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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2016	2016_414110_0005	011096-16	Resident Quality Inspection

Licensee/Titulaire de permis

JARLETTE LTD.
689 YONGE STREET MIDLAND ON L4R 2E1

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

THE VILLA CARE CENTRE
689 YONGE STREET MIDLAND ON L4R 2E1

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

DIANE BROWN (110), JANET GROUX (606), VALERIE PIMENTEL (557)

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): April 19, 20, 21, 22, 25, 27, 28, 29, May 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 2016.

The following complaints and critical incident (CI) report inspections were conducted concurrently during this RQI:
Complaints:
Log # 015961-15 complaint related to improper care, allegations of abuse, lack of falls management, disorganized dining service, lack of continence care and bowel management, plan of care not provided, lack of recreational and social activities.
Log #01292-16 complaint related to uncleanliness of privacy curtains.
Log #013133-16 complaint related to resident rights for preferred bed height.
Critical Incidents:
Log #030452-15, Log #016412-15, Log# 003705-15, Log# 013282-16, Log# 030472-16, Log# 004855-14, Log# 030464-15, Log# 030440-15, Log# 008908-15 and Log# 005562-15 related to allegations of staff /visitor to resident abuse or neglect.
Log #000827-15, Log #008988-15 and Log #009124-16 related to fall prevention and management.
Log 3030480-15 related to residents bill of rights.

During the course of the inspection, the inspector(s) spoke with administrator, director of resident care (DORC), resident care coordinator, staff educator, resident and family services coordinator (RFSC), environmental services supervisor (ESS), resident assessment instrument (RAI) coordinator, life enrichment coordinator, restorative care coordinator, nutrition manager (NM), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), health care aides (HCA), dietary aides (DA), physiotherapy aides (PTAs), housekeeping aides, maintenance staff, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

s. 6. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident;

On an identified date, the Ministry of Health and Long Term Care received a CI (critical incident) report. The incident was submitted as a mandatory report related an altercation between resident #34 and resident #36. The outcome of the home's investigation indicated the home would implement every 15 minute checks for resident #034.

Record review of the written plan of care for resident #034's identified focus, goals and interventions for behaviors, however, there was no written interventions identified to complete a tool named "Every 15 Minute Monitoring Schedule", a screening protocol for behaviors the home used. Record review of the documentation identified the tool was

incomplete.

Interviews with RPN #109 and the DOC confirmed that the written plan of care did not contain interventions to complete a tool named "Every 15 Minute Monitoring Schedule" which was part of the plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

The inspector observed resident #010 to have a pressure relieving device on his/her bed, wheelchair and an identified area of the body. Resident #010 had two areas of altered skin integrity.

Record review of resident #010's written plan of care revealed there was no direction to staff who provide direct care to the resident related to the application of a pressure relieving device to an identified area of the body.

Interviews with PSW #100 and RN #105 confirmed the kardex and the written plan of care did not provide clear, direction to staff who provide direct care to resident #010. [s. 6. (1) (c)]

3. An interview with resident #007 identified that he/she did not receive oral hygiene assistance as required. The resident wore upper dentures and had a few natural bottom teeth and he/she had a preference for using a toothbrush when completing oral care.

Record review of resident #007's kardex directed staff to set up a toothbrush for him/her to complete oral hygiene. There were no directions related to the use of dentures or the care of those dentures.

Staff interviews with PSW #112 and #114 revealed resident #007 wore upper dentures that were cleaned by staff, and a few bottom teeth for which the resident was provided a sponge swab and mouthwash to independently clean. Interview with PSW #114 revealed he/she was unclear whether a toothbrush or swab sponge was required.

An interview with the DOC confirmed a resident kardex is the tool provided and available to front line staff to direct care for residents and is part of the resident's written plan of care. Upon review of resident #007's kardex, the DOC could not determine whether the

resident wore dentures and confirmed the kardex did not provide clear direction to staff regarding oral care for resident #007 including his/her need for dentures. [s. 6. (1) (c)]

4. A complaint was received on June 17, 2015, by the Ministry of Health and Long Term Care Infoline. The complainant indicated his/her loved one was always sitting in a wet brief whenever they visited.

Record review of the written plan of care, on an identified date, for resident #033 revealed the following: two staff to assist resident to transfer on and off toilet; provide peri care; apply a brief and adjust resident's clothing. A toileting pattern to identify frequency of toileting was not identified.

The resident no longer resides in the home so could not be observed or interviewed by the inspector.

Upon reviewing the plan of care with PSW #135 and RPN #109, both staff confirmed the written care plan did not provide clear, direction to staff who provided continence care to resident #033. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Observation and interview of resident #007 confirmed he/she had upper dentures and a few natural bottom teeth. The resident revealed staff provide him/her a swab sponge and sometimes a toothbrush to clean his/her teeth. Resident #007 indicated a preference for using a toothbrush when completing oral care.

Record review of progress notes identified a dental note on an identified date. The note revealed the resident was seen by a hygienist and the resident had poor oral hygiene, heavy plaque, bleeding, and very inflamed tissues.

Record review of resident #007's kardex directed staff to set up a toothbrush for him/her in order to complete oral hygiene. A review of resident #007's care plan directed staff to provide and hand resident a brush for mouth care.

Staff interviews with PSW #112 and #114 revealed resident #007 had upper dentures, which were cleaned by staff and a few bottom teeth for which a swab sponge and mouthwash was provided. When questioned, why a toothbrush was not provided, staff

#112 stated the swab was softer on his/her gums and since the resident had only a few teeth they would not provide a brush. PSW #114 was unclear whether a toothbrush or swab sponge was required.

An interview with the DOC confirmed staff are expected to offer resident #007 a toothbrush. The DOC further confirmed the plan of care was not provided to meet resident #007's oral care needs and that care was not provided as specified in the plan. [s. 6. (7)]

6. On an identified date observations and resident interview revealed the resident does not attend meal service in the dining room at lunch or supper or receive tray service. The resident confirmed he/she is given fluids at breakfast, snack time three times a day and with his/her medication.

Record review of the written plan of care for resident #038 revealed the following:
- Kardex indicated staff to limit the resident's fluid intake to 1200 milliliters (mls) per 24 hours.
- Written care plan indicated, under eating interventions, staff to limit fluid intake to 1200 mls per 24 hours, with a breakdown of milliliters the resident was to consume at breakfast, lunch and dinner, medication passes, morning, afternoon and his/her bedtime snack.
- Point of Care (POC) identified resident #038 received on 13 out of 14 days anywhere from 25mls to 235 mls more fluid than he/she was required to receive.

Interviews with the nutrition manager and the administrator confirmed the resident's fluid intake was greater than the required amount of 1200 mls and the care was not provided as directed in the plan of care [s. 6. (7)]

7. The licensee has failed to ensure the provision of care set out in the plan was documented.

A complaint was received on an identified date, on the Ministry of Health and Long Term Care Infoline. The complainant indicated his/her loved one was always sitting in a wet brief whenever they visited, his/her therapeutic equipment wasn't always available as required and the resident had experienced multiple falls.

Record review for resident #038's written plan of care and point of care (POC) revealed the following:

-Toileting – 2 staff assist at identified times on flow sheets as per POC
-Elevation of head of bed (HOB): related to his/her medical diagnosis to be documented every shift as per POC
-an identified therapeutic equipment available related to his/her medical diagnosis to be documented every shift as per POC
-monitoring system on when in bed: related to risk of falls to be documented every shift as per POC.

Point of care documentation revealed the staff did not document

- 7 times in May 2015 and 33 times in July 2015, on various shifts, that continence care was provided to resident #038.
- 23 times in July 2015, on various shifts, that therapeutic equipment was on resident #038 at all times.
- 5 times in May 2015 and 21 times in July 2015, on various shifts that residents #038's head of bed was elevated.
- 9 times in May 2015 and 23 times in July 2015, on various shifts that residents #038's monitoring system was in place.

An interview with the DOC confirmed the PSWs did not document in the above identified areas the provision of care as set out in the plan of care. [s. 6. (9) 1.]

8. The licensee has failed to ensure that when a resident was reassessed and the plan of care was revised because care set out in the plan had not been effective, the licensee failed to ensure that different approaches were considered in the revision of the plan of care.

Review a CI, on an identified date identified an allegation of neglect related to care not being provided. On the identified date, the substitute-decision-maker(SDM) observed resident #024 naked with a blanket partially covering him/her with no sheets on the bed and the privacy curtain not closed. Four days later, it was reported by the SDM the resident was observed in bed with no bottom sheet on the bed and the continence product he/she was wearing was soaked with urine.

Review of resident #024's plan of care indicated the resident was to be approached from a distance and asked if he/she would like to receive care, as resident had responsive behaviours related to being resistive to care.

Interviews with PSWs #106, #107, #142, and RPN #143 revealed resident #024 was challenging to provide care for due to his/her responsive behaviours and would refuse care on a daily basis. Staff indicated the plan of care directed them to leave the resident when he/she refused care and continue to re-approach. Staff interviews confirmed this intervention was not always effective and resident #024 would at times go all shift without receiving care and that other interventions were not considered.

An interview with the DOC confirmed the above intervention had not always been effective for resident #024 and that other interventions had not been considered. [s. 6. (11)]

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 clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required 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 was complied with.

Review of a CI report on an identified date, reported an allegation of staff to resident abuse/neglect. Resident #024 was found by resident's SDM on two identified occasions, lying clothed on his/her bed, with no bottom sheet on the bed and his/her incontinent brief soaked with urine.

Review of the home's policy entitled "Responsive Behaviour, effective date September 16, 2013, indicated PSWs shall ensure "any changes to resident's abilities including cognition, mood and behaviour were to be promptly reported to the charge nurse".

Interviews with PSWs #142 and #106 revealed it was the home's policy to report to the charge nurse when a resident had refused care and confirmed a charge nurse was not informed of resident #024's refusal to receive continence care.

An interview with RPN #143 confirmed he/she was not informed of resident #024's refusal of care on the two identified occasions in 2013.

An interview with the DOC confirmed it was the home's policy for staff to notify the charge nurse when a resident has refused care. [s. 8. (1) (b)]

2. The home's policy in the Resident Care Manual, titled "Resident Rights, Care and Services – Nutrition Care and Hydration, Programs – Meal Service", revised date 2015-11-03, identified the meal service shall promote residents eating in the dining room unless their needs are better met in another location.
The home's policy in the Resident Care Manual, titled "Resident Rights, Care and Services – Nutrition Care and Hydration, Programs – Tray Service", revised date 2014-11-18, identified that all residents are offered tray service to continue to meet their nutritional and hydration needs when not in attendance in the dining room. The policy continued to state the registered staff are to assess and determine the reason why the resident does not want to attend meals when no infectious illness is present and only residents who are cognitively impaired will receive a meal tray. If a resident refused the meal choices offered then an alternative will be offered.

Record review of resident #038's plan of care revealed in the progress notes that resident #038 needs were not assessed as to the reason why the resident did not want to

go to the dining room for meals and tray service was not offered as the resident was not ill.

An interview with PSW #141 and RPN #117 confirmed they were informed only residents who were ill could receive a tray in their room, so therefore, they did not offer resident #038 tray service. RPN #117 did not assess the reason why the resident did not want to go to the dining room other than the resident always refused as reported by the PSWs.

An interview with the nutrition manager and the administrator confirmed the home did not follow the home's policy with regards to meal and tray service for resident #038. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "verbal abuse" as: "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

Review of a CI report identified an allegation of verbal abuse. The incident identified staff #153 overhearing staff #156 say in a loud voice an abusive comment, while portering resident #013 out of the dining room.

Resident #013 no longer resides in the home and could not be observed or interviewed by the inspector.

Interview with staff #156 revealed that he/she did not recall the resident or the incident in question. Staff #156 no longer works in the home.

Interviews with staff #153 and staff #106 who witnessed the incident confirmed the statement made by staff #156. Staff member #153 identified the comment as verbal abuse.

The inspector's inspection confirmed that staff #156's comments constituted verbal abuse towards resident #013. [s. 19. (1)].

2. The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "physical abuse" as: (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident."

Review of a CI report identified an altercation between two residents. It was witnessed by staff that resident #031 had called resident #043 a demeaning name and resident #043 responded in a manner that resulted in an injury.

Review of resident #031's progress notes revealed a number of altercations involving several co-residents.

Review of resident #031's progress notes revealed an incident of responsive behaviour toward residents #046, #047, #048, #049, #050, #051, #052, #053, #054, #055, #056, #057, and #058 prior to the incident with resident #043 on the identified date.

Review of resident #031's plan of care revealed the resident exhibited responsive behaviours when other residents entered his/her personal space. Resident #031 required assistance to get through crowded areas and staff were directed to allow a walking path around nursing station for him/her so he/she could ambulate independently.

Interviews with PSWs #127, #128, and the DOC, revealed resident #031 's responsive behaviours were difficult to manage.

3. The Long-Term Care Homes Act, 2007, O. Reg 79/10, defines "sexual abuse" as: "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Review of a CI report identified an allegation of abuse. The report identified that substitute decision maker (SDM) #152, made an inappropriate comment to resident #030 and that resident #030 was upset by the comment.

Review of the home's abuse policy entitled "Abuse-Zero Tolerance-Staff Acknowledgement" effective date September 16, 2013 indicated the SDM will be informed of the following:
-the Home's "Zero" Tolerance Policy for Abuse and Neglect of Residents.";
-What acts or omissions constitutes abuse and neglect of a resident; and
-the consequences for having abused or neglected a resident.

Interviews with PSWs #131, RN #122, staff educator #153 and RAI coordinator #103 revealed the SDM #152 was known by the home to verbalize inappropriate comments towards others, particularly females.

The inspector attempted to contact the SDM #152 on three occasions for an interview but the SDM did not respond.

Interview with the RFSC#133 revealed he/she attempted to provide the SDM #152 information on the home's abuse policy on admission but the visitor/SDM refused to acknowledge it. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. . The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions.

Review of a CI report identified an allegation of abuse.

Review of resident #031's progress notes between 2010 and 2014 revealed nineteen incidents of altercations with other residents.
Further review of resident #031's progress notes between 2010 and 2015 revealed incidents of responsive behaviours towards staff during care.
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The plan of care directed the staff to:
-Document a summary of each episode. Note cause & successful interventions to include frequency and duration.
-Becomes aggressive when other residents are in his/her way, he/she is impatient and will not wait and required assistance to get through crowded areas.
-Staff to allow a walking path around nursing station for him/her so he/she can ambulate independently.

Interview with PSWs #128, and RPN #101 revealed resident #031 had behaviours of being in a rush and very impatient and would push through other residents to get where he/she is going and indicated the resident was difficult to manage as he/she would not listen to direction and staff were not always able to prevent his/her responsive behaviours with the interventions in place.

Interview with the DOC revealed the interventions were not always effective and confirmed the home did not have other interventions in place to manage the behaviours. [s. 54. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of three meals daily.

On two identified dates, the inspector observed resident #038 not attend meal service in the dining room at lunch or supper or receive tray service.

Resident interview revealed it was too difficult, given his/her physical condition to go to the dining room for such a short period of time.

An interview with PSW #141 and RPN #117 confirmed the resident was not always offered lunch or supper and was only offered breakfast.

An interview with the nutrition manager confirmed that resident #038 was not offered three meals daily. [s. 71. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of three meals daily, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following element: meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.

On an identified date observations and resident interview revealed the resident did not attend meal service in the dining room at lunch or supper or receive tray service. Resident interview revealed it was too difficult, given his/her physical condition to go to the dining room for such a short period of time.

Record review of the resident's plan of care revealed the resident's level of nutritional risk was high.

An interview with RPN #117 confirmed the resident needs were not assessed related to his/her medical condition and that they followed the home's tray service policy. The home's tray service policy permits a resident to receive tray service only when they are assessed and determined to be sick. In the case of resident #038, it was documented the resident refused meals even though the resident did not refuse lunch, he/she refused to go to the dining room. The nutrition manager confirmed the home was delivering too many trays and residents would only get a tray if they were assessed as being sick or cognitively impaired. The administrator confirmed the resident's plan of care was not based on the assessed needs of resident #038 . [s. 73. (1) 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 home has a dining and snack service that includes, at a minimum, the following elements: meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in mandatory reporting, an area mentioned in that subsection at times or at intervals provided for in the regulations.

On an identified date an incident involving an inappropriate comment by staff #156 towards resident #013 was heard by staff #153. Staff #153 reported the witnessed incident to the home's administrator, who subsequently submitted a CI report to the Ministry of Health and Long Term Care.
An interview with staff #153, revealed he/she would not have reported the incident to the Ministry but would discuss such incidents with the DOC and administrator allowing them to decide whether to report to the Director.

Staff were interviewed throughout the home and questioned by inspectors #606, #557 and #110 of their understanding of mandatory reporting under section 24 of the LTCHA. Twenty-one staff responded in a manner not consistent with the legislative requirement. Interviews revealed knowledge of reporting abuse to their manager or administrator. The staff had no knowledge of mandatory reporting under section 24 of the Act, which states, "a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006, 2007, c.8. 24 (1), 195 (2).

A review of the home's policy titled: Resident Rights, Care and Services – Abuse – Zero Tolerance – Staff Acknowledgement, Revised Date: 2015-03-23 identified an explanation of Duty to Report. The home's policy also included under the title of "Investigating and Responding to Alleged Abuse and Neglect" the following statement:
Staff members, volunteers, substitute decision--makers, family members or any other person who has reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most senior administrative personnel on site at the Home.

An interview with the administrator identified that staff were advised during training that they can also call the Ministry but confirmed the home's practice had been to have staff notify the most senior person in the building should they witness or suspect abuse and management would contact the Ministry. [s. 76. (2) 4.]

2. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in whistle blowing protections, an area mentioned in that subsection at times or at intervals provided for in the regulations.

Review of a CI report identified an allegation of neglect.

Review of the home's investigation revealed the incident occurred on an identified date, but was not reported until two days after the incident had occurred.

Interview with PSW #132, revealed he/she witnessed the incident on the identified date, but did not report it. PSW #132 revealed that he/she knew he/she should have reported the above incident immediately but did not have knowledge of the Whistle Blower's Protection afforded by section 26 by the LTCHA.

An interview with the DOC revealed that during his/her interview with PSW #132, that the PSW informed him/her that he/she did not report the above incident because he/she was afraid of being identified. Further interview with the DOC revealed the policies on mandatory reporting and the whistle blower's protection policy were reviewed with PSW #132 after the investigation. [s. 76. (4)]

3. A review of the home's policy titled: Resident Rights, Care and Services – Abuse – Zero Tolerance – Staff Acknowledgement, revised date: 2015-03-23 and the "Read and Sign" educational material included the following statement:

It is the policy of this Home that no person shall retaliate against another person, whether by action or omission, or threaten to do so because:
-anything has been disclosed to a Ministry inspector or manager of the Home;
-anything has been disclosed to the Director of the Ministry of Health and Long-term Care including, without limitation:
-a report made pursuant to a person's duty to report as outlined above;
-advising of a breach of a requirement under the Long-term care Home act, 2007;
-advising of any other matter concerning the care of a resident or the operation of the Home that the person reporting believes ought to be reported to the Director.

Twenty staff interviews revealed an understanding that Whistle Blowing Protection against retaliation was provided by the home with no awareness of Whistle Blowing Protection afforded by section 26 of the LTCHA. This understanding by staff is consistent with the home's abuse policy and "read and sign" educational material.

An interview with the staff educator and administrator confirmed that Whistle Blowing Protection afforded by section 26 of the LTCHA had not been communicated to staff. [s. 76. (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 the persons who have received training under subsection (2) receive retraining in mandatory reporting and whistle-blowing protections, mentioned in that subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Review of a CI report identified an allegation of abuse.

Review of the home's investigation indicated the home submitted the CI report on an identified date, three days after the incident occurred.

Interview with the DOC confirmed the home had not reported the above incident immediately. [s. 24. (1)]

2. Review of a CI report identified an allegation of abuse.

Review of the home's investigation revealed the incident occurred on an identified date, and was reported to the home two days later.

An interview with PSW #132 revealed he/she witnessed the incident on the identified date, but did not report to the home until two days later.

Interview with the DOC confirmed the incident was not reported to the Director until two days after the incident had occurred. [s. 24. (1)]

3. Review of a CI report identified an allegation of neglect.

Review of the home's investigation revealed the incident was reported by PSW #155 to the Charge Nurse RPN #117 on an identified date, but was not reported to the DOC until the following day.

Interviews with RPN #117 revealed a resident not being provided care, such as toileting, was considered neglect and must be reported immediately. Further interview with RPN #117 confirmed he/she was unaware of mandatory reporting.

An interview with the DOC revealed it is the home's practice to inform the Director immediately of any alleged abuse or neglect. The DOC confirmed the home did not immediately inform the Director [s. 24. (1)]

4. Review of a CI report identified an allegation of abuse whereby resident #037 reported an individual touched him/her.

Record review of the plan of care for resident #037 revealed in the progress notes and in the 24 hour summary and shift report, that an incident did occur but this incident was not between resident #037 and an identified individual but between resident #037 and resident #034.

An interview with resident #037 was inconclusive related to a decline in his/her cognitive awareness. An interview with resident #034 confirmed that an incident did happen between resident #037 and him/herself and that it was a misunderstanding between them.

An interview with the DOC and the Administrator revealed the purpose of the 24 hour summary and shift report was to review incidents at the morning management team meetings to ensure that incidents of risk can be identified and followed up on if not already initiated for submission to the ministry. When the 24 hour summary and shift report was reviewed with the DOC and the Administrator they had no concrete answer as to why a CI was not submitted on the identified date. The home did not immediately report the alleged abuse between resident #034 and #037. [s. 24. (1)]

5. Review of a CI report identified an allegation of abuse.

The CI report indicated staff #153, overheard staff member #156 make a disrespectful statement about resident #013 while portering this resident out of the dining room, and in front of other residents.

An interview with staff #153, revealed he/she considered the incident as verbal abuse but would never have reported the incident of abuse to the Ministry. Staff #153 revealed he/she would discuss the incident with the DOC and administrator allowing them to decide whether to report to the Director.. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee did not ensure the home's procedures for cleaning soiled and/or stained privacy curtains were implemented in the home.

An anonymous complaint, was received on an identified date, with a concern that privacy curtains between residents beds were filthy.

On an identified date, observations of resident privacy curtains identified soiled privacy curtains in three identified rooms. The curtains were noticeably stained and soiled on the identified date, and remained in place, in the same condition for three days. On the third day, the identified curtains were confirmed by HCA #121 as soiled and required cleaning. Interviews with housekeeping aid #120 and HCA #121 revealed soiled and stained privacy curtains were to be removed, cleaned by laundry and brought back to the resident rooms within the same day. Interviews with HCA #121 and ESM #116 revealed that any soiled or stained curtains were to be documented in the maintenance log by staff or a PSW would notify nursing, housekeeping, or maintenance staff directly.

Record review of the licensee's environmental services policy for "Environmental Services – Cleaning Procedures: Bedrooms, Daily", dated April 2010, required staff to maintain proper care and appearance of bedrooms which included inspecting and spot cleaning privacy curtains for dust, dirt, debris, stains, and spills.

Record review of the licensee's environmental services provider policy for "Environmental Services – Cleaning Schedule for Draperies" dated April 2010, required all drapes and curtains to be cleaned on a regular basis to maintain a sanitary environment by implementing the following procedure: privacy curtains will be cleaned in-house at time of the annual cleaning routine schedule or sooner if necessary.

An interview with the ESM confirmed an unawareness of the soiled condition of the above noted privacy curtains. A review of maintenance logs further confirmed the privacy curtains in the three rooms had not been identified as soiled and required cleaning.

On the third identified date, observations of the three privacy curtains were conducted with the ESM. The ESM confirmed the curtains were soiled, required cleaning and the home's procedures had not been implemented. [s. 87. (2) (a)]

2. The licensee did not ensure that procedures were implemented for addressing incidents for lingering offensive odours.

The licensee's policy "Environmental –Odour Mitigation" dated February 27, 2015, required the environmental service supervisor to implement the following procedures, especially for challenging odours:
a. Spot clean with vinegar; soak for 2 minutes then blot dry.
b. Apply baking soda to surface; allow soda to sit for 10 minutes
c. Apply 3% hydrogen peroxide to baking soda. Mixture will foam.
d. Allow to sit for 5 minutes then blot dry

Between an identified nine day period lingering odours suspected of being related to urine were noted in an identified resident washroom. The urine odour was pervasive, offensive and confirmed by registered staff #117 and PSW #118. Despite housekeeping interventions, the odour persisted.

Interview with resident #012 revealed the urine odour had been present for the past year and stated there was nothing worse than that smell. Resident #012 revealed housekeeping did clean daily and that the odour is covered up but not gone.
An interview with housekeeping aide #119 confirmed regular daily and monthly deep cleaning for the identified room and that it is his/ her manager that deals with persistent lingering odours and the vinegar intervention.

An interview with the ESM confirmed an unawareness of the persistent and offensive odour in bathroom of the identified room. The ESM further confirmed that the home's policy related to procedures a.-d. noted above had not been followed with respect to the lingering offensive odours in identified resident room washroom. [s. 87. (2) (d)]

Issued on this 8th day of August, 2016

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

Original report signed by the inspector.