
b) food and fluids on trays are to be covered while being transported;
c) personal care equipment, including urinals, bed pans and inhalation masks should be stored and cleaned after each use;
d) syringes used for irrigation or medication administration should be covered and stored in bedside tables; and
e) hair brushes and combs are labeled for individual use and not to be used communally.
[O.Reg. 79/10, s. 229(4)]
5. A Registered staff member was observed administering medications to residents, December 7, 2011, without washing hands or using hand sanitizer before or after administration.
During the initial tour of the home, infection control risks were observed including:
a) communal hair brushes in two tub rooms as well as an unlabeled urinal hanging on the drain in a tub room; and
b) dirty, unlabeled face masks used for inhalation therapy and a build up of debris on the nebulizing unit were observed on two floors.
[O.Reg. 79/10, s. 229(4)]
6. Chart reviews, on November 29, 2011, revealed 3 newly admitted residents did not receive their first step tuberculosis (TB) skin testing within 14 days:
Resident # 1 did not receive the first step TB testing until 28 days post admission.
Resident # 5 did not receive TB skin testing until 21 days post admission.
Resident # 6 did not receive TB skin testing within the first 23 days post admission.
[O.Reg. 79/10, s. 229(10)1]
7. During the inspection of another tub room, November 29, 2011, infection control risks were observed including an unlabeled comb and brush, with hair in it, in a wash basin in the cupboard above the toilet and an inappropriately stored plastic bed pan sitting on the floor near the shower.
During the lunch meal, November 28, 2011, the plastic table cloths in the main dining room were noted to be soiled and stained. The raised pattern on the table cloths had black coloured debris embedded in the pattern.
A staff interview with the Nutrition Manager confirmed the condition of the table cloths was an infection control concern.
[O.Reg. 79/10, s. 229(4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection control program; residents are screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee; residents are offered immunizations against tetanus and diphtheria; and any pet living in the home or visiting pet has up-to-date immunizations, to be implemented voluntarily.

WN #8: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. On December 6, 2011, chart reviews for two identified residents revealed that the MDS assessments indicated that each resident had a pressure relieving device on their chair and bed.
A staff interview with a Registered Nurse confirmed that these devices were in place for both residents. However, there is no documented evidence on the care plans that pressure relieving devices were being used or in place.
[LTCHA, 2007,S.O.2007, c.8, s.6(1)(c)]
2. During a chart review, for an identified resident, it was noted that clear directions for staff are not included on the resident's plan of care related to recent changes in the resident's condition. For example, the resident is no longer ambulating by self in corridors, and the identified resident is using a wheelchair with a seat belt and table top.
A staff interview, on December 6, 2011, with a Registered Practical Nurse verified that this information was not current.
[LTCHA, 2007,S.O.2007, c.8, s.6(1)(c)]
3. A chart review conducted for an identified resident, on December 6, 2011, revealed the resident's plan of care does not reflect recent changes in behaviour, ambulation, and safety measures required. For example, the resident now requires the use of 2 bedside rails while in bed.
A staff interview with a Registered Practical Nurse verified that the resident uses 2 bedside rails while in bed.
[LTCHA, 2007,S.O.2007, c.8, 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 the written plan of care provides clear direction to staff and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. A resident interview on December 7, 2011 revealed that the resident receives bed baths but their preference would be showers.
A flow sheet review confirmed that the resident has been receiving bed baths.
A staff interview with a Personal Support Worker revealed the resident's preference is a shower.
[O.Reg. 79/10, s. 33(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 each resident of the home is bathed by the method of his or her choice, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. A resident interview on December 7, 2011 revealed that the resident receives bed baths but would prefer to have showers. The resident has not been receiving showers as the shower chair broke in July 2011 and has not been repaired/replaced to date.
A staff interview with the Executive Director revealed that the delay in getting the shower chair repaired has resulted in not meeting the resident's personal care needs.

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

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.
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.
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.
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. A review of the Quality Improvement records revealed the Required Programs have been evaluated. However, there is no documented evidence to support a summary of the changes made nor the date that all the changes were implemented.
A staff interview with the Executive Director confirmed that a summary of changes has not been made nor have all the changes been implemented.
[O.Reg. 79/10, s. 30(1)4]

WN #12: 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 subsections:

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

Findings/Faits saillants :

1. Observation during a lunch meal service in the main dining room revealed that ten residents were not provided with the assistance that they required when they were served whole sausages. Not only were the residents unable to cut up the sausages, but they were also placed at a potential choking risk when staff did not cut up the sausages.
A review of Policy# LTC-H-460, Nutritional Care and Meal Service, dated September 2004, revealed that staff are not following the policy in relation to ensuring residents are provided with the assistance they require to cut their food.
A staff interview with the Nutrition Manager confirmed that all residents who require their meat cut up, were expected to be provided the assistance they required at each meal from either a Dietary Aide or a Personal Support Worker/Health Care Aide.
2. A review of Policy# FSO -D-30-10, Cook's Meal Production Daily Temperature Record, confirmed that staff are not following the policy in relation to ensuring that hot food is held at a minimum of 60 degrees Celsius.
A staff interview with the Nutrition Manager revealed that the expectation is that hot food is served to residents at a minimum of 63 degrees Celsius. She acknowledged that the soup served, at one of the lunch meals, was not hot enough.
3. On December 8, 2011, Policy# CQI-C-20, Manager By Walk About(MBWA) was reviewed and it indicates that the Executive Director and each manager are to do walk abouts daily and to complete the MBWA checklist for their respective departments.
Quality improvement records were reviewed and revealed that the MBWA checklists were not consistently completed.
A staff interview with the Executive Director revealed that she does walk abouts but does not complete the checklist. The Assistant Director of Care confirmed that nursing completed the checklist in January and February 2011. The Program Manager confirmed that she does walk abouts but has not completed the checklists.
[O.Reg. 79/10, s. 8(1)(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 policies and procedures are complied with, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Restoril was observed stored in a pre-packaged strip in a medication cart, on December 7, 2011.
A staff interview with the Registered Practical Nurse confirmed that the home does not double-lock benzodiazepines.
An interview with the home's pharmacist confirmed that the home does not have a separate, double locked area for benzodiazepines.
[O.Reg. 79/10, s. 129(1)(b)]
2. Ativan was observed stored in a labeled bottle in a resident's individual storage compartment, in a medication cart, on December 7, 2011.
A staff interview with the Registered staff confirmed that only narcotics are double-locked.
[O.Reg. 79/10, s. 129(1)(b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following subsections:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. A staff interview was conducted, December 8, 2011, with the Resident Services Coordinator/liaison with Family Council. She revealed that the minutes from March 2011 did identify concerns related to the upkeep of the exterior of the home, especially in regard to the cigarette butts. No written response was sent to Family Council.
[LTCHA, 2007, S.O. 2007, c.8, s. 60(2)]
2. The minutes from Family Council were reviewed, December 7, 2011 and it was noted that there is no written response from the licensee related to the concerns raised in the March 27, 2011 minutes.
An interview with the President of the Family Council confirmed that he is not aware of a response from the licensee within 10 days of receiving concerns or recommendations from Family Council.
[LTCHA, 2007, S.O. 2007, c.8, s. 60(2)]

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

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 r. 21.	CO #001	2011_093145_0021	145
O.Reg 79/10 r. 30.	CO #002	2011_093145_0021	145

Issued on this 5th day of January, 2012

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