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
Division de la responsabilisation et de la performance du système de santé
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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
Apr 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, May 1, 2, 3, 8, 10, 14, 17, Jul 31, Sep 4, 5, 2012	2012_026147_0013	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF ERIN MEADOWS
2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4

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

LALEH NEWELL (147), ASHA SEHGAL (159), MARILYN TONE (167), PHYLLIS HILTZ-BONTJE (129)

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 Administrator, Director of Care, Assistant Director of Care, Food Service Manager, Environmental Manager, Program Manager, Registered nursing staff, Personal Care Aides (PCA), housekeeping, dietary aides, recreational aides, physiotherapy, Kiniseologist, dietitian, families, and residents.

During the course of the inspection, the inspector(s) reviewed residents records, home's policies and procedures, and Resident and Family Council minutes. Observed resident care, dining and program activities in the home. Completed physical tour of home and observed care and services provided to the residents and medication passes.

Log # H-000659-12

PLEASE NOTE: An Environmental Inspection, Inspection #2012-072120-0039 (H-000845-12) was conducted by Inspector #120, concurrently with this inspection.

The following Inspection Protocols were used during this inspection:

Admission Process

Continence Care and Bowel Management

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

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) 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 subsections:

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.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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).

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
(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 the plan of care for the resident was not reviewed and revised to reflect the changes in the resident's health status and assessed needs. [s. 6.(10)(b)]

A. The plan of care for the resident was not reviewed and revised to reflect the changes in the resident's health status and assessed toileting needs. [6(10)(b)]

(PLEASE NOTE: The above evidence of non-compliance related to an identified resident which was found during Inspection # 2012_064167_0013)

B. Five of six residents identified as experiencing a decline in functional abilities were not reassessed and the plan of care was not revised to address the changing care needs, in relation to the following:[s.6(10)(b)]

i. A Minimum Data Set (MDS) full assessment completed for an identified resident indicated that there had been a decline in functional abilities including related to mobility. The Resident Assessment Protocol (RAP) assessment indicated that this RAP problem will be care planned with the goal of improving. Care plans reviewed prior to this assessment and following this assessment were not revised to reflect the changes in the resident's condition and this was confirmed by the Resident Assessment Instrument (RAI) Coordinator.
ii. A MDS full assessment completed for an identified resident indicates that there has been a decline in functional abilities in relation to bowel function and a deterioration in urinary function. The plan of care has not been revised to reflect the decline in function identified in the assessment. The RAI coordinator confirmed that this was identified as an existing RAP and as a result confirmed that there were no changes made to the care being provided to the resident even though there had been a decline in bowel and urinary function for this resident.
iii. A MDS full assessment completed for an identified resident indicated the resident has experienced a decline in functional abilities related to mobility and transferring.. The RAI Coordinator confirmed that a RAP assessment related to the above noted areas of decline was not completed for this resident and the plan of care for the resident was not altered to reflect these changes in the condition of the resident following the full assessment noted above.
iv. A MDS full assessment completed for an identified resident indicated a decline in functional abilities related to bowel control and bladder incontinence. The RAP does not address the decline in bowel and bladder function. The RAI Coordinator confirmed that there were no actions taken in response to the decline in the resident's condition identified and the plan of care was not revised to address this decline in bowel and bladder function.
v. A MDS full assessment completed for an identified resident indicated a decline in functional abilities related to urinary continence. The RAP indicated that this is an adjusted RAP and the plan of care will be updated with a goal of having more periods of urinary continence. A review of the plan of care indicated that there were not changes to the plan of care to address this decline in urinary continence. The RAI Coordinator confirmed that the plan of care was no revised to address this change in the resident's condition,
vi. An identified resident was identified as palliative due to the decline in condition. The nutritional plan of care was not revised to reflect changes related to changes in food texture. The Director of Food Services confirmed that the resident was not reassessed when the resident's condition changed and the plan of care was not revised to reflect these changes. . (129)
vii. The plan of care for an identified resident did not reflect the current health status of the resident. Review of the progress notes and interview with the nursing staff identified resident was on palliative care measures. Resident health status had declined after an injury. Progress notes and clinical records documented by the registered staff identified resident at high risk for dehydration due to insufficient fluid intake. The plan of care was not reviewed and revised to reflect the current nutritional status in relation to palliative. (159)

2. The licenses failed to ensure that when a resident is reassessed and the plan of care reviewed and revised, (b) the plan of care is being revised because care set out has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. [s.6(11)(b)]

A. The plan of care for an identified resident was not reviewed and revised to ensure that the different approaches implemented were included in the revision of the plan of care when the resident was reassessed. [s.6(11)(b)]

i. The plan of care for the resident related to falls prevention did not include intervention and strategies related to minimizing of falls.

ii. Review of the progress notes and interview with the staff, confirm the resident had multiple falls in a two month period. (147)

B. The plan of care for an identified resident was not revised and different approaches were not considered when care set out in the plan not effective in relation to significant gradual weight loss (Low Body Mass Index) and insufficient fluid intake.[2007, c. 8, s. 6 (11)b]
i. A review of resident's weight record indicated the resident had experienced gradual unplanned weight loss. The Registered Dietician completed an assessment in February 2012 but did not include an evaluation of food consumption nor effectiveness of interventions in relation to unplanned weight loss and poor oral intake. The interventions in place were ineffective as resident continued to loose weight, the plan of care was not revised nor different approaches were consider in relation to gradual unplanned weight loss, and poor oral intake. (159)

3. The care set out in the plan of care was not provided to the residents as specified in the plan of care. [s.6(7)]

A. The plan of care related to toileting for an identified resident directed staff to provide two staff extensive assistance.

i. Interview with staff and observation of the resident indicated the resident did received assistance with toileting as per the plan of care. (167)

(PLEASE NOTE: The above evidence of non-compliance related to an identified resident which was found during Inspection # 2012_064167_0013)

B. An identified resident's physician ordered IV hydration if the resident did not eat or drink enough fluids. The Registered Practical Nurse (RPN) confirmed that this order would be implemented if the resident had not consumed 1500cc of fluids for two consecutive days. A review of the fluid monitoring indicated that the resident consumed below the recommended fluid intake for several days, however the IV hydration was not initiated as directed. (129)

C. An identified resident was ordered by the physician to consume at least 2000cc per 24 hours. Review of the Nutrition and Hydration flow sheet for two consecutive months indicated the resident did not receive the amount prescribed by the physician. (147)

(PLEASE NOTE: The above evidence of non-compliance related to an identified resident which was found during Inspection # 2012_0126147_0015)

4. The licensee did not ensure that the care set out in the plan of care for an identified resident was documented. [LTCHA, 2007, S.O. 2007, c.8, s. 6(9)1]

A. Review of the the MDS assessment identified resident had a low body mass index. The food and fluid intake records completed by personal care aides did not identify what was consumed by the resident as per the care set out in the resident's plan of care. (159)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the care set out in the plan of care is provided to the resident as specified in the plan [6(7)] and when a resident is reassessed and the plan of care reviewed and revised, because the care set out in the plan has not been effective, the licensee shall ensure different approaches are considered in the revision of the plan of care [6(11)b]., 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 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. The licensee did not ensure that were the Act or this Regulation requires the licensee to have, institute or otherwise put in place any policies, procedures or strategies, that those policies, procedures or strategies are complied with, in regards to the following: [s.8(1)b]

A) Nursing Policy [Pharmacy Signature Report/MEDISYSTEM], required under the medication management system, O. Reg. 79/10, s.114(1), dated December 2010 indicates the pharmacy will fax a Medication Administration Signature Reminder to each home area 30 minutes before the end of the shift – the team leader will verify the list and check against Medication Administration Record (MAR) to make sure that all medications are signed, if a discrepancy the Director of Care will be notified. The team lead will initial the Signature Reminder and forward to the Director of Care. The Director of Care will complete an audit to verify that there are no missing signatures on the MAR. The Director of Care confirmed that the auditing responsibility identified in this policy has not been complied with. (129)

B) Policy #04-08-10 [Disposal of Discontinued/Expired Drugs and Narcotics] required as part of the medication management program under O. Reg. 79/10, s. 136(1) was not complied with. This policy dated September 8, 2003 directs that discontinued outdated narcotics will be stored in a double locked container in the medication room or in a narcotic drawer of the medication cart. Staff in the home did not comply with this policy when it was noted that discontinue narcotics were being stored in a locked desk drawer in an unlocked office in the home. The Director of Care confirmed that this is the practice within the home for the storage of discontinued/expired narcotics.
This policy also directs that the collection and destruction of discarded medications will be handled by a third party contractor. This policy was not complied with as it was noted that narcotics and controlled drugs, that according to the Director of Care were destroyed, were noted to be stored in a sharps container in the Director of Cares unlocked office. The medications were visible through the lid of the sharps container and it was noted that not all medication were altered or denatured consumption impossible or improbable. The consultant pharmacist indicated that this is not the usual process for the destruction of narcotics and controlled drugs. (129)

C) Policy [Responsive Behavior/Aggression Prevention] dated January 2011 directed staff to assess residents for risk of responsive/aggressive behaviour and triggers. An identified resident had been demonstrating physical and verbal aggressiveness and socially inappropriate behaviours over the last several months and was receiving mediation to manage these behaviours. Registered staff and the Assistant Director of Care confirmed that this policy had not been complied with, because there were no attempts to determine behavioural triggers for this resident. (129)

D) Policy [Palliative/End of Life Care] required under the organized program of nursing services, LTCHA 2007, c. s. 8(1)(a), dated December 2010 directed staff to have a care conference with the multidisciplinary team, resident, and/or POA when the resident's health status was deteriorating towards end of life. An identified resident was deemed palliative and according to the Registered staff and the Director of Care confirm that a multidisciplinary conference was not held for this resident as per policy. (129)

E) Policy [Nutrition and Hydration (LTC)] required under the organized program of dietary services and hydration, LTCHA 2007, c. 8, s. 11(1), dated April 2012 included in the organized program of nutrition care and hydration program required under O. Reg. 79/10 s. 68(1)(a)(b) directs that Personal Care Aides (PCA) will take note of the meals each resident is served, as well as the total amount of fluids served to each resident to ensure accurate documentation. This policy was not complied with in relation to the following:

i. During two observed meal times, staff did not document an accurate amount of fluids for three identified residents. Review of the The food and fluid flow sheets indicated that all three residents were not an accurate of intake. (159)

F) Policy [Nutrition and Hydration (LTC] dated April 2012 included in the organized program of nutrition care and hydration program required under O. Reg. 79/10 s. 68(1)(a)(b) directs that any resident who consume less than 1500 ml/day for two consecutive days will be referred to the Physician. Refer to the Registered Dietitian on the third (3rd) day of fluid intake less than 1500 ml daily. This policy was not complied with in relation to the following:

i. Review of food and fluid intake record for an identified resident identified fluid consumption most days was less than 1500ml/day. There were no documentation to support that a referral was made to the Registered Dietitian in relation to

insufficient fluid consumption for four consecutive days. The policy was not complied with in relation to a referral was not made to the dietitian. (159)

ii. Review of food and fluid intake record of an identified resident's fluid consumption most days were less than the recommended intake per day. There are no documentation to support that the PCA staff reported the fluid intake to the registered staff or the resident's refusal to drink as per the home's policy. Resident was subsequently sent to hospital for further assessment for dehydration. (147)

(PLEASE NOTE: The above evidence of non-compliance related to an identified resident was found during inspection #2012_026147_0015)

iii. Review of food and fluid intake record of an identified resident identified the fluid intake most days was less than 1500ml/day. Review of progress notes and interview with nursing staff confirmed a referral was not made to the doctor and the dietitian as required in policy. (129)

G) Policy [Nutrition and Hydration (LTC] dated April 2012 included in the organized program of nutrition care and hydration program required under O. Reg. 79/10 s. 68(1) (a) (b) directs that Personal Care Aides (PCA) will take note of the meals each resident is served, as well as the total amount of fluids served to each resident to ensure accurate documentation. This policy was not complied with in relation to the following:

i. The home's Nutrition and Hydration policy dated April 2012 -Tab 07-24, states "each resident will have a Nutrition and Hydration flow sheet and Personal Care Aide will complete the flow sheet accurately". The food and fluid intake record for an identified resident was incomplete with numerous missing entries Policy states at the end of each meal, the Registered Nursing Staff will review the Nutrition and Hydration binder for completion. Interview with the Assistant Director of Care and a review of food and fluid intake records confirmed that the nutrition and hydration intake records were incomplete and not monitored as the policy. (159)

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

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

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Registered Dietitian who is a member of the staff of the home, (a) completed nutrition assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and (b) assess matters referred to in paragraphs 13, 14 of subsection (3). [s.26(4)(b)].

A. The licensee failed to ensure that an assessment of an identified resident's hydration status and risks related to hydration was completed when the resident had a significant change in health status and decline in food and fluid intake. The Registered Dietitian did not assess the resident's hydration status and risks related to nutrition care. Resident had a decline in food and fluid intake, not meeting the recommended hydration goals. The nutrition assessment completed by Registered Dietitian, did not include an evaluation of the resident's food and fluid consumption. The plan of care included a requirement for the resident's daily fluid intake, however, food and fluid intake documentation reviewed for a two month period, reflected the resident was consuming fluids poorly. The resident was sent to hospital for further assessment.

B. The Registered Dietitian did not complete a nutritional assessment for an identified resident when the resident had a significant change in health status and decline in food and fluid intake.
Review of the progress notes identify the resident had a fall resulting in an injury, nursing staff confirmed that the resident's health status declined after the injury. Dietary assessments did not include nutritional assessment related to inadequate fluid intake and risk or dehydration for resident. The plan of care includes a daily estimated fluid requirement, however, food and fluid intake documentation for the resident was consuming less then the daily requirement.

C. An identified resident was sent to hospital for further assessment of her condition due to dehydratation. The attending physician ordered to encourage fluids for the resident. Nutrition and Hydration flow sheet identified the resident was consuming less than the ordered amount of fluids per day, placing the resident at risk for dehydration.

2. The licensee failed to ensure that an interdisciplinary assessment of hydration status and any risk relating to hydration was completed, with respect to the following; [s.26(3)14]

A. An interdisciplinary assessment of an identified resident's hydration status in relation to dialysis treatment was not completed. The RAP related to dehydration and fluid maintenance completed by RAI Coordinator did not include resident's fluid intake in relation to fluid restriction recommended by the dietitian and risk of dehydration. Interview with the RAI coordinator, Registered Dietitian and nursing staff confirmed that an interdisciplinary assessment and care planning of resident's hydration status and risk related to hydration did not occur for the resident.

B. An Interdisciplinary assessment of an identified resident's hydration status and risks related to hydration was not completed. The triggered dehydration Resident Assessment Protocol summary (RAP) stated resident is to maintain fluid intake with staff encouragement to prevent dehydration. This was contrarily to the fluid consumption of resident recorded by personal care aides and the progress notes documented by nursing staff. The Resident Assessment Protocol (RAP) related to dehydration/fluid maintenance completed by Resident Assessment Instrument Coordinator (RAI Coordinator) did not include assessment of the resident's current fluid intake in relation to recommended fluid intake identified on the resident's plan of care, despite of a history of poor fluid intake. Interview with the RAI Coordinator confirmed that a written care plan for the resident was not developed to address resident's specific health needs. Registered Dietitian and RAI coordinator confirmed that an interdisciplinary assessment did not include resident's hydration status and risk relating to hydration.

C. An Interdisciplinary assessment of an identified resident's hydration status and risk related to hydration was not completed when resident had a decline in fluid intake and did not meet the recommended hydration goals.
Interviewed Registered Dietitian and the RAI coordinator confirmed that the triggered RAP summary for dehydration was completed by RAI coordinator without Registered Dietitian's and the nursing staff involvement, an interdisciplinary assessment of resident's hydration status did not occur. The progress notes identified that the resident had a fall with injury. Since then resident's health status has declined. The resident was identified at high nutritional risk for dehydration, poor appetite.

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following subsections:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;
(b) attends regularly at the home to provide services, including assessments; and
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. The licensee did not ensure that either a physician or a registered nurse in the extended class, conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination. [r. 82(1)(a)]

Review of the residents scheduled for annual physicals indicated that for the months of January, February, March and April the annual physicals had not been completed. Several charts reviewed with the registered staff confirmed that the physician had not completed the scheduled annual physicals since January 2012.

Interview with the physician also confirmed that the annual physicals had not been completed for residents scheduled for January, February, March and April 2012.

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 either a physician or a registered nurse in the extended class, conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination, to be implemented voluntarily.

WN #5: 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. The licensee failed to ensure that concerns and recommendation were responded to in writing within 10 days of receiving advice from the Family Council 2007, c. 8, s. 60 (2)

Review of Family Council minutes and Interview with the President and members of Family Council confirmed that the licensee did not respond to concerns in writing within 10 days of receipt from Family Council. The ongoing issues and concerns identified in Family Council meetings of June 8, 2011, July 13, 2011 and August 10, 2011, regarding toileting, meal time assistance and hydration, were not responded to.

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 Family Council has advise shall be responded to in writing within 10 days of receiving that advise, 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 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 licensee did not ensure that the dining and snack service included, providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, in relation to the following: [73(1)9]

A. An identified resident's plan of care identified resident for high risk for choking related to behaviours around eating. During an observed meal time the resident was noted to be eating large quantity of food. Staff were aware of the safety issues for this resident in relation to choking, but did not supervise or monitor this resident until the behaviour was identified to them.

B. An identified resident was in the dining room during a meal period and was noted to not be eating the food that was provided. Staff in the dining room did not provide assistance or encouragement for this resident to eat. After a lengthy period of time a staff member reminded the resident to eat. The staff person left the table and the resident was noted again not to be eating. Staff did not provide any further encouragement or assistance and as a result the resident did not consume any food during the meal.

C. During an observed meal it was noted that an identified resident was not eating the food that was provided. Staff were noted to be sitting at the table assisting other residents; however they did not provide assistance or encouragement to this resident.

2. The licensee did not ensure that appropriate furnishings were available in the dining room to meet the needs of the residents, related to the following: [73(1)11]

During an observed meal an identified resident was noted to be sitting at a table with the table surface just below the level of the resident's chin. The resident had to hold their arms up at shoulder level in order to get food off the plate.

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, provide residents with personal assistance and encouragement required to safely eat and drink as comfortably as possible and to ensure that appropriate furnishings were available in the dining room to meet the needs of the residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following subsections:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Resident Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, in relation to the following: [116(1)]

A. A review of the minutes and other documentation included with the Health Care Advisory Committee were reviewed for the periods of January/April/July/October 2010, February/May/July/October 2011 and January 2012 and an annual review to evaluate the effectiveness of the medication management system was not conducted over this two year period of time. The Director of Resident Care indicated that if an annual review was completed it would be included in the minutes documented as part of the Health Care Advisory Committee.

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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Resident Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #8: 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. The licensee did not ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the medication cart. [129(1)(b)]

The home demonstrated that controlled drugs that are to be destroyed are kept in a locked drawer in a desk in an office. It was also demonstrated that controlled substances that had been destroyed were noted to be in an unsecured sharps container on the floor of the office. Destroyed medications, including tablets and capsules were noted to be whole and intact were visible in this container. The office door remained unlocked and open during the day.

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 controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the medication cart, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, in relation to the following: [131(2)]

A. An identified resident was ordered medication by the physician to be administered at bedtime, however this medication was not administered to the resident until a few days later because the pharmacy did not send the medication. The Medication Administration Record (MAR) indicated that the medication was first administered several days after the medication was initially ordered. The registered practical nurse (RPN) on the unit confirmed that the medication was ordered twice by the physician, however at times the home does not receive medications from their pharmacy or the after hours pharmacy as required. (167)

(PLEASE NOTE: The above evidence of non-compliance related to an identified resident was found during Inspection # 2012_064167_0013)

B. The DOC confirmed that when medications are given to residents the staff signs the Medication Administration record indicating that the medication had been consumed by the resident. Documentation of care provided for six of twelve residents reviewed indicated that the residents did not receive medication in accordance with the directions for use identified by their physicians. (129)

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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs there is monitoring and documentation of the effectiveness of the resident's response and the effectiveness of the drug, in relation to the following: [134(a)]

A. Staff indicated that an identified resident was receiving medication once a day since admission to the home in 2012 due to anxiety. Staff also indicated that the resident's plan of care specifically, directs staff to provide the resident's medications on time. Staff confirmed and the clinical record indicated that there was not an evaluation of the effectiveness of the medication in relation of the non-pharmacological interventions that were put in place to manage the resident's anxiety.

B. An identified resident was receiving medication twice a day to manage responsive behaviours. Documentation in the clinical record indicates that over a 2 month period the resident demonstrated numerous episodes of verbal and physical aggression. There is no evidence in the clinical record of the effectiveness of these drugs in managing these behaviours. The RPN and the Assistant Director of Care confirmed that there is not a system in place to monitor if the medications ordered for the resident have been effective in managing or reducing episodes of responsive behaviours.

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 when a resident is taking any drug or combination of drugs, including psychotropic drugs there is monitoring and documentation of the effectiveness of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following subsections:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee did not ensure that when medications that are not controlled substances are destroyed it was done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and one other staff member appointed by the Director of Nursing, in relation to the following: [136(3)(b)]

A registered staff responsible for medication administration in the home indicated that when a drug is to be destroyed, the drug is placed in a sharps container that is located in each medication room and at regular intervals the sharps container is collected for disposal. The registered staff confirmed that two staff are not involved in this process. The Director of Care indicated that the sharps containers are picked up by a contracted service, removed from the home and disposed of and confirmed that there are not two people acting together during this process.

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 drugs must be destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and one other staff member appointed by the Director of Nursing, to be implemented voluntarily.

WN #12: 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. The licensee did not ensure that the home's continence care and bowel management program (Tab 04-29 of the Nursing Policy and Procedure Manual dated December 2012 – Continence) required under section 48 of the regulation contains goals and objectives.
The Director of Care provided the policy and confirmed that it was the policy that is currently being followed.

(PLEASE NOTE: This evidence of non-compliance was found during Inspection # 2012_064167_0013)

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the required approaches, strategies and protocols were developed to meet the needs of residents with responsive behaviours, in relation to the following: [53(1) 1, 2, 3, 4]

Information provided by the home regarding the program in place for the management of responsive behaviours was a Responsive Behaviour/Aggressive Prevention policy dated January 2011. The focus of this policy is on occupational health and safety related to staff injuries as a result of aggressive behaviour. The DOC confirmed that the home does not have a program in place to meet the needs of residents demonstrating responsive behaviours that includes:

a. written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers,
b. written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours,
c. resident monitoring and internal reporting protocols
2. The licensee did not ensure that behavioural triggers were identified for residents demonstrating responsive behaviour, with respect to the following: [53(4)(a)]

An identified resident was receiving antipsychotic medication to manage behaviours. Staff documented multiple episodes of inappropriate behaviour. Staff have not attempted to determine the triggers for these behaviors. This was confirmed by the registered staff and the Assistant Director of Care.

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 for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible and to ensure that the required approaches, strategies and protocols are developed to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to ensure the security of the drug supply by keeping all areas where drugs are stored locked at all times, related to the following: [130)1)]

The inspector entered the nursing station area and noted the door to the medication room was open, there was not a registered staff member in the medication room and there was not a registered staff member in the vicinity of the nursing station. Shortly after this a registered staff person entered the nursing station where it was pointed out that the medication room door was left open. Staff indicated that a vender was placing something in the medication room and must have left the door open.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that improvements made to the quality of the accommodation, care, services or programs provided to residents are communicated to the Residents' Council and Family Council on an ongoing basis. [O. Reg. 79/10, s. 228.3]

a. Review of Family Council minutes and interview with the President and members of Family Council confirmed that results of audits, quality indicators and quality improvement initiatives have not been communicated to the Family Council.

b. Review of Residents' Council minutes for 2011 and January , February 2012, and interview with the administrator and President of Residents Council confirmed that results of audits, quality indicators and quality improvement initiatives have not been communicated to Residents' Council.

WN #16: 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 licensee failed to ensure that the results of the survey are made available to the Family and Residents' Council to seek their advice. [2007, c. 8, s. 85. (4) (a)]

a. Interview with the President and members of the Family Council and review of Family Council minutes for 2011 and January, February 2012 found no evidence of discussion related to the sharing of results of the satisfaction survey and seeking the advice of Family Council about the survey.

b. Interview with the administrator and President of Residents' Council and review of Residents' Council minutes for 2011, and January, February 2012 found no evidence of discussion related to the sharing of results of the satisfaction survey and seeking the advice of Residents' Council about the survey.

2. The licensee failed to ensure that the advice of the Family and Residents' Council was sought in developing and carrying out the survey and in acting on its results. [2007, c. 8, s. 85 (3)]

a. Interview with the administrator, President and members of the Family Council confirmed that Family Council was not consulted in the development and carrying out of the satisfaction survey and acting on its results.

b. Interview with the administrator and President of Residents' Council confirm that Residents' Council was not consulted in the development and carrying out of the satisfaction survey and acting on its results.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

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 did not ensure that the planned menu items are offered and available at each meal and snack. [r. 71 (4)]

During the breakfast meal observation residents were not offered planned menu items.
The planned breakfast menu posted outside the dining room was cranberry juice, cream of wheat, or assorted cold cereals, fruit yogurt, morning glory muffin or toast. Residents were served cereal, ½ muffin and a piece of toast and jam. Yogurt listed on the planned menu was not offered to residents. Residents on renal diet were not offered scrambled eggs as per planned breakfast menu.

Interview with the dietary staff confirmed that the scrambled eggs were not prepared and offered to residents.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information