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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 16, 2015	2015_413500_0009	T-1771-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WESTSIDE
1145 Albion Road Rexdale ON M9V 4J7

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

NITAL SHETH (500), NICOLE RANGER (189), SARAN DANIEL-DODD (116), SHIHANA RUMZI (604)

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): June 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, and 26, 2015.

The following complaint inspection intakes were inspected during this RQI: T-951-14, T-1593-14, and T-2104-15.
The following critical incident intakes were inspected during this RQI: T-952-14, T-1474-14, T-1891-15, T-1979-15, T-2398-15, T-2601-15.
The following follow-up order intake was inspected during this RQI: T-1500-14.

During the course of the inspection, the inspector(s) spoke with executive director (ED), director of care (DOC), assistant director of care (ADOC), nurse manager, program manager, food service manager (FSM), registered dietitian (RD), environmental service manager (ESM), resident services coordinator (RSC), RAI coordinator, staff educator, scheduler, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), cook, housekeeper, maintenance staff, residents and family members.

During the course of the inspection the inspector(s) conducted tour of the home, observations of the meal service, residents' and home area, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_378116_0008	116

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be protected from abuse.

During a family interview resident #018's power of attorney (POA) for care informed the inspector of two incidents of alleged abuse between PSW #162 and resident #018. Resident #018 described feeling rushed by PSW #162 during bathing. On a separate occasion, PSW #162 found resident #018 with his/her legs hanging out of the bed, got upset and told the resident to stay in bed, while flinging the resident's legs back into bed.

The PSW had used a loud tone and left the room.

During a review of the home's Customer Service Response (CSR) binder for 2014, the inspector found a CSR which was created on by the home's DOC. The complaint was brought to the DOC by the POA for care related to resident #018's interactions with homes staff member.

Interview with the POA for care of resident #018 identified the resident is not able to remember the incident and it was the resident's roommate who would keep the POA for care informed of incidents which occurred with the resident. Since the roommate has left the home, the POA for care was concerned for resident #018's safety, POA for care visits resident each day.

PSW #162 involved in the incident was terminated shortly after the incident due to a similar incident.

Interview with the DOC confirmed the above mentioned two incidents of abuse had occurred. [s. 3. (1) 2.]

2. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Observation on an identified day revealed resident #005's washroom door was opened one quarter wide and the resident was sitting on the toilet.

Interview with PSW #113 indicated that he/she left that door open a little bit, because the resident may not call the staff for assistance and might attempt to stand up by him/herself. PSW #113 indicated he/she left the door opened only a little bit but the door slid back by itself and remained one quarter wide open and confirmed that the resident's privacy was not maintained.

Interview with the registered staff #114 and ADOC #116 confirmed the resident's privacy was not maintained and ensured to communicate it with the maintenance to fix the washroom door. [s. 3. (1) 8.]

3. On June 8, 2015, at 10:05 p.m., the inspector was outside the hallway on an identified home area and observed the spa room door wide open and a shower in progress with a

resident inside. The inspector spoke with RPN #157 who informed that PSW #149 was providing resident #024 a shower and stated that the shower door is open because the shower room is hot when the shower is in use. The inspector approached PSW #149 providing care to the resident about the privacy issues, and PSW #149 confirmed that the bathroom door should have been closed and privacy was not provided to the resident.

An interview with ADOC #116 confirmed that the bathroom door should have been closed and that privacy was not provided to the resident. [s. 3. (1) 8.]

4. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On June 11, 2015, at 9:01 a.m., the inspector observed an unattended medication cart to be stored outside of the dining room during breakfast on an identified home area. The Electronic Medication Administration Record (E-MAR) screen was left open to resident #032's personal medication administration record which was visible to the public.

On June 17, 2015, at 11:35 a.m., the inspector observed an unattended medication cart to be stored outside of an identified resident's room. The E-MAR screen and medication cart was left open and unlocked to resident #033's personal medication administration record which was visible to the public.

RPN #102 confirmed that the medication screen was unlocked and was visible to anyone passing by and did not protect the resident's personal health information.

A review of the home's policy entitled "Medication Administration LTC-F-20" under national operating procedure #18 states: Residents confidential information will be protected during and after medication administration.

An interview with the ADOC #101 confirmed the medication cart and E-MAR screen is to be kept locked at all times when the cart is left unattended. [s. 3. (1) 11. iv.]

5. On June 8, 2015, at 9:45 a.m., on an identified home area, the inspector observed the medication cart parked directly outside a resident's room, left unattended with the Electronic Medication Administration Record (E-MAR) screen resident #025 medication profile. The inspector remained with the medication cart and noted RPN #107 coming out the residents' room.

Inspector spoke with RPN #107 who confirmed the medication cart was left unattended and confidential medication information was visible to anyone passing by. RPN #107 confirmed that E-MAR screens are to be locked as per home's policy when the medication cart is not in use. [s. 3. (1) 11. 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 the following rights of residents are fully respected and promoted:
- every resident has the right to be protected from abuse
- every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs
- every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Observation on June 19, 2015, at 2:00 p.m., revealed a loose TV cable lying in the corner on the floor in resident #046's room and resident #041's floor had hoses on the floor creating safety hazard for the resident and staff.

Interview with the ADOC #116 and environmental service supervisor confirmed that the loose TV cable was a safety hazard for resident #046.

Interview with and identified PSW #137 and ADOC #116 confirmed the hoses on the floor were a safety hazard for resident #041 and staff members.

Interview with the environmental service manager confirmed above mentioned safety hazards for identified residents and staff members.

Observation on June 15, 2015, at 10:09 a.m., revealed approximately a three inch wide gap between resident #005's head board and the mattress. There were no mattress stoppers in placed on the bed. The environmental service manager measured the bed and it was 80 inches in length and the mattress was 78 inches in length.

Observation on June 19, 2015, at 2:00 p.m., revealed that resident # 046's bed had approximately a three inch wide gap between the foot board and the mattress. The mattress had no mattress stoppers and was sliding off of the bed frame. The mattress was visibly shorter than the size of the bed.

Observation conducted on June 19, 2015, at 11:14 a.m., revealed that resident #047's mattress was sliding off of the bed frame and it was not properly fitted into the mattress stoppers.

A review of the home's bed system evaluation completed on April 2015, indicated that resident #005's bed failed in zone 7 and required corner mattress stops at foot end. Resident #046's bed did not pass the zone 7, and indicated to add corner mattress stops at the head and the foot end.

Interview with resident #005 confirmed that the mattress is sliding off from the bed when sleeping on the bed.

Interview with the environmental service manager confirmed that above mentioned mattresses were not safe for residents, as they were sliding off from the bed and ensured to replace them. [s. 5.]

2. Observations on June 8, 12, 15, and 17, 2015, revealed resident #018's bed had no mattress stoppers. The bed had a blue wedge (a pad) between the mattress and the foot board; the mattress was still sliding off and moving with ease.

A review of the home's bed system evaluation completed on April 2015, indicated resident #018's bed failed in zone 7 with a short mattress, no mattress stops, and

identified space between the head or the foot board between the mattress.

A review of the home's policy entitled "Resident Bed System/Entrapment LTC-K-25" indicated national policy #4: When zones of entrapment are identified, there are to be corrected immediately and prior to a Resident using the bed.

Interview with the environmental services manager confirmed the above-mentioned beds were not safe for specified residents.

Interview with the executive director confirmed identified beds being unsafe and indicated to replace them. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to the staff and others who provide direct care to the resident.

Observations on three identified days revealed an identified intervention when resident #004 was lying in bed.

Interviews with PSW #105 and registered staff #130 indicated the identified intervention is required for positioning and preventing resident from a fall.

A review of written plan of care did not indicate the use of an identified intervention for positioning and preventative measure for falls.

Interview with the DOC confirmed the use of an identified intervention for the resident

should have been identified in the resident's plan of care. [s. 6. (1) (c)]

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

Record review of the written plan of care for resident #016 revealed the resident was to be up in the wheelchair on three alternative days at a specified time, to attend activities.

Observations for resident #016 on five identified days revealed the resident was not taken out of bed to attend activity programs as directed in the plan of care.

A review of the activity attendance record did not show resident #016 attending activities, only one-on-one visits were carried out for identified days.

Interviews with PSW #112, RN #104 and ADOC #101 confirmed the resident #016 was not taken out of bed on specified days as directed in the plan of care. [s. 6. (7)]

3. A review of resident #005's plan of care revealed that the resident was at medium risk for falls. Interventions included an identified logo to identify immediate risk of falls, and to keep the bed at the lowest position.

Observations on June 15, 2015, at 12:00 p.m., and 3:40 p.m., indicated that an identified logo was not in place anywhere on the resident's wheel chair or in the resident's room. On the same day at 10:09 a.m., the resident was in his/her bed and the bed was in a high position.

Interview with PSW #113 confirmed that the bed should be always in the low position for him/her to ensure his/her safety.

Interview with the registered staff #114, nurse manager #115, and the DOC confirmed the bed should be always low position for the resident when the resident was in bed and the identified logo should have been in placed in the resident's room to identify immediate risk for the fall. [s. 6. (7)]

4. An interview with resident #040 revealed on an identified night, while the resident was asleep in his/her room, a person the resident could not identify at the time entered the room and administered a needle into resident #040's upper left arm and left the room. Resident #040 indicated the person mumbled something but did not understand what

was being said. The following morning the resident report to RPN #122 that a person had entered his/her room to administer a needle and that this left the resident feeling uncomfortable.

A review of resident #040's plan of care indicates two staff is to go into resident #040's room for care such as medication administration as the resident had become sensitive due to progressing health condition and staff are to explain and demonstrate each activity/care procedure prior to beginning and throughout a procedure to the resident.

An interview with RN #108, indicated resident #040 was approached at 10:00 p.m. in his/her room and informed the resident of an identified injection. RN #108 confirmed he/she administered medication to resident #040 without a second staff present. RN #108 stated the next morning resident #040 had called her POA and stated he/she did not report the incident to the events concerning the administration of the needle the previous evening.

Interviews with RN #108 and DOC confirmed the care set out in the plan of care for medication administration was not followed for resident #040. [s. 6. (7)]

5. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

A review of resident #005's plan of care revealed that the resident is at medium risk for falls and directs the staff to check every hour to ensure safety.

Interview with PSW #113 confirmed that he/she was not aware about hourly safety checks for the resident and indicated the resident did not require any monitoring. He/she stated that he/she kept an eye on the resident.

Interview with registered staff #114 and the DOC confirmed that PSW #113 should have been aware of hourly safety checks as specified in the plan of care. [s. 6. (8)]

6. A review of resident #011's MDS assessment completed on an identified day indicated the resident has impaired vision and does not use visual appliances.

A review of the resident's written plan of care revealed there was no care set out for the resident's impaired vision.

Interview with registered staff #118 indicated that the resident #011 did not have visual appliances, he/she never seen the resident with visual appliances.

Interview with PSW #119 confirmed the resident had two sets of visual appliances, one was broken and family took it home to fix it.

Observation conducted in the resident's room with registered staff #118 and PSW #119 revealed the resident having a visual appliance in his/her room.

Interview with ADOC #116 confirmed all direct care staff should be aware of residents' plan of care. [s. 6. (8)]

7. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary; or care set out in the plan has not been effective.

A review of resident #005's written plan of care indicated the resident was at medium risk for falls and chair/bed alarm is to be in place at all the time.

Interview with PSW #113, registered staff #114, and ADOC #116 confirmed that the alarm had been in place but the resident did not like it and currently the resident was not using a bed/chair alarm. The plan of care had not been revised for the resident not using bed/chair alarm. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the plan of care sets out clear directions to the staff and others who provide direct care to the resident
- the care set out in the plan of care is provided to the resident as specified in the plan
- the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary; or care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas:
- equipped with locks to restrict unsupervised access to those areas by residents, and
- locked when they are not being supervised by staff.

Observations on an identified home area on June 8, 9, 10, and 24th, 2015, revealed the spa room door was not locked. Inspector was able to enter the spa room without the utilization of a code. RN #104 and PSW #129 confirmed the spa door does not lock. The ADOC tested the spa room door and revealed the lock did not work three out of four times. ADOC #101 stated the door will be addressed immediately.

Interview with ADOC #101, and DOC confirmed the doors are to be kept locked unless staff is with the resident and identified the malfunctioning lock is a risk to residents. [s. 9. (1) 2.]

2. On June 8, 2015, at 10:22 a.m., on an identified home area, the inspector observed the housekeeping room to be unlocked. The inspector was able to open the door and observed multiple chemical containers in the room.

Interview with housekeeping staff #124 and registered staff #104 confirmed that the housekeeping door should have been locked and staff proceeded to immediately lock the door [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas:
- equipped with locks to restrict unsupervised access to those areas by residents, and
- locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: 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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Interview with resident #041's family member revealed that the elevator had a problem and usually one of the elevators was out of order once in every two months.

The inspectors observed the east elevator out of order from June 8-June 18, 2015.

Interview with the environmental service manager confirmed the elevator had been broken down since June 8, 2015, and the technicians were searching for a part to fix the elevator. The elevator was fixed on June 19, 2015.

Observation conducted on June 19, 2015, at 2:00 p.m., revealed room #231, #241, #309, #341, and #342 had broken and chipped door frame protectors.

Interview with the environmental service manager confirmed that the above mentioned door frame protectors need to be replaced. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

Observation on June 8, 2015, at 2:23 p.m., on an identified home area, revealed the call bell monitoring system was not functioning properly. When the inspector activated the call bell in an identified resident's room, both at the bed side and in the washroom, the alert was not activated on the call bell system monitor at the nursing station.

Registered staff #107 and ADOC #116 and the environmental service manager confirmed that the monitor was not activated upon activating call bell in an identified resident's room. The call bell monitoring system was repaired by the home on the same day after the home was notified by the inspector. [s. 17. (1) (b)]

2. The licensee has failed to ensure that the resident-staff communication and response system uses sound to alert staff, is it properly calibrated so that the level of sound is audible to staff.

Observations carried out on June 8, 2015, during the initial tour by inspector #189, June 17 and 24, 2015, it was noted when a call bell is activated in the hall on an identified home area the call bells were not audible in the hall unless you are sitting inside the nursing station.

Interviews carried out on June 17, 2015; with the environmental service manager and PSW #129 stated staff are unable to hear the call bell unless the staff were very close to the nursing station.

Observations and interview were carried out with the DOC on June 24, 2015. The DOC confirmed the call bell cannot be heard in the halls and that the call bell can only be heard when inside the nursing station and confirmed the call bell should be heard in the halls. [s. 17. (1) (g)]

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 resident-staff communication and response system uses sound to alert staff, is it properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #7: 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 protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On April, 2015, the licensee submitted a critical incident report to the Director reporting assertions of staff to resident physical and verbal abuse. The CIS indicated that at the commencement of the meal service, PSW #112 was observed to ask resident #052 to go back to his/her room because the resident was on isolation precautions. Resident #052 did not respond to the request. PSW #112 was observed to yell at the resident, pulled the resident's chair from where he/she was seated and forcefully removed the clothes protector and grabbed the resident's right arm.

A review of the home's investigation notes and interviews with resident #052, RPN #130, the DOC and the E.D. confirmed that the alleged verbal and physical abuse were founded. PSW #112 denied the allegations of verbal and physical abuse occurred. As a result of the home's investigation; PSW #112 was disciplined and was provided with retraining on the home's zero tolerance for abuse policy and the Resident Bill of Rights. [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 protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. 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 O. Reg. 79/10, s. 26 (4).
(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 plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: vision.

A review of resident #011's Minimum Data Sheet (MDS) assessment completed on an identified day indicated the resident had impaired vision and did not use visual appliances.

A review of the resident's written plan of care revealed there was no care set out for the resident's impaired vision.

Interview with the resident confirmed that he/she had difficulty in reading and there was a set of visual appliances his/her room. [s. 26. (3) 4.]

2. A review of resident #017's MDS assessment completed on an identified day indicated the resident had moderately impaired vision and did not use visual appliances.

A review of the resident's written plan of care revealed there was no care set out for the resident's impaired vision.

A review of admission progress notes made on an identified day indicated the resident with impaired vision. On a specified day, the resident was referred to the eye specialist.

Interview with the registered #118, the nurse manager #117, and ADOC #116 confirmed that the plan of care should have been based on the resident's visual status and a plan should have been developed for the resident's impaired vision. [s. 26. (3) 4.]

3. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Dental and oral status, including oral hygiene.

During an interview with resident #019, the resident reported that he/she requires assistance with denture care. Interview with PSW #161 and registered staff #143 reported that the resident is able to provide denture care independently with minimal assistance.

A review of the written plan of care failed to indicate dental and oral status, including oral hygiene for resident #019.

Interview with registered staff #143 and nurse manager #117 confirmed that each resident's individualized oral care needs will be documented in their care plan as per the home's policy and that oral care needs should have been identified on the written plan of care. Nurse Manager #117 informed the inspector that oral care was added to the written plan of care on a specified day. [s. 26. (3) 12.]

4. The licensee has failed to ensure that a registered dietitian who is a member of the

staff of the home, assesses the matters referred to in paragraphs 13 and 14 of subsection (3).

A review of resident #009's progress notes indicated a referral was sent to the registered dietitian (RD) for the resident's total fluid average intake 57.1% for six identified days.

A review of the resident's plan of care revealed that there was no assessment completed by the RD for the above mentioned referral for poor fluid intake.

Interview with the RD confirmed that he/she did not assess the resident after he/she received the above mentioned referral. [s. 26. (4) (a),s. 26. (4) (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
- a plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: vision
- the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: . Dental and oral status, including oral hygiene
- a registered dietitian who is a member of the staff of the home, assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

WN #9: 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 the home has a dining and snack service that includes, at a minimum, the following elements: proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Observation conducted on an identified day, in a specified home area, revealed that residents #002 and #014 were assisted for feeding by staff using forks.

Observation conducted by the inspector #604, on a specified day, at lunch time, in third floor dining room revealed one of the PSW feeding resident #002, when the resident was sitting in a tilted wheel chair around at 60 degree and food was coming out of the resident's mouth.

A review of resident #002's written plan of care indicated the resident required total assistance to eat all meals and beverages and the resident required textured modified food to maintain safe chewing and swallowing.

A review of resident #014's written plan of care indicated the resident unable to eat independently and required assistance and to minimize risk for choking and swallowing, a teaspoon should be used to feed the resident.

Interview with the nutrition manager and RD confirmed that the staff should have been used tea spoons instead of forks to feed above mentioned residents. RD confirmed that resident #002 should have been positioned at 90 degree at meals. [s. 73. (1) 10.]

2. The licensee has failed to ensure that 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.

Observation on an identified day, on an identified home area, revealed resident #044 served a pureed dessert on table without feeding assistant available. The inspector did not see the resident eating dessert.

A review of the resident's written plan of care indicated the resident is unable to eat independently and required feeding assistance.

Interview with the nutrition manager and registered dietitian confirmed that the resident should not have served dessert without feeding assistance available. [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 the home has a dining and snack service that includes, at a minimum, the following elements: proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #10: 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:

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).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council, if any, in developing and carrying out the survey, and in acting on its results.

Interview with assistant of the Residents' Council #160 and the ED confirmed that the home did not ask for Residents' Council's input in developing and carrying out the satisfaction survey, and in acting on its results in 2014. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure to seek the advice of the Residents' Council, if any, in developing and carrying out the survey, and in acting on its results, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 129 (1).
(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 has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On June 12, 2015, inspector carried out medication cart observation on an identified home area.
The following items were found in the medication cart:
Non-Drug related items:
-Medium sized black purse
-Black watch
-Arrid Deodorant

RPN #102 confirmed the above findings and placed all items in a white basket. RPN #102 confirmed the medium black purse was his/her personal item.

The DOC confirmed the above findings above and only medication related items are to be stored in the medication cart at all time. The DOC removed the purse from the cart and followed up with the RPN #102. [s. 129. (1) (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 drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #12: 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 has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On June 11, 2015 at 09:05 a.m. and June 22, 2015 at 09:45 a.m., the inspector had noted the medication room on an identified home area to be left open with a housekeeping staff cleaning the medication room with no registered staff present.

Interview with housekeeping staff #103 and #124 confirmed that registered staff #122 and registered staff #123 gave medication room keys to housekeeping staff to gain access and the keys were returned to the registered staff once the door to the medication room was unlocked. Housekeeping staff #103 and #124 stated to the inspector it was normal for registered staff to give housekeeping staff keys to the medication room in order to have the room cleaned and normally no registered staff are present in the medication room.

On both occasions, the medication room was unlocked by housekeeping staff, the inspector observed medication storage cupboards over the counter to be open and accessible to staff.

Registered staff #122 and #123 confirmed they had given the medication room keys along with keys for the medication cart and narcotic storage area to housekeeping staff #103 and #124 to gain access to the medication room. They also confirmed the housekeeping staff are not monitored during the cleaning of the medication room.

A review of the home's policy set out by Classic Care Pharmacy, policy #4.8, entitled "Safe Storage of Medication", the policy states: At all times, keys to access medication storage areas must be in the possession of a person with authority to dispense, prescribe, or administer drugs in the home or the administrator.

Registered staff #122 and #123 confirmed they were not to give the keys to the medication room to non-registered staff and the housekeeping staff are to be monitored when in the medication room.

ADOC #101 confirmed registered staff are not to provide the housekeeping staff keys to the medication room or medication cart at any time. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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 has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On an identified day, a complaint was received related to resident #040 not receiving a prescribed medication by the physician for two days.

During the telephone interview with the complainant, the complainant stated resident #040 called POA and informed him/her that he/she did not receive his/her identified medication and did not remember for how many days. The complainant informed the DOC of resident #040's concern to the DOC.

An interview with resident #040, revealed the nurse giving him/her the medication stated the identified medication was not sent by the drug store.

A review of the resident #040's Medication Administration Record (MAR) indicated on two identified days the prescribed medication dose was checked off indicating medication was administered by RN #108.

An interview with RN #108 stated he/she signed the MAR on the above mentioned identified days, as administered but did not administer the identified medication to resident #040 due to not having the medication.

Review of the home's investigation file revealed RN #108 during an interview confirmed he/she did not administer the identified medication as prescribed to the resident.

Interview with the DOC confirmed RN #108 did not administer the identified medication as prescribed by the physician to resident #040 [s. 131. (2)]

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

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the falls prevention and management training was provided to all staff that provide direct care to residents.

A review of staff training records revealed that not all direct care staff received falls prevention training in 2014.

During interviews with staff members indicated that they received training in falls prevention and management however, they were not able to confirmed approximate time frame when they received the training.

Interview with the staff educator confirmed that 25.4% of direct care staff did not receive training in falls prevention and management in 2014. [s. 221. (1) 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 for the purposes of paragraph 6 of subsection 76 (7) of the Act, the falls prevention and management training was provided to all staff that provide direct care to residents, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management

An interview with the DOC who is also the home's Infection Prevention and Control Program (IPAC) lead revealed he/she did not have the education required to be the home's infection prevention and control program lead.

An interview held with the home's ED confirmed the infection prevention and control program lead did not possess the following required education and the education needed to be the lead of the infection prevention and control program.
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis

The ED informed the inspector the home will be enrolling the infection prevention lead for the upcoming six month infection prevention education course with Infection Prevention

and Control (IPAC). [s. 229. (3)]

2. The licensee has failed to ensure that all staff participates in the implementation of the program.

Observation conducted on June 8, 2015, at 12:00 p.m., in an identified dining room revealed PSW#135 cleared soiled dishes on the dirty utility cart, and without performing hand hygiene grabbed some wipes from the nursing station and wiped resident's mouth with different wipes and threw them in the garbage and performed hand hygiene with sanitizer at the end.

Interview with PSW #135 confirmed that he/she should have performed hand hygiene before grabbing wipes from the nursing station.

Interview with nurse manager #115 confirmed that PSW #135 should have performed hand hygiene before grabbing wipes from the nursing station. It is an expectation from the staff to perform hand hygiene after clearing soiled dishes and before doing another task. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participates in the implementation of the program, to be implemented voluntarily.

WN #16: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

On June 9, 2015, the inspector noted a half of a white pill at the foot of resident #031's bed. The power of attorney was present at the time.

The inspector took the white pill to the second floor nursing station and approached RN #120 who was informed as to where the half white pill was found.

Review of the medications administered to the residents in room #206, revealed the half of the white pill was to be administered at 8:00 p.m. to resident #031.

The homes policy "Medication Administration LTC-F-20" under procedure #11 states: Medication must be observed for ingestion otherwise it cannot be considered administered.

Interview with RN #120 confirmed the registered staffs are to ensure they watch the resident take the medication when administered.

ADOC #101 confirmed the medication belonged to resident #031 and it was the previous day's 8:00 p.m., dose, which was not administered.

On June 17, 2015 at 3:05 p.m., the inspector was on an identified home area at the nursing station when inspector observed evening RN #110 carrying out the narcotic count outside the nursing station on her own.

Inspector approached the RN #110 once he/she had begun to put her narcotics in to the medication cart bin, when asked RN #110 what he/she was doing, the RN stated he/she carried out the narcotic count. The inspector asked if he/she carried out the narcotic count on her own and RN #120 confirmed narcotic count was done alone. RN #110 stated days RN #104 had counted and signed the narcotics already.

The inspector spoke to day RN #104 who stated he/she was in a rush and counted the narcotics on him/her own prior to the evening RN coming in.

When inspector asked both RNs what the home's policy was related to carrying out the narcotic counts the RN's both stated the narcotic count is to be carried out by two nurses together.

The home's policy "Management of Narcotic and Controlled Drugs/Benzodiazepins - Ontario, LTC-F-80-ON" under Drug Counts #15 states: Two Nurses will count the narcotic and controlled drugs as per National policy.

Interview carried out with the DOC confirmed the two RN staff were not following the homes policy as the narcotic count is to be carried out by two nurses. [s. 8. (1) (a)]

WN #17: 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 has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

During stage one family interview POA for care, informed the inspector of an incident, when PSW #162 gave rough care to resident #018 and PSW #162 was angry at the resident, talked to the resident very loud. PSW #162 would rush the resident during bathing.

Interview carried out with the POA in stage two for resident #018 stated the incident was brought to the home's DOC by the POA on the next day of the incident. POA stated it was the first incident occurred with PSW #162.

A review of the home Client Services Response Form (CSR) binder, a CSR completed for resident #018 was found. PSW #162 was loud during providing care to resident #018 in the spa room rushing resident. The home had carried out an internal investigation, PSW #162 was asked to be extra gentle and mindful of his/her tone. PSW #162 involved was disciplined.

Interview carried out with the DOC confirmed the home carried out internal investigation but failed to complete a Critical Incident (CI) report for the incident. [s. 24. (1)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care.

Resident #016 was observed in bed with bilateral half rails in the up position on five identified days.

Resident #016 was un interviewable due to a specified health condition and the inspector was unable to contact POA after several attempts.

A review of the plan of care does not identify the use of half bed rails as a PSAD for turning and repositioning when resident is in bed.

Interviews conducted with PSW #109 and ADOC #101 confirmed the resident's bed rails are in the up position and are being used to assist the resident in for turning and repositioning when in bed.

DOC stated if a resident is utilizing bedrails as a PSAD the plan of care is to have the information. [s. 33. (3)]

WN #19: 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,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system, at a minimum, provide for, standardized recipes for all menus.

Observation conducted on June 8, 2015, at 12:00 p.m., on an identified dining room revealed residents were served split pea soup that was noted to be thin in consistency. The inspector did not observed residents complaining about thin consistency of the soup.

A review of a standardized recipe for split pea soup indicated to use spilt peas dry and to prepare it from scratch.

Interview with cook #133 confirmed that she prepared readymade (instant) split peas soup from Knorr, heated and served to residents. He/she did not have a standardized recipe to prepare readymade (instant) split pea soup.

Interview with registered dietitian (RD) confirmed that the kitchen should have standardized recipe for readymade (instant) split peas soup.

Interview with the nutrition manager confirmed that he/she did not have a standardized recipe for readymade (instant) split peas soup. The home had some instant readymade soup available in the kitchen therefore they used it [s. 72. (2) (c)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): a breakdown of major equipment or a system in the home.

Observation conducted by inspectors in the home revealed that from June 8 to June 12, 2015, one of the elevators was out of service with a caution sign posted on it.

Interview with the environmental service manager confirmed that the elevator had broken down. It required one of the parts to be replaced however; there was another elevator for residents, staff and people to use. The home did not submit critical incident report for elevator being broken down because they were not aware that the home needed to inform to the director.

Interview with the executive director confirmed that the home did not submit critical incident report to inform the director about elevator broken as they were not aware that it was reportable and ensured to submit the critical incident report.

A review of critical incident (CI) report revealed that the home first submitted CI report for elevator being out of service for five days on June 12, 2015, at 2:27 p.m. after the inspector notified the home. [s. 107. (3) 2.]

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

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Issued on this 30th day of November, 2015

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

Original report signed by the inspector.