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 6, 2015	2015_168202_0013	T-1751-15	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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), DIANE BROWN (110), JOELLE TAILLEFER (211)

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): August 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, rai-coordinator, registered dietitian (RD), manager of nutrition services (MNS), environmental services manager (ESM), physiotherapist, life enrichment coordinator, registered nursing staff, personal support workers, nurse aide, maintenance worker, dietary aides, cook, housekeeping aides, residents and families.

During the course of this inspection the inspector: reviewed clinical records, conducted a tour, reviewed relevant polices, reviewed Residents' Council meeting minutes, conducted a dining observation.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
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.

12 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (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).

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

Findings/Faits saillants :

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

Observation made on August 19, 2015, identified a fall mattress on the floor beside resident #008's right side of the bed.

Record review of the current written plan of care and the Kardex did not indicate to use a

fall mattress to be used beside resident's bed.

Interview with RN #108 revealed the resident needed a fall mattress because he/she is a high risk for fall.

Interview with RPN #107, RN #108, and DOC confirmed that the written plan of care and the Kardex did not indicate that a fall mattress was to be placed on the floor beside resident #008's bed and did not give clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Review of the current written plan of care and the current Kardex for resident #005's oral care indicated the following:

• Poor oral hygiene,
• Has dentures and/or removable bridge,
• Broken, loose or carious teeth,
• Daily cleaning of teeth or denture, or daily mouth care,
• Assess oral hygiene every am with oral care,
• Assess oral cavity daily for any obvious sores or deterioration of teeth and gums.

Review of the form titled, "PSW observational flow sheet" and interview with PSW #121 indicated that the resident is offered mouth care two to three times a day.

Interview with PSW #121 and RPN #125 revealed that a mouth swab is used to clean resident's mouth cavity since the use of a toothbrush and paste are problematic. The above staff and the DOC confirmed that the written plan of care and the Kardex did not set out any directions to staff and others who provide mouth care to the resident. [s. 6. (1) (c)]

3. 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.

Review of the resident #009's current written plan of care indicated the resident was admitted to the home on an identified date, and consent was signed on admission to have a dental assessment by a contract company.

Interview with RN #107 revealed that the resident did not receive a dental assessment six months after admission because the form titled, "Free Dental Assessment Consent

Form" had not been faxed to the company MultiGen HealthCare.

Interview with the DOC indicated the MultiGen Healthcare professional came into the home to provide dental assessments twice since the resident's admission, but resident #009 had not received a dental assessment because the form had not been faxed to the above company.

Interview with the DOC confirmed that the care set out in the plan of care to have a free dental assessment provided by MultiGen Healthcare, had not been provided to the resident as specified in the plan. [s. 6. (7)]

4. 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.

A review of resident #014's clinical records revealed that the resident had been admitted to the home on an identified date three years ago, with highly impaired vision. A review of the written plan of care directs staff to ensure that resident #014's glasses are clean and to be worn daily. Interviews with PSW #103 and #104 indicated that the resident has not worn glasses for sometime and does not currently wear them. An interview with RN #105 confirmed that the resident does not currently wear glasses and that the resident's care plan had not been reviewed and revised to reflect that eye glasses were not necessary for the resident. [s. 6. (10) (b)]

5. The licensee has failed to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches been considered in the revision of the plan of care.

Record review of resident #007 identified the resident at moderate nutrition risk. Resident #007 trialed dietary interventions implemented by the RD on an identified date in 2014, related to an increase in abdominal symptoms and resident's suspicion that consuming particular foods contributed to the increase of symptoms.

Resident received an identified diet, with dietary interventions. Resident #007's weight in month A in 2014, was recorded as 77.7kg.

Record review revealed that resident #007's weight decreased 10 kgs, one year later, in month A of 2015 and had been confirmed by two reweighs.

Month A of 2015, RD assessment revealed that the RD questioned the accuracy of resident #007's weight loss. The assessment revealed that there have been reports of abdominal issues often initiated 12-24 hours after the resident had been on an outing.

Resident #007's diet remained unchanged. There were no changes made to the resident’s plan of care.

Month B, RD assessment, confirmed that the resident had some weight loss the previous month and that that there had been some reports of abdominal issues. The resident’s weight of month B, was 66.5 kg. The RD assessment revealed that the resident is on an identified diet with identified interventions and consumed 100% of his/her meals. The assessment revealed that the RD suspected that resident #007 experienced occasional abdominal issues when he/she did not follow the dietary interventions. There were no changes made to the resident’s plan of care.

Month C, RD assessment related to a 13.2% weight loss over three months revealed that the RD had addressed the weight issues in previous progress notes and that the resident is on a regular diet/regular texture with dietary interventions and tends to go out into the town often. There were no changes made to the resident's plan of care.

An interview with the RD revealed that the weight loss was related to resident having abdominal issues. The RD confirmed that alternative approaches had not been considered when the resident continued to experience these issues after consuming specified foods while receiving the identified diet with dietary interventions. [s. 6. (11) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, 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, to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches been considered in the revision of the plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy, Monitoring Weight Nursing, #CS-12.33, effective January 2011, is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Review of the above mentioned policy stated, it is the responsibility of the PSW staff to weigh and record each resident's weight monthly; registered staff are to ensure weights are reviewed and necessary reweighs are assigned and completed and that registered

staff are to enter weights into Mede-care system by the 15th of the month.

The home's policy fails to include the requirement of O.Reg 79/10, s. 69. whereby, the long-term care home shall ensure that residents with weight changes of 5 per cent of body weight, or more, over one month, 7.5 per cent of body weight, or more, over three months, 10 per cent of body weight, or more, over 6 months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Interviews with a registered nurse #105 and the registered dietitian confirmed that nursing staff are not involved in the assessment of resident's with weight changes.

An interview with the Director of Care confirmed that the home's policy is not in compliance with O.Reg 79/10, s. 69., related to weight changes. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or this regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a policy, protocol, procedure, strategy or system, the licensee is required to ensure that the policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Record review of the home binder titled, "Classic Care Pharmacy, Policy and Procedure Manual Multi-Dose System Med e-care" and interview with the DOC revealed that the home does not have a policy and procedure related to the Act r. 131. (4), indicating that a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administered a drug to a resident to administer a topical if,
a) The staff member has been trained by a member of the registered nursing staff in the administration of topical.
(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff. [s. 8. (1) (a)]

3. The licensee has failed to ensure that the home's policy, titled, Reporting Medication Incidents, Number 7.3, revised July 2014, is complied with.

The home's above mentioned policy, directs registered staff to assess the resident's condition, notify the physician and complete a medication incident report for any medication incident, including the wrong time of medication administration.

A review of resident #013's clinical records directs registered staff to administer eight identified medication at 8:00 a.m. daily.

On August 19, 2015, at 1:50 p.m., the inspector observed a small measuring cup containing eight tablets of medication on resident #013's night stand. An interview with RPN #106 confirmed the above observation and revealed that the medications were the resident's morning medications that he/she had delivered to the resident's room at 9:45 a.m. RPN #106 indicated that the resident did not take the medications at the time of delivery because the resident requested that the medications be left in the room on the night stand. At 1:55 p.m., the RPN #106 was observed to administer the medications located on the resident's night stand to resident #013. RPN #106 further confirmed that the above medications prescribed for resident #013 should have been administered at 08:00 a.m., as prescribed.

An interview with the DOC on August 20, 2015, revealed that he/she had not been informed that resident #013 received his/her morning medications on August 19, 2015 at the wrong time and had not received a medication incident report. A further interview with RPN #106 on August 21, 2015, confirmed that he/she did not complete a medication incident report and had not notified the physician, nor assessed resident #013 at the time of incident and confirming that the home's above mentioned policy had not been complied with. [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 where the Act or this regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a policy, protocol, procedure, strategy or system, the licensee is required to ensure that the policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with all applicable requirements under the Act and to ensure that the home's policy, Reporting Medication Incidents, Number 7.3, revised July 2014, is complied with, to be implemented voluntarily.

WN #3: 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, furnishing and equipment are kept clean and sanitary.

During the course of the inspection the inspector observed the following:

On August 13, and 17, 2015, the inspector observed the raised toilet seat in an identified resident room, soiled with feces. On August 19, 2015, the inspector observed the toilet seats and raised toilet seat in three identified resident rooms, soiled with feces.

Interviews with PSW #104 and RPN #106 confirmed the above observations and revealed that all the above mentioned washrooms are shared by four residents. PSW #104 revealed that it is the responsibility of the PSWs to clean soiled toilets when observed. PSW #104 further indicated that not all PSWs agree with this responsibility and feel that the housekeeping aide is responsible. An interview with housekeeping aide #110, revealed that all resident rooms are to be cleaned by housekeeping once daily and that PSW staff are responsible for the random cleaning of toilets. Housekeeping aide #110 further revealed that there is no housekeeper in the home after 5:00 p.m., daily and that he/she finds uncleaned toilets with feces so prevalent, that he/she is only able to start his/her cleaning at one end of the hallway and work throughout the home area until all the rooms are cleaned by the end of his/her shift.

Interviews with the ESM and the DOC revealed that it is the responsibility of the PSWs to clean urine and feces from resident toilets at the time of observation. The PSWs are to

then contact housekeeping staff, so that the housekeeper can then further sterilize the toilets. The ESM and the DOC further indicated that all PSWs should be aware of their responsibility to clean toilets as required, and that there has been no formal direction to PSWs on the monitoring and cleaning requirements of resident toilets. [s. 15. (2) (a)]

2. 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.

On August 12 and 13, 2015, the raised toilet seats in bathrooms of rooms #204, #214, #201 and #220 were observed to be loose when jarred. The raised toilet seats had a clamp to tighten the appliance to the toilet and secure it in place. Registered staff #107 and PSW #125 confirmed that the seats were not secure.

Both staff were unable to tighten the raised seat by turning the clamp, and confirmed that the raised seats posed a safety risk for residents when using the toilet.
An interview with maintenance worker #124 confirmed that the seats were not designed for the new toilets and were unsafe.

An interview with the ESM confirmed that the home had purchased a number of new low flush toilets and that the design of the raised toilet seats used in the home were not compatible with the new toilets and could not be locked in place.

The ESM revealed that PSW #102 and the administrator did an audit to identify and remove unsecure raised toilet seats in the home. PSW #102 confirmed that an audit had been completed during the inspection and that seven raised toilet seats were removed related to the seats not locking in place. [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, furnishing and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that a change of 5 per cent of body weight, or more, over one month is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Record review identified that resident #002 had a unplanned weight loss of 5 per cent between month A and month B, when resident's weight decreased by 3.4 kilograms. Record review further confirmed the lack of an interdisciplinary approach when resident #002's weight change between month A and month B.

An interview with a registered nurse #105, the registered dietitian and the director of care confirmed that nursing staff are not involved in the assessment of residents with weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. Resident #009 had an unplanned weight loss of greater than 5 per cent between month A and month B when the resident's weight decreased from 5.4 kilograms.

Record review and an interview with the registered dietitian confirmed that she had not received a referral from nursing regarding the weight loss and that she had not assessed resident #009's weight change.

An interview with the director of care confirmed that nursing staff are not involved in the assessment of residents with weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 a change of 5 per cent of body weight, or more, over one month is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #5: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

Record review of the "Nutrition Information of all Clients" sheets identified resident #018, with a preferred item for all meals and to have meals in his/her room on the unit.

At lunch on August 21, 2015, resident was observed to be provided a meal tray without the preferred item. The tray was delivered to the resident without the preferred item being offered. Inspector confirmed that the resident likes the preferred item. PSW #116 who delivered the tray was questioned whether the preferred item was offered to resident #018, PSW #116 stated he/she was unaware the preferred item was to be offered to the resident. [s. 73. (1) 5.]

2. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

On August 11, 2015, during the first meal of an unannounced visit, resident #019 was observed being totally assisted in a position whereby the resident's chair was reclined and the resident's head leaned back at an approximate 75 degree angle. Resident's chin was pointing upward. An interview with registered staff #107 supervising the dining room confirmed that resident's head was slightly back. When questioned if the resident was in a safe feeding position, registered staff #107 stated that he/she is always fed in this position.

The DOC present in the dining room confirmed that the resident had not been positioned for safe feeding.
Record review of resident #019’s plan of care identified a focus on swallowing and requiring resident #019 to be positioned at a 90 degree angle when feeding. [s. 73. (1) 10.]

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 ensure that there a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences and that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #6: 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).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

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.

A review of resident #013's clinical records directs registered staff to administer eight identified medications at 8:00 a.m. daily.

On August 19, 2015 at 1:50 p.m., the inspector observed a small measuring cup containing eight tablets of medication on resident #013's night stand. An interview with RPN #106 confirmed the above observation and revealed that the medications were the resident's morning medications that he/she had delivered to the resident's room at 9:45 a.m. RPN #106 indicated that the resident did not take the medications at the time of delivery and that the resident had requested that the medications be left in the room on the night stand. At 1:55 p.m., the inspector observed RPN #106 administer the medications located on the resident's night stand to the resident. RPN #106 further confirmed that the above medications prescribed for resident #013 had not been administered at 08:00 a.m., as prescribed. [s. 131. (2)]

2. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:
(a) The staff member has been trained by a member of the registered nursing staff in the administration of topical.
(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

Review of the medication administration record (MAR)for resident #038 directs staff to apply an identified topical medication.

Interview with nurse aide #115 revealed he/she applied the above medicated cream in the morning for resident #038 and indicated that he/she had been trained by three PSWs on how to apply the medicated cream.

Interview with the DOC confirmed that the nurse's aide had not received the proper training in the home for the application of the topical drug administration and he/she should have been trained by a member of the registered nursing staff. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: 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 (IPAC) program has 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 along

with the ESM. Interviews with both the DOC and the ESM confirmed that neither have the required education in infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. [s. 229. (3)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

During the course of the inspection the inspector observed the following:

-August 19, 2015, at 1:45 p.m., the call bell cord was resting on the floor of an identified washroom resting on the floor approximately ten centimeters, a white unlabelled medicine collection basin turned over in the hand sink, a blue wash basin was resting on the back of toilet along with another white unlabelled medicine collection basin.

-August 20, 2015 at 09:30 a.m., in an identified room, the end of the call bell cord in the washroom was resting on the floor and an unlabelled white medicine collection basin was hung behind the door, feces were observed on the toilet seat and lid. In a second identified room the end of the call bell cord in the residents' washroom was resting on the floor and an unlabelled urinal was hung on the wall. In the third identified room, the end of the call bell cord was resting on the floor of the residents' washroom and an unlabelled bed pan was hanging on the wall.

An interview with the DOC confirmed the above findings and revealed that all the above mentioned residents' washrooms are shared by four residents. The DOC further stated that all personal care equipment of shared washrooms are to be labelled and that both the unlabelled personal care items and call bell cords resting on the floor are a potential infection and prevention and control issue. The DOC proceeded to remove the items and shortened the call bell cords. [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 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, to be implemented voluntarily.

WN #8: 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:
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 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.

On August 19, 2015, at 09:00 a.m., the inspector observed that the residents' personal health information was visible on the computer screen on top of the medication cart located on an identified area.

Interview with RPN #106 and RN #108 and the DOC confirmed that the computer screen should be closed when it is not being used to keep the residents' personal health information confidential. [s. 3. (1) 11. iv.]

2. The inspector observed on August 20, 2015, at 08:15 a.m., on an identified home area residents' empty medication packages labelled with resident names and prescribed medications thrown into the garbage basket attached to the medication cart. Additionally, the inspector observed RPN #111 discard resident #037's empty medication packages into the above garbage.

Interviews with RPN #111 and housekeeping aide #112, revealed the above garbage is thrown into the general garbage of the home.

Interview with the DOC confirmed that the current process to discard residents' empty medication packages did not protect the residents' personal health information. [s. 3. (1) 11. iv.]

WN #9: 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. (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 failed to ensure that the registered dietitian who is a member of the staff of the home assess the resident's nutritional status, including weight and any risks related to nutrition care.

A review of resident #002's progress notes identified the resident to be at high nutritional risk related to a significant unplanned weight loss when the resident's weight decreased 3.4 kgs, between month A and month B. The RD assessment of month B, acknowledged the resident's change in appetite. A nutritional supplement was ordered to be offered twice per day at am and pm snack.

An interview with food service workers #120 and #117 and observations identified that the resident eats only a specified food item at lunch.

An interview with the RD confirmed that food intake was a component of a nutritional assessment, and that the RD was aware that the resident only consumed a specified food item at lunch.

Record review and RD interview revealed that the nutritional assessment of month B, did not include the resident estimated nutritional intake. The RD confirmed that she was unable to demonstrate that the interventions of the ordered supplement, compensated for the resident's poor intake at lunch and would meet resident's energy requirements to prevent further weight loss. Resident #002 continued to lose weight in both month C and month D, at which time further nutritional interventions were put in place. [s. 26. (4) (a),s. 26. (4) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring and in the case of new items.

The inspector observed on August 18, 2015, and interview with PSW #102, revealed that resident #008's eyeglasses had not been labelled with his/her name.

Interview with the DOC confirmed that resident's eye glasses should have been labelled. [s. 37. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

On August 19, 2015, at 1:50 p.m., resident #013 was in his/her room searching for his/her phone. The resident indicated that he/she wanted to call someone because he/she had not been offered lunch and was very hungry. The resident further revealed that he/she ate breakfast and that the empty tray had been sitting on the wheelchair all morning and no one had come in to offer lunch.

An interview with RPN #106 revealed that resident #013 is normally in the dining room for meals. RPN #106 further indicated that the resident had remained in bed the day before and had been staying in his/her room. RPN #106 indicated that because the resident did not come to the dining room at lunch time, the resident had not been offered a lunch meal. RPN #106 proceeded to obtain a lunch tray from the dietary department to give to the resident. [s. 71. (3) (a)]

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

The posted menu stated 250 mls milk is offered at breakfast, 125 mls is offered every day at lunch and dinner.

An interview with the RD revealed that milk is to be offered at breakfast, lunch and dinner. An interview with the manager of nutrition services further confirmed that milk is to be offered to all residents at each meal. The manager expressed a concern and awareness that staff do not always ask residents if they would like milk, as staff feel they know which resident would prefer milk to drink.

At lunch on August 11, 2015, during the first meal of an unannounced visit, milk was not observed to be served or offered to residents in an identified dining room.

An interview with dietary aide #117 working during this meal, stated that his/her position is to serve juice and water and that the dietary aide serving tea and coffee offers milk to the residents. Observations and an interview with dietary aide #118, serving tea and coffee confirmed that he/she only offers tea and coffee and not milk.

The administrator who was present in the dining room confirmed that milk had not been offered.

An interview with resident #015 during stage 1 interviews revealed that he/she likes to drink milk and drank 2% milk all his/her life. When asked when he/she drinks milk, the resident responded "whenever they give it to me". Resident responded "no" when asked if he/she is offered milk at meals. Record review of resident #015 identified that he/she required calcium. Resident #015 was observed at lunch on August 18, 20 and 21, 2015, and at breakfast on August 19, 2015. No milk was offered at all four meals.

An interview with the registered nurse serving beverages, in the main dining room, stated that he/she did not offer resident #015 milk as he/she knows who prefers milk.

Residents #016, #017, and #018 with a documented preference to drink milk were not offered milk when observed at lunch on August 21, 2015.

A review of the "Nutrition Information of all clients" sheets for 84 residents in the home identified that only one resident had a dislike for milk, and therefore all other residents should have been offered milk according to the home's planned menu. [s. 71. (4)]

3. An interview with the manager of nutrition services revealed that portion sizes are part of the planned menu and are required to be followed by staff when serving meals.

At lunch, on August 11, 2015, during the first meal of the unannounced inspection, the portions of pureed foods served were observed. The portion sizes served were compared to the required sizes on the planned menu with food service/worker #119. Food service worker #119 confirmed the serving sizes that had been used were incorrect and not according to the planned menu as follows:

Pureed frittata, was served using a #12 scoop(80mls) and not a #6 scoop (180mls) as planned;
Pureed beef was served using a #8 scoop(125mls) and not 3 x #12 scoop (240mls) as planned;
Pureed mixed vegetables were served using a #16 scoop (60mls) and not 3 x #12 scoop (240mls) as planned.

The manager of nutrition services confirmed that the staff did not follow the planned menu providing smaller portions than required. [s. 71. (4)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The inspector reviewed the OMNI Health Care Policy/Program evaluation for June 2015. The section titled, "Pharmacy/Drugs, revealed the following participants were in attendance:
-the medical director,
-DOC,
-CCC,/RAI Coordinator,
-registered personnel, and
-consulting pharmacist.

Interview with the DOC and the administrator revealed that both the administrator and the registered dietitian had not been present for the annual evaluation of the effectiveness of the medication management system.

Interview with the Administrator revealed that he/she was not aware of the legislation requirement indicating that he/she shall be present in the annual multidisciplinary meeting to evaluate the effectiveness of the medication management system. [s. 116. (1)]

Issued on this 23rd day of November, 2015

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

Original report signed by the inspector.