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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2015	2014_168202_0027	T-117-14	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

THE WILLOWS ESTATE NURSING HOME
13837 YONGE STREET AURORA ON L4G 3G8

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

VALERIE JOHNSTON (202), JUDITH HART (513), SLAVICA VUCKO (210), SUSAN SEMEREDY (501)

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): November 28, December 01, 02, 03, 04, 05, 08, 09, 10, 11, 12, 2014.

The following Critical Incident Inspection was completed during this inspection: T-583-14.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), life enrichment coordinator (LEC), environmental services manager (ESM), registered dietitian (RD), rai-coordinator, nutritional care manager (NCM), cook, pharmacist, registered nursing staff, personal support workers, dietary aides, housekeeping staff, activation aides, president of Residents' Council, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
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
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

21 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident right not to be neglected by the licensee or staff is fully respected and promoted.

On November 28, 2014, during the first meal of an unannounced visit, the inspector observed resident #30 receive a main course pureed meal at 12:20 p.m. The resident was sitting in a Broda wheelchair, slightly inclined and placed in an angled position to the table. An identified RPN placed the resident's meal on the resident's chest, provided him/her with a spoon and proceeded to feed another resident at a different table. The inspector observed the resident use his/her right hand to feed him/herself. The resident was able to eat two spoons of the main course meal from the sectional plate on his/her chest. On the third spoonful, the plate of food slid off his/her chest and onto the floor. The RPN saw that the resident's plate fell to the floor, got up from his/her table, picked up the resident's plate, covered the food with a clothing protector and proceed back to his/her table. The RPN did not acknowledge or offer the resident a replacement meal. Resident #30's table mate continued to eat his/her main course lunch meal as he/she sat idle.
At 12:45 p.m., the RPN approached resident #30 and offered him/her dessert. The resident ate the dessert and remaining fluid that he/she had. An interview with the RPN confirmed that he/she did not acknowledge or offer the resident a replacement main course meal after his/her meal fell to the floor because there was no more pureed food in the servery left to offer. The RPN indicated that the resident would be fine because he/she ate a good breakfast, had fluids with dessert at lunch, and would be eating dinner later.
An interview with the NCM indicated that the home did not run out of pureed foods at lunch. The NCM indicated that he/she had heard resident #30's plate fall to the floor, however, he/she did not assist or offer the resident another meal as he/she was feeding another resident at the time. The NCM indicated that the resident would not be hungry as

he/she had dessert and fluids at lunch and would receive a snack at 2:00 p.m.

Resident # 32's plan of care identified the resident with a significant weight loss of seven percent noted for an identified month. The resident's plan of care directs staff to provide total assistance for eating as the resident has limited mobility on both upper extremities. On December 01, 2014 at 5:10 p.m., the inspector observed the dietary staff to place a dinner meal in front of resident #32, with no staff present. At 5:25 p.m, the resident was observed to reach for his/her juice slowly and uncontrolled, his/her left hand appeared to be contracted with minimal mobility. The resident held the upper portion of the cup, unable to fully grasp the cup, spilling the entire cup of juice on his/her plate of food. At 5:55 p.m, an identified PSW walked past the resident and indicated that the resident had spilled his/her juice and not been provided assistance at dinner. The PSW then stood beside the resident, scooped a spoon of the resident's food mixed with the juice from his/her plate and offered it to the resident. As the food touched the resident's mouth, the resident refused, shaking his/her head. The PSW then tried to feed the resident again with another spoonful of food for which he/she declined. The PSW then realized an inspector had observed the feeding assistance offered to the resident and indicated that he/she would provide the resident with a new warm plate of food. The PSW then went into the kitchen and left the dining room.
At 6:05 p.m., the inspector observed the cook to come out of the kitchen with a plate of food, questioned who the food was for, assuming it was for resident #32, he/she placed the meal on the table in front of the resident. A PSW then pushed a stool over to the resident and assisted him/her with the meal. No further fluids were offered.

An interview with an identified PSW indicated that he/she had concerns for residents in the dining room. The PSW indicated that the meal services in the dining room are disorganized and not well managed. The PSW indicated that the dietary aides are responsible to distribute the meals to residents in the dining room. The PSW indicated that there is not always staff available to feed, and that there are no set tables or residents assigned to staff. The PSW indicated that it is not uncommon for residents to not receive assistance from staff in the dining room and that some residents are not always provided meals.

Additional Required Actions:

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

WN #2: 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).

Findings/Faits saillants :

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

Record review revealed that resident #9's plan of care in the eating section directs staff to provide a regular textured diet and to cut up food. In the nutritional section of the plan of care there is direction to provide resident #9 with a pureed textured diet. Interview with an identified PSW revealed he/she was unaware of resident #9's diet texture. Interview with the RD confirmed that the plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

The written plan of care for resident #33, directs staff to provide one person assistance and to constantly encourage him/her to eat because he/she forgets and will eat using one finger to scoop his/her food. An interview with the RD indicated that resident #33 needs total staff assistance with feeding, as the resident will forget to use utensils and eats only with his/her one finger and therefore, does not receive adequate intake of his/her meals. On December 01, 2014 at 5:10 p.m., the inspector observed resident #33 receive his/her dinner meal. The meal was placed in front of him/her with no staff assistance and the resident was observed eating his/her meal by scooping the food with

one finger. At 5:50 p.m., the resident had eaten only 25 percent of his/her meal, confirmed by a PSW. The PSW indicated that the resident does not receive assistance with her dinner meal because he/she prefers to eat with his/her fingers. [s. 6. (7)]

3. On December 8, 2014, the inspector observed resident #51 coughing while eating regular textured soup during the lunch meal. Record review revealed that resident #51 is to receive a minced textured diet and according to the home's menu residents on a minced diet should receive a pureed textured soup. Shortly after the resident was observed coughing, the cook changed his/her soup to a pureed version. Interview with the cook confirmed he/she had given resident #51 the wrong soup at first. [s. 6. (7)]

4. On December 9, 2014, the inspector observed that resident #9 was not served ground flax or protein powder in his/her cereal at breakfast nor was he/she served prune juice. Record review revealed that the plan of care for resident #9 indicated that he/she is at risk for constipation and requires ground flax in his/her cereal and prune juice at breakfast and is at risk for skin breakdown and requires protein powder in his/her cereal and soup daily. Interview with the dietary aide serving the cereal revealed he/she did not think any resident in this dining room received protein powder in their cereal and he/she does not add flax to the cereal because residents do not like it and will not eat it. Interview with the NCM confirmed that resident #9 should have been served flax and protein powder in his/her cereal and prune juice to drink. [s. 6. (7)]

5. On October 8, 2014, the inspector observed resident #11 served a regular salad on his/her lunch tray. Record review revealed that resident #11 is on a total minced textured diet. Interview with the registered staff confirmed the resident had been served a regular salad and was on a minced textured diet. Interview with the nutritional care manager confirmed resident #11 should have been served a minced textured salad.

On October 8, 2014, the inspector observed resident #11 to be lying in bed after lunch with snacks on his/her bed table and no fluids in sight. The resident stated he/she was not hungry but would like a glass of water. Record review revealed that resident has a history of dehydration and is to have 250 millilitres of water left at his/her bedside. Interview with an identified PSW revealed that he/she was not aware of resident #11's plan of care to have water at his/her bedside but would offer him/her some.

On October 9, 2014, the inspector observed resident #11 to have two glasses of juice on his/her lunch tray but did not have any milk. Record review revealed that resident #11 has a diagnosis of osteoporosis and a previous hip fracture and is to receive 250

millilitres of milk at meals to ensure he/she receives calcium. Record review and interview with the resident confirmed he/she likes milk. Interview with the RD confirmed resident #11 should have received 250 millilitres of milk at lunch as per the plan of care. [s. 6. (7)]

6. The written plan of care for resident #32, directs staff to provide total assistance with eating and that he/she is unable to feed him/herself due to weakness, decreased cognition and limited mobility in both arms. A review of the resident's clinical records indicated that he/she had a seven percent weight loss for an identified month. On December 01, 2014 at 5:10 p.m., the resident was observed to receive a dinner meal. The dietary aide placed the meal in front of the resident beside his/her glass of juice. At 5:25 p.m., the resident was observed to reach out slowly with his/her contracted hand, grasp the top of the cup of juice and spilling the juice over onto his/her plate of food. At 5:55 p.m., an identified PSW walked past the resident, indicated that the resident had spilled his/her juice on his/her food and that staff had forgotten to provide the resident with assistance. The PSW indicated that the resident requires total assistance with feeding and would not be able to feed him/herself. [s. 6. (7)]

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

WN #3: 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 the policy Infection Control, Methicillin Resistant Staphiloccocus Aureus (MRSA) is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Review of the policy Infection Control, MRSA, number IF-8.2, dated February 2014, states that contact precautions should not be discontinued until two sets of negative screens are obtained one week apart at site specific areas, taken one week apart. Should the resident become positive again after negative cultures are obtained, precautions shall again be implemented.

The policy is not in accordance with all applicable requirements under the Act, the Provincial Infectious Diseases Advisory Committee (PIDAC) guideline for discontinuing precautions. This states: If an individual has undergone decolonization therapy for MRSA, this may affect the duration of Contact Precautions. In the event that three sets of specimens for MRSA have been taken at least one week apart and have been found to be negative, the ICP (or their delegate) may discontinue Contact Precautions. When decolonization is not attempted, the majority of people remain colonized with MRSA for weeks to months, and should remain on Contact Precautions.
In long-term care:
If Contact Precautions have been discontinued, monthly screening for six months is recommended following eradication of MRSA, since re-colonization can occur.

Review of the clinical record indicated resident #41 was colonized with MRSA on an identified date, was treated for it and had three consecutive negative results. Interview with registered nursing staff confirmed that the contact precautions were discontinued since the third negative result and no other tests were performed. [s. 8. (1)]

2. The licensee failed to ensure that the policy Pressure Ulcer and Wound Management is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Review of the policy, "Pressure Ulcer and Wound Management", from January 2012, states the following procedures for Stage 1 pressure ulcer:
The interdisciplinary team will: report changes in skin condition, assess skin condition and check that Braden Scale is current with appropriate interventions to reduce identified risk factors, establish turning schedule by repositioning resident at small increments to relieve pressure. Less than 90 degrees reposition is effective. Maximize movement and mobility to relieve pressure from boney prominences. Sitting time may require reduction if buttocks, sacrum,or ischial areas are involved. Assess seating devices for correct use and ability to decrease pressure. Transfer and position correctly to prevent shearing and friction. Monitor nutritional intake for adequate protein and hydration of 1500 millilitres of fluids/24 hours. Manage moisture. Encourage involvement in social programs. Ensure that the resident and /or Substitute Decision Maker (SDM) is informed of plan of care. Evaluate and document preventative interventions, resident outcomes and update care plan.

The policy "Pressure Ulcer and Wound management is not in compliance with the O. Reg. 79/10, s. 50 (2) b. iii, skin and wound care, that states: every licensee of a long-term care home shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented. [s. 8. (1) (a)]

3. The licensee has failed to ensure that the home's Interventions to Prevent and Manage Constipation policy, dated January 2012, is complied with.

On an identified date during the two week inspection, prior to lunch, resident #11 was observed to be lying in his/her bed and crying out in pain. The resident indicated to the inspector that he/she was in extreme pain and wanted staff assistance. Two PSW's entered the room and indicated that the resident was constipated, had received an enema earlier that day and was to be placed on the toilet. The written plan of care for resident #11 identified that he/she has difficulty moving his/her bowels and that staff are to provide a bowel improvement routine and protocol. The bowel protocol identified in the above mentioned policy, directs staff to provide bowel interventions on the identified days

of no recorded bowel movements. Day two, staff are to provide high fiber prune juice 125ml three times per day, day three staff are to encourage fresh fruit and 30 milliliters of milk of magnesia, day four staff are to provide a glycerin suppository and on day five, staff are to provide a fleet enema.
A review of the resident's clinical records for an identified month, indicated that the resident had four bowel movements during that time.
The first identified date, the resident received an enema, with results;
The second identified date, the resident received an enema with results and no other interventions identified for the proceeding five days;
The third identified date, the resident received an enema with results with no other interventions identified for the proceeding six days;
The fourth identified date, the resident received 30 milliliters of milk of magnesia and 125 ml of prune juice at 12:00 p.m., with no results;
On the identified date during the two week inspection, the resident received 30 milliliters of milk of magnesia and an enema at noon with results, of no previous bowel movement recorded in eleven days.

An interview with a registered nurse indicated that the resident is chronically constipated because he/she does not consume enough foods and fluids. The registered nurse indicated that resident #11 is high risk for constipation and that he/she is to be monitored for bowel elimination daily and the interventions provided as directed in the home's bowel protocol. The RN confirmed resident #11's elimination patterns above and that the bowel protocol interventions had not been used for this resident as in accordance with the home's Interventions to Prevent and Manage Constipation policy. [s. 8. (1) (b)]

4. The licensee failed to ensure that the home's Medication Disposal policy #5.8, dated October 2010, is complied with.

On December 5, 2014, the second floor medication room was observed to have four unopened bottles of APO acetaminophen 500 mg, DIN 45007, expiry date of September 2014, in the government stock cabinet.

The medication disposal policy directs the home to routinely inspect all medication storage areas, monthly, for the ongoing identification, destruction and disposal of expired drugs.

Interview with the charge nurse confirmed that the above mentioned medications had expired September 2014, and should not have been in the cabinet. Interview with the

DOC confirmed that monthly audits are completed and these drugs should have been removed from circulation. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Interventions to Prevent and Manage Constipation policy, dated January 2012, and the Medication Disposal policy #5.8, dated October 2010, is complied with and that the policy Infection Control, Methicillin Resistant Staphiloccocus Aureus (MRSA) and the policy Pressure Ulcer and Wound Management is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #4: 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 equipment is kept clean and sanitary.

On December 3, 2014, the following raised toilets in rooms #109, #110 and #123 were observed to be soiled.

An interview with the charge nurse and environmental services manager confirmed that the raised toilets seats in the above rooms were soiled. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the equipment is maintained in a safe condition and in a good state of repair.

On December 3, 2014, the following raised toilet seats in rooms #102, #121, #123 and #224 were observed to be loose and resting on the toilet. The raised toilet seat for the shared bathroom for #109 and #110 was loose and the clamp used to tighten the toilet seat was broken.

An interview with the charge nurse and ESM confirmed that the raised toilets seats in the above rooms were loose and posed a safety risk for residents when using the toilet. The ESM tightened the clamp for room #123. The ESM indicated that new raised toilet seats with tightening clamps and arm rests would be ordered and installed immediately.

On December 3, 2014, the following arm rests attached to the raised toilet seats in rooms #102, #109, #110, and #121 were observed to be torn. Interview with the charge nurse confirmed that the raised toilet seat arm rests were not maintained in good repair. [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 equipment is kept clean and sanitary and that the equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the hydration program includes the identification of any risks related to hydration as there is no clear direction to identify when a resident has not been consuming enough fluids.

On November 28, 2014, inspector #513 observed that resident #9 had dry lips and tongue. Record review revealed that resident #9 should be provided 1500 millilitres of fluid per day as per meal and snack plan. Review of the daily food and fluid intake for resident #9 revealed that from an identified two week period, resident #9's average fluid consumption was 920 millilitres. Interviews with registered staff and RD revealed that daily tallies of fluid consumption should be made by the nursing staff but that it is not the current practice. The RD revealed she does not get referrals for decreased fluid intake and has not recently assessed resident #09's hydration status [s. 68. (2) (b)]

2. On November 28, 2014, inspector #513 observed resident #11 to have a dry tongue and requested water when asked. On December 8, 2014, resident also requested water from inspector #501.
Record review revealed that resident #11 was sent to hospital on an identified date, for dehydration and the plan of care directs staff to provide a minimum of 1500 millilitres fluid per day as per meal and snack plan. Review of the daily food and fluid intake for resident #11 revealed that for an identified ten day period, resident #11's average daily fluid consumption was 940 millilitres. Interviews with registered staff and RD revealed that daily tallies of fluid consumption should be made by the nursing staff but that it is not the current practice. The RD revealed he/she does not get referrals for decreased fluid intake and has not recently assessed resident #11's hydration status.

Review of the home's policy #NC.1.6 titled Dietitian Referral indicates that one of the criteria for dietitian referral is a concern with intake – a sudden change in food and fluid intake. The referral form has a check box for leaving 25% or more of fluid for two of the three meals over a period of seven days. Another policy or guideline titled Hydration indicates that residents who have a fluid intake of less than 1200 millilitres in 24 hours over past 7 days should be observed carefully for weight loss and poor nutrition. Interviews with registered staff, the RD and the clinical care and RAI coordinator confirmed that the home should be identifying those whose intake is less than 1500 millilitres per day and that the home could do a better job at identifying those at risk for dehydration. Interview with the DOC confirmed that fluid intake is not considered in the identification of risk related to hydration because there is no current practice that captures all fluids the residents are consuming. [s. 68. (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 hydration program includes the identification of any risks related to hydration to identify when a resident has not been consuming enough fluids, to be implemented voluntarily.

WN #6: 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).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are standardized recipes for all menus.

On October 8, 2014, the inspector observed during the lunch meal that the puree bread pudding was very stiff with a glue-like consistency. Interview with the NCM confirmed that this was not an appropriate texture to offer those residents on a puree textured diet. Record review revealed that there was no standardized recipe for this menu item. During the same meal, the inspector observed regular pineapple being served as a dessert option, however, the menu stated "blushing pineapple" was to be served. Interview with the NCM confirmed that red jelly powder is usually added to the pineapples to give it a "blushing" colour. Record review revealed there was no standardized recipe for this menu item. [s. 72. (2) (c)]

2. The licensee has failed to ensure that all menu items are prepared according to the planned menu.

On October 8, 2014, the inspector observed during the lunch meal that pureed salad was prepared instead of pureed cauliflower as per the pureed menu. During the same meal, mashed potatoes were prepared but no puree bread as per the pureed menu. Interview with the cook revealed many residents prefer mashed potatoes so the home makes mashed potatoes instead of puree bread. Interview with the RD confirmed that puree bread should be prepared as per the menu and those who prefer mashed potatoes should have this as part of their plan of care.

On October 9, 2014, the inspector observed during the breakfast meal that raisin toast was not prepared for the Sunshine Dining Room residents as per the menu. Interview with the cook revealed that no residents asked for raisin toast so it was not made. Interview with staff serving in the dining room revealed they did not offer or suggest that raisin toast was available. Interview with the NCM confirmed raisin toast should have been prepared, offered and available to residents in the Sunshine Dining Room. [s. 72. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are standardized recipes for all menus and that all menu items are prepared according to the planned menu, to be implemented voluntarily.

WN #7: 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 can be easily seen, accessed and used by residents, staff and visitors at all times.

On an identified date during the two week inspection, resident #11 was observed to be lying in his/her bed calling out in pain. The resident's call bell cord was positioned behind the head of the bed and wrapped around the bottom of the raised side rail. The resident appeared to be in distress and indicated to the inspector that he/she needed staff assistance and was unable to reach the call bell. An identified PSW entered the room and confirmed that the resident's call bell was in a position that the resident was unable to access. [s. 17. (1) (a)]

2. Observation performed on December 5, 2014, at 3:15 p.m. indicated the call bell for resident #14 was not at reach of the resident while he/she was in bed. The resident was observed lying in bed on his/her left side and the call bell cord was attached to the bed frame on the right side.
Interview with an identified PSW indicated the resident is not able to turn on the right side in order to reach the call bell that was attached to the bed frame. The identified staff indicated that the call bell cord was short for some period of time and confirmed that it was not attached on the left side of the bed for the resident to be able to activate it because of the length. The process is whenever the call bell cord is short or needs to be replaced staff to put a request in the maintenance book that was located at the nursing station.
Interview with the environmental services manager confirmed that it is responsibility of everybody in the home to report any malfunctioning or none accessible call bells for maintenance to fix.

Observation on December 8, 2014, at 11:00 a.m. and interview with environmental services supervisor confirmed the call bell cord for resident #14 was extended with an additional piece of cord. [s. 17. (1) (a)]

WN #8: 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 are protected from abuse by anyone.

Review of the clinical record indicated on an identified date, resident #10 was physically abused by an identified staff.
Review of the written plan of care for the resident indicated the resident had responsive behaviors. Resident is agitated if toileting demands are not met immediately. Two staff to assist with toileting with the mechanical lift using the hygiene sling. He/she is verbally abusive, using profanity towards staff and residents. Staff has to approach the resident using calm, non-threatening manner and remind him/her that inappropriate language is unacceptable. Staff caring for him/her should maintain a calm, soothing manner and ensure that his/her needs would be met, and ask for permission before providing any care. Staff to assess his/her ability to understand or control his/her behavior. If he/she is verbally abusive during care, staff to ensure safety and leave, to re-approach in 10 minutes. The resident is physically abusive, he/she is known to strike out at staff when agitated. The interventions recommended are: staff to always approach the resident from front, unexpected attention triggers behavior. Staff to encourage him/her to verbalize his/her feelings rather than striking out. If the resident is agitated when approached for care, staff to leave and re-approach after 10 minutes.

Interview with two identified staff indicated on an identified date, the resident was assisted with toileting and while being with one staff and the other staff approached to help, the resident tried to reach the second staff. The first staff tried to prevent the resident from striking the staff, grabbed the hand and held it. The resident sustained several bruises on the left hand. The police were notified and internal investigation was performed.

The resident was not protected from physical abuse from staff when he/she was assisted with toileting according to the plan of care. [s. 19. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the policy "Zero Tolerance of Abuse and Neglect of Residents", contains an explanation of the duty under section 24 to make mandatory reports.

Review of the Zero Tolerance of Abuse and Neglect of Residents policy, dated September 2013, states: any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Home's Administrator or appropriate designate. Each incidence of neglect or abuse shall be considered and reported as a critical incident and, as such, shall be reported to the Director of Operations and the Ministry of Health and Long Term Care (MOHLTC) by telephone and computerized submission of a Mandatory Critical Incident System (MCIS)

form.

Observation of the home's environment indicated the MOHLTC info line is posted on the main floor, in the hallway, on the wall besides the windows, leading to the second dining room.

Interview with two identified staff indicated staff are aware that they have to report alleged or suspected abuse to the registered nursing staff and management, and to MOHLTC if needed, but they were not aware where to find the contact information/info line from MOHLTC in order to report alleged or suspected abuse. When the identified staff asked the inspector to get the contact information from MOHLTC to report alleged or suspected abuse, the inspector pointed towards the MOHLTC board with the information that was available for everybody.

An interview with the DOC confirmed that the above mentioned policy does not contain an explanation of the duty under section 24 to make mandatory reports. A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).)
to make mandatory reports. [s. 20. (2) (d)]

WN #10: 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:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's vision.

Review of the clinical record for resident #6 indicated the resident was admitted several years ago, and had normal vision until the last year, when it became impaired and the resident did not use any visual appliances for correction.

Review of the written plan of care indicated interventions for impaired vision such as: staff to announce self when approaching the resident, furniture in the room to be maintained in the same position at all times, and staff to use touch to assist with communication.

Interview with registered nursing staff and review of the clinical record indicated once the resident started having impaired vision he/she was not referred to an eye specialist in order to have the vision assessed. [s. 26. (3) 4.]

2. The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

Review of the clinical record and interview with the registered nursing staff indicated resident #14 was found with altered skin integrity on an identified date. The area of skin deteriorated by an identified date. The resident was up in wheelchair for lunch and dinner.
According to the policy "Preventative skin care" the interdisciplinary team will develop

and implement an interdisciplinary plan of care, to encourage resident participation in range of motion exercises, seating and positioning program, and for residents in bed or chair to be referred to Occupational therapist (OT) or Physiotherapist (PT) for seating assessment and seating devices for special needs.

Review of the clinical record and interview with registered nursing staff confirmed resident #14 was not referred to OT or PT for an interdisciplinary assessment with respect to the resident's skin condition. [s. 26. (3) 15.]

3. Review of the clinical record and interview with the registered nursing staff indicated resident #14 had altered skin integrity on an identified date. The area of skin identified deteriorated by an identified date.

According to the policy, "Pressure Ulcer and Wound Management" the resident with a Stage 2 pressure ulcer should be referred to a Wound and Skin Specialist if the ulcer deteriorates or new areas develop and implement recommendations, to consult Physician or Enterostomal Therapist for review of treatment plan if the size of the wound has not decreased by 20-30% in three to four weeks of initiating the treatment.

Review of the clinical record and interview with registered nursing staff confirmed resident #14 was not referred to a Wound Care Specialist or Enterostomal Therapist when the resident's skin condition had deteriorated. [s. 26. (3) 15.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Review of the clinical record and interview with registered nursing staff indicated resident #14 was found with altered skin integrity on an identified date. A referral to registered dietitian (RD) to assess the nutrition and hydration status in regards to the resident's skin was not sent until one month later, when appropriate changes to the plan of care related to nutrition and hydration had been implemented.

Review of the clinical record, interview with registered nursing staff and RD confirmed when the resident was found with altered skin integrity, a referral to RD was not sent for one month for nutrition and hydration assessment. [s. 50. (2) (b) (iii)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

An interview with the Residents' Council assistant indicated that concerns raised at Residents' Council are forwarded to the administrator, and she receives the response in writing within 10 days of the concern. The Residents' Council assistant indicated, however, that the written response is only shared with the Residents' Council at the next monthly meeting and not within 10 days. [s. 57. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that if there is no Family Council, the licensee shall, (a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and (b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

An interview with the LEC indicated that the home does not have a Family Council established in the home and confirmed that the home does not convene semi-annual meetings to advise such persons of the right to establish a Family Council. [s. 59. (7) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized menu is developed for the resident if their needs cannot be met through the home's menu cycle.

Resident #09's plan of care identified the resident at medium nutritional risk and directs staff to provide additional monitoring of his/her food and fluid intake due to his/her dislike of Canadian food. Staff and clinical record review indicated that the resident has a cultural preference and dislikes Canadian food. Staff interviews indicated that the resident will eat a large breakfast and less than 25 percent of his/her lunch and dinner meal, unless the resident's POA brings in home-made cultural foods that he/she likes. An interview with the resident's POA indicated that he/has been bringing in home-made cultural foods for the resident since his/her admission several years ago. The POA indicated that he/she would bring in home-made cultural foods for the week, made available for staff to provide and were to be stored in the fridge for when he/she was not in the home. The POA indicated, that he/she has stopped preparing and storing foods for the resident because the food would be left in the fridge and not always given to the resident at meals. The POA indicated that he/she now brings home-made cultural foods for the resident four to five times per week and will feed them to the resident when he/she comes to the home.
An interview with the RD indicated that resident #09 prefers a cultural food and does not like the Canadian foods served on the menu. The RD indicated that the resident has maintained optimal weight and is offered sweets which is one of his/her preferences. The RD indicated that the resident eats the foods brought in and made by his/her POA several times per week and is supplemented with diabetic boost three times per day at snack and resource 2.0 four times per day at the medication pass. The RD confirmed that the resident does not have an individualized menu developed to meet his/her preference to have cultural foods, as the resident has maintained a stable nutritional status eating foods from the home's standardized menu and foods the POA brings in. [s. 71. (5)]

WN #15: 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. (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 residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance.

On December 01, 2014, during the dinner meal service in the Sunshine dining room the following was observed:

At 5:05 p.m., resident #34 was served his/her dinner meal by a dietary aide and was provided assistance at 5:20 p.m. Resident #34's plan of care directs staff to provide total staff assistance with feeding as he/she would not be able to feed him/herself;
At 5:10 p.m., resident #32 was served his/her dinner meal by a dietary aide and was provided assistance at 5:55 p.m. Resident #32's plan of care directs staff to provide total staff assistance with feeding due to limited mobility and decreased cognition;
At 5:15 p.m. resident #33 was served his/her dinner meal by a dietary aide and was not provided assistance. The resident ate a small portion of his/her meal with his/her finger. Resident #33's plan of care directs staff to provide total assistance during meals as he/she will eat with his/her finger and not consume his/her assessed nutritional requirements.
Staff interviews confirmed that the above mentioned residents were not provided assistance with their meal when served. Staff indicated that the dining room meal services are not organized to ensure that all residents receive a meal and the required assistance once the meal is served to the resident by the dietary aide. [s. 73. (2) (b)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Review of the education records and interview with DOC indicated 28% staff were not provided training in 2013 in the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (4)]

WN #17: 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. (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); 2007, c. 8, s. 85. (4).
(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; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(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 has failed to ensure that the licensee document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Interviews with the LEC and the administrator confirmed that the results of the home's satisfaction survey have not been made available to the Residents' Council. [s. 85. (4) (a)]

WN #18: 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 failed to ensure that drugs are stored in an area or a medication cart, which is used exclusively for drugs and drug-related supplies.

On December 5, 2014, the medication cart on second floor was observed to contain three wrist watches, one necklace, money, and hearing aid batteries.
Interview with the charge nurse confirmed that the above items did not constitute exclusive use of the medication cart for drugs and drug related supplies.

On December 5, 2014, resident #20's bedside nightstand was observed to contain a pump lotion bottle of A535 and a reused prescription bottle containing large white tablets, labeled in handwriting as caltrate plus. Record review indicated these medications were not prescribed to be at the bedside nor to be self-administered.

The charge nurse observed these items at the bedside and on interview confirmed that the medications should not be at the bedside, should be locked in a secure area and removed the medications from the room. [s. 129. (1) (a)]

WN #19: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident who is permitted to administer a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On December 5, 2014, in resident #5's bedroom was observed to contain a partially filled bottle of an over the counter medication on a shelf. The resident confirmed that he/she self-administers the medication at night, when needed, and that the physician or nursing staff of the home were not aware of self use of this medication.

A review of the resident's record revealed that resident self-administration of this drug was not approved by the resident's prescriber.

The charge nurse and pharmacist confirmed that this medication should not be consumed by the resident without prescriber approval in discussion with the resident. [s. 131. (5)]

WN #20: 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. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff receive the required training in dealing with residents with responsive behaviors annually.

Review of the education records and interview with DOC indicated 21 percent of staff did not receive training in 2013 on techniques and approaches related to responsive behaviors.

Record review and interview with DOC confirmed that the training related to mental health issues, including care for persons with dementia, including training in techniques and approaches related to responsive behaviors was not provided to all direct care staff in 2013. [s. 221. (2)]

2. The licensee has failed to ensure that all direct care staff receive the required training in infection prevention and control program annually or if the licensee has assessed the individual training needs of a staff member, the training was received based on these assessed needs.

Review of the education records and interview with DOC indicated that 27 percent of direct care staff were not provided training in 2013 on infection prevention and control program.

Record review and interview with DOC confirmed that the training related to infection prevention and control program was not provided to all direct care staff in 2013. [s. 221. (2)]

WN #21: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated staff member to co-ordinate the infection prevention and control (IPAC) program is 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

Interview with the DOC indicated that he/she is the leader of the IPAC program and he/she has been in the role in the last year together with two other management members. He/she confirmed that he/she does not have the education in infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management and was not able to present proof of the same. [s. 229. (3)]

2. The licensee has failed to ensure that staff participate in the implementation of the

infection prevention and control program.

Interview with two identified PSWs indicated that they clean the shower chair and the bath tub on the first floor with either soap or alcohol normally used for hand hygiene between each resident's use. Interview with two environmental staff indicated that they clean the bath tub once every day, wiping with Disinfectant R2a and Virox, with no identified schedule of cleaning. Interview with the leader of the IPAC program indicated that nursing department is responsible to clean and disinfect the equipment that is shared between residents such as the shower chair and the bath tub. He/she referred to a note that was on the wall in the shower room that stated the following disinfecting procedure: wash surface with cleaner Virox, rinse surface off, spray surface with Virox, let sit for ten minutes then rinse clean.

Interview with identified PSWs confirmed that they were not able to explain the procedure of proper cleaning and disinfecting the bath tub and the shower chair, neither were they aware that the disinfectant Virox was in the locked cupboard in the shower room for them to use. [s. 229. (4)]

3. The licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Review of the clinical records of residents and interview with the IPAC program leader confirmed that the residents are not offered immunization against tetanus and diphtheria, and the vaccine is not available in the vaccine fridge. [s. 229. (10) 3.]

Issued on this 9th day of January, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202), JUDITH HART (513), SLAVICA VUCKO (210), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2014_168202_0027
Log No. / Registre no:	T-117-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 9, 2015
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	THE WILLOWS ESTATE NURSING HOME 13837 YONGE STREET, AURORA, ON, L4G-3G8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Linda Burr

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the resident right not to be neglected by the licensee or staff is fully respected and promoted. The plan should include, but not be limited to ensuring that the care set out in the plan of care is provided to the residents, specifically related to food being offered and available to residents at meal time and assistance with feeding residents is provided as needed, and that residents are not neglected by staff or the licensee during meal service. Please submit the plan to valerie.johnston@ontario.ca by January 31, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident right not to be neglected by the licensee or staff is fully respected and promoted.

On November 28, 2014, during the first meal of an unannounced visit, the inspector observed resident #30 receive a main course pureed meal at 12:20 p.m. The resident was sitting in a Broda wheelchair, slightly inclined and placed in an angled position to the table. An identified RPN placed the resident's meal on the resident's chest, provided him/her with a spoon and proceeded to feed another resident at a different table. The inspector observed the resident use his/her right hand to feed him/herself. The resident was able to eat two spoons of the main course meal from the sectional plate on his/her chest. On the third spoonful, the plate of food slid off his/her chest and onto the floor. The RPN saw that the resident's plate fell to the floor, got up from his/her table, picked up the resident's plate, covered the food with a clothing protector and proceed back to

his/her table. The RPN did not acknowledge or offer the resident a replacement meal. Resident #30's table mate continued to eat his/her main course lunch meal as he/she sat idle.
At 12:45 p.m., the RPN approached resident #30 and offered him/her dessert. The resident ate the dessert and remaining fluid that he/she had. An interview with the RPN confirmed that he/she did not acknowledge or offer the resident a replacement main course meal after his/her meal fell to the floor because there was no more pureed food in the servery left to offer. The RPN indicated that the resident would be fine because he/she ate a good breakfast, had fluids with dessert at lunch, and would be eating dinner later.
An interview with the NCM indicated that the home did not run out of pureed foods at lunch. The NCM indicated that he/she had heard resident #30's plate fall to the floor, however, he/she did not assist or offer the resident another meal as he/she was feeding another resident at the time. The NCM indicated that the resident would not be hungry as he/she had dessert and fluids at lunch and would receive a snack at 2:00 p.m.

Resident # 32's plan of care identified the resident with a significant weight loss of seven percent noted for an identified month. The resident's plan of care directs staff to provide total assistance for eating as the resident has limited mobility on both upper extremities. On December 01, 2014 at 5:10 p.m., the inspector observed the dietary staff to place a dinner meal in front of resident #32, with no staff present. At 5:25 p.m, the resident was observed to reach for his/her juice slowly and uncontrolled, his/her left hand appeared to be contracted with minimal mobility. The resident held the upper portion of the cup, unable to fully grasp the cup, spilling the entire cup of juice on his/her plate of food. At 5:55 p.m, an identified PSW walked past the resident and indicated that the resident had spilled his/her juice and not been provided assistance at dinner. The PSW then stood beside the resident, scooped a spoon of the resident's food mixed with the juice from his/her plate and offered it to the resident. As the food touched the resident's mouth, the resident refused, shaking his/her head. The PSW then tried to feed the resident again with another spoonful of food for which he/she declined. The PSW then realized an inspector had observed the feeding assistance offered to the resident and indicated that he/she would provide the resident with a new warm plate of food. The PSW then went into the kitchen and left the dining room.
At 6:05 p.m., the inspector observed the cook to come out of the kitchen with a plate of food, questioned who the food was for, assuming it was for resident #32, he/she placed the meal on the table in front of the resident. A PSW then pushed

a stool over to the resident and assisted him/her with the meal. No further fluids were offered.

An interview with an identified PSW indicated that he/she had concerns for residents in the dining room. The PSW indicated that the meal services in the dining room are disorganized and not well managed. The PSW indicated that the dietary aides are responsible to distribute the meals to residents in the dining room. The PSW indicated that there is not always staff available to feed, and that there are no set tables or residents assigned to staff. The PSW indicated that it is not uncommon for residents to not receive assistance from staff in the dining room and that some residents are not always provided meals. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

Service Area Office /
Bureau régional de services : Toronto Service Area Office