Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2015	2014_266527_0022	H-001469-14	Resident Quality Inspection

Licensee/Titulaire de permis

VILLA FORUM
175 FORUM DRIVE MISSISSAUGA ON L4Z 4E5

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

VILLA FORUM
175 FORUM DRIVE MISSISSAUGA ON L4Z 4E5

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

KATHLEEN MILLAR (527), ASHA SEHGAL (159), YVONNE WALTON (169)

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): October 27, 28, 29, 30, 31, November 4, 5, 6 and 7, 2014

Two Critical Incidents: Log #H-001228-14 and #H-001229-14, and a Complaint: Log #H-001002-14 were included in the Resident Quality Inspection

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Food Service Manager (FSM), the Social Worker, the Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary aides, housekeeping, laundry and maintenance staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
5 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the residents, in relation to the following.

A) The Minimum Data Set (MDS) review completed in August 2014 coded in section “D Vision Patterns” identified the resident had impaired vision. A statement written in the triggered RAP completed in September 2014 stated the care plan was to be updated. A review of the assessment identified that staff were to ensure the resident was re-oriented to where the plate or cups were located on the table when eating. The plan of care was reviewed and confirmed the last care plan update was completed by registered staff in September 2014 and did not include care directions in relation to vision impairment for this resident. The staff and clinical documentation confirmed that the written plan of care for resident #023 did not provide clear directions to staff and others who provided direct care to this resident. The Resident Assessment Instrumental (RAI) Coordinator confirmed the hearing and vision section of the plan of care did not contain care directions related to vision impairment.

B) The MDS review completed in August 2014 indicated in section “D Vision Patterns” that the resident had impaired vision. A statement written in the triggered RAP completed in August 2014 stated the care plan was reviewed and updated. A review of the assessment and plan of care records confirmed the last care plan review completed by registered staff was in August 2014 and did not include care directions in relation to vision impairment for this resident. The staff and clinical documentation confirmed that the written plan of care for resident #036 did not provide clear directions to staff and others who provided direct care to this resident. The RAI Coordinator confirmed the hearing and vision section of the plan did not contain care directions related to vision impairment.

The RAI Coordinator reviewed the clinical records including care plans with the LTC Inspector and confirmed that the care directions for vision impairment for the identified residents were not documented in the plan of care. [s. 6. (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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the 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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that furnishings were kept clean and sanitary.

The following were observations by the LTC Inspector in October 2014:

A) Floors had stains and visible dust. They included an activity room and the second floor SPA.
B) Carpets were not clean and were stained. They included home areas on each floor.
C) Lounge furniture was not clean. There was stains on the chairs and they were visibly soiled. They included easy chairs, wing back chairs and love seats throughout all the home areas.
D) The ceiling fan in the SPA room on the first floor was observed to be very dusty.

These were confirmed by observation and in discussion with the Administrator. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home is maintained in a good state of repair.

In October 2014 the following items and areas were observed by the LTC Inspector throughout the home.

A) Six of the home areas had several pieces of furniture that were worn on the arms and legs.
B) Walls had areas of damage on the drywall throughout the home, in multiple resident rooms and in the activity rooms.
C) The cabinet under the sink in the activity rooms in various home areas were chipped and the laminate was damaged.
D) The resident dining rooms had chipped counter tops.
E) Several ceiling tiles were stained around the dryer and in the SPA.
F) Flooring in the SPA in multiple home areas were lifting.
G) The SPA room in five home areas had corner beading at the entrance to each shower, which was covered with duct tape.
H) One of the home areas had handrails in the hallway that were broken and repaired with duct tape.
I) Flooring at the entrance to a resident room was not smooth resulting in a tripping risk to residents.
J) The vent cover on the fridge was falling off in several home areas.

This was confirmed by observation and discussed with the Administrator. [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 furnishings were kept clean and sanitary, and to ensure that the home is maintained in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that menu substitutions made were comparable to the planned menu.

In November 2014 the breakfast meal had a menu substitution of cheese for pancakes, and at the lunch meal ice cream was substituted for bananas. The menu items substituted did not contain the same nutrients, therefore substitutions made were not comparable to the planned menu. [s. 72. (2) (e)]

2. The licensee has failed to ensure that menu substitutions were communicated to staff and residents.

In November 2014 the planned posted menu for the residents on one of the resident units had pancakes for breakfast. The staff and the Food Service Manager (FSM) confirmed that cheese was served instead of pancakes for breakfast, and bananas was served for dessert at the lunch meal. The dietary staff and the FSM confirmed that the menu substitutions were not documented and communicated on the home's daily and weekly menu posted on the resident units. [s. 72. (2) (f)]

3. The licensee has failed to ensure that the food production system in the home provided documentation on the production sheet of any menu substitutions.

During the course of the Resident Quality Inspection several menu substitutions were made and substitutions were not documented on the production sheets. In November 2014, pancakes were listed on the menu for breakfast, the FSM reported the pancakes were not in stock, and cheese was substituted. Ice cream was substituted for bananas at the lunch meal. The menu substitutions were not documented on the production sheets. The FSM confirmed that the menu substitutions were made but were not documented on the food production sheets. [s. 72. (2) (g)]

4. The licensee has failed to ensure that all food and fluids in the food production are prepared, stored and served using methods to preserve taste, appearance and food quality.

Not all foods were served to residents using methods which preserved taste, nutritive value, appearance and food quality.

A) In November 2014, during the lunch meal production, a cook was observed preparing a pureed cold entrée. The cook was noted mixing salami and capicola cold meat and then adding salad dressing. The recipe called for chicken broth to be added for pureed meat. The cook confirmed they added salad dressing instead of chicken broth and the cold cuts should have been pureed separately and not mixed together; they had looked at the wrong recipe. The cook did not measure or weigh the ingredients as the recipe had called for. The FSM confirmed that the recipe for the pureed cold entrée was not followed, and the cook had looked at the wrong recipe. The food preparation method used had compromised the appearance, taste and also the food quality.

B) The texture of the pureed food items served was too runny, resulting in reduced nutritive value as the food was diluted with additional liquid. At the supper meal in October 2014, the pureed beef pot roast, green beans and peas were noted to be too runny and did not hold their form on the plate. The pureed food items were noted running into each other on the plate.

C) In November 2014 the cold pureed menu items served to residents were noted to be very dry and lumpy. The meat and the salad had a large amount of thickener added to them, affecting the taste appearance and nutritive value. The lunch meal observed by the

LTC Inspector was not well received by the majority of residents.

D) In November 2014 the pureed Chicken a La King served at lunch did not characterize a texture of chicken. The consistency of the food was runny and soupy due to excessive liquid, which reduced the nutritive value and created a choking risk for residents requiring pureed food and thickened liquid. The pureed food served to residents did not appear appetizing, did not preserve taste and food quality. [s. 72. (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 all food and fluids in the food production are prepared, stored and served using methods to preserve taste, appearance and food quality. In addition, to ensure that menu substitutions made were comparable to the planned menu, that menu substitutions were communicated to staff and residents, and that the food production system, provided documentation on the production sheet of any menu substitution, 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:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

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

with eating, including safe positioning of residents who required assistance.

Not all residents who required assistance with eating were positioned safely at the dinner meal in October 2014, and November 2014 at the lunch meal.

A) Resident #101 was sliding down in their chair and had their head tilted back with their chin pointed towards the ceiling while being fed at both meals, creating a risk for choking. Registered staff confirmed the resident was not safely positioned during meal. The resident was taken to their room and repositioned after the LTC Inspector intervened.

B) In November 2014 during the lunch meal resident #035 was observed being fed in their chair. The resident's head was leaning to the left side and their chin pointed down creating risk for choking. The staff assisting the resident was feeding at an angle and did not have eye contact with the resident. The LTC Inspector observed the resident being fed in a very uncomfortable and unsafe position. [s. 73. (1) 10.]

2. The licensee has failed to ensure that the residents who required assistance with eating and drinking were served their meal when someone was available to provide the assistance required by the residents.

Residents that required assistance with eating and drinking were served their meal prior to assistance being provided. Meals were placed on the table for residents #036, #100 and #101, prior to assistance being available at the dinner meal in October 2014.

A) In October 2014 resident #036 was observed in the dining room on the first floor during the supper meal sitting at the table with food and fluids in front of them. The resident was served food at 1705 hours and the resident was sitting until 1720 hours with no assistance with eating. At approximately 1725 hours the resident was assisted with eating by a registered staff only after the LTC Inspector intervened and spoke with the staff. The staff left the resident before the resident had finished eating and went to assist another resident. The plan of care for this resident had stated in the evening resident may be tired and require extensive assistance. The resident was identified to be at nutritional risk.

B) Resident #100 was not provided the level of personal assistance they required to safely eat and drink as comfortably and independently as possible at the supper meal in October 2014. During the supper meal service the resident was served their food at 1710 hours and was observed making an effort to eat independently, but was having difficulty

scooping the food. The resident had spilled most of the pureed food on their clothes. The resident sat with the food in front of them for approximately 10 minutes with no assistance and encouragement. The registered staff confirmed the resident required assistance with eating, but the staff was not available to provide assistance.

C) In October 2014 the LTC Inspector observed resident #101 with food sitting in front of them for over 10 minutes without assistance being provided. The plan of care for this resident had identified that they required total assistance with eating.

Registered staff and the PSW indicated to the LTC Inspector they did not feel there was sufficient staffing to meet residents’ needs at meal time because there were many residents who required assistance with eating. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, and that residents are served their meal when someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

The home's policy titled "Personal Clothing - Missing", policy NESM-E-01.01, section 4 and revised February 2011 stated that the person reporting the lost clothing will be directed to the lost and found clothing area for an initial search of the items reported missing. In November 2014 two staff working in Laundry services confirmed that families and residents were not coming down to the laundry room in search of lost clothing. The clothes found not labeled were stored in a clear plastic bag in the laundry room and the PSW comes to the laundry room to search for any resident clothing missing. The LTC Inspector found two baskets of clothes in the laundry room, which were not labeled. The laundry staff reported that the unlabeled clothes were found in the last two months (September and October 2014), and no one had come to search for lost clothing. The laundry staff also reported that they were not aware of any formal process for notification and tracking of lost items.

In November 2014 the Administrator confirmed that the families and the residents were no longer going to the laundry to search for missing personal clothing. The Administrator further confirmed that the current procedures being followed for missing resident clothing did not reflect the home's policy.

Resident #005, #016 and #032 reported to have had missing laundry in 2014 and stated they reported the missing items to staff.
- Resident #005 reported to have lost two pairs of pants.
- Resident #016 reported to have lost pyjamas and it was reported to the staff, but no one came to inform the resident if they found them.
- Resident #032 reported to have lost three pairs of stockings and reported it to staff, but no response received. Residents' interviewed confirmed lost clothing and personal items were still missing.

The complaint log and the home's concern log for 2013 and 2014 were reviewed. The missing clothing check list and the response form were not completed for the residents. The home's policy titled Personal Clothing – Missing stated that the person receiving the report of lost clothing will document all information on the missing clothing report form. If the item/s reported missing were not found in the laundry room, the Environmental

Services Manager (ESM) would post the missing clothing list report in the laundry room for three consecutive days. Laundry staff interviewed confirmed there was no list posted of the missing clothing in the laundry room and they have not received a report of the missing laundry. The procedures for missing clothing and management of personal belonging was not followed and communicated to the residents, families and power of attorney (POA) . [s. 89. (1) (a) (iv)]

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 their procedures were implemented to ensure that there was a process to report and locate residents' lost clothing and personal items., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The Residents' Council advised the home of concerns at their meetings in June and July 2014, and their concerns were not responded to by the home in writing within ten days of receiving. The Social Worker, the Assistant to the Residents' Council confirmed that not all concerns at the meetings were responded to in writing within ten days of receiving. The Vice President of the Residents' Council interviewed in November 2014 confirmed they did not receive the written responses to the residents' concerns related to food, and the breakdown of the elevators. The members of the Residents' Council interviewed also voiced their concerns regarding the elevators not functioning most of the time. [s. 57. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

In October 2014, the menu posted for mince and pureed diets for dinner stated buttered whole wheat bread was to be served with their meal. Residents on pureed and mince diet were not offered or served bread with their dinner meal. The dietary staff confirmed the bread was only served to the residents on a regular diet and not to residents on a pureed and mince diets. The pureed bread was not available at the dinner meal. [s. 71. (4)]

Issued on this 23rd day of January, 2015

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

Original report signed by the inspector.