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
Jan 8, 2015	2014_266527_0024	H-001630-14	Resident Quality Inspection

Licensee/Titulaire de permis

YEE HONG CENTRE FOR GERIATRIC CARE
2311 MCNICOLL AVENUE SCARBOROUGH ON M1V 5L3

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

YEE HONG CENTRE - MISSISSAUGA
5510 Mavis Road MISSISSAUGA ON L5V 2X5

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

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

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 24, 25, 26, 27, 28 and December 2, 3, 4, 5, 2014

Critical Incident Log #: H-000550-14 was inspected during the Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DOC), the Assistant Directors of Resident Care (ADRC), the Registered Nurses (RNs), the Registered Practical Nurses (RPNs), the Personal Support Workers (PSWs), the housekeeping aides, the maintenance technicians, the Facilities Manager, the Food Services Manager (FSM), the Registered Dietician (RD), residents, and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **10 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. 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 did not ensure that every resident had their personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with this Act.

On December 4, 2014 during the noon medication pass, registered nursing staff were observed disposing of medication packages in the common garbage cans. The medications were administered to the residents, then the packaging which contained the residents name and the type and dose of medication they received, were disposed of in the garbage can, and ultimately to the public landfill site. The packages of five residents were retrieved and it was confirmed with the DOC the residents personal health information was not kept confidential for all five residents. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has their personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with this Act, to be implemented voluntarily.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 plan of care for residents provided clear directions to staff and others who provide direct care to the resident.

A) Resident #061 developed a virus in September 2014 requiring isolation to prevent the spread to other residents, staff and visitors. The plan of care was not updated to include interventions to manage the virus and therefore did not provide clear direction to staff and others who provide direct care to the resident. This was confirmed by the lack of clinical documentation and the Director of Care.

B) In December 2014 during the dining observation resident #056 was observed using an uncoventional tool as a utensil for cutting and eating. The resident was observed picking up cut pieces of chicken with an uncoventional tool and putting in their mouth. The plan of care had identified the resident prefers their own uncoventional tool to cut meat instead of a knife, but did not include that the resident can use an uncoventional tool as a utensil for eating. The ADOC and the Administrator confirmed the concerns for the resident's safety when using the unconventional tool as a utensil to eat. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other (a) in the assessment of the resident so their assessments were integrated and consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complement each other.

A) A review of resident #027 health records confirmed the RD recommended prune juice for the resident as an intervention for constipation. There was no documentation to support that the staff collaborated with each other and an integrated, consistent assessment was done in relation to the bowel management program. The RD confirmed that in November 2014 prune juice was recommended for constipation, and that the nutrition and hydration protocol for the treatment and interventions was not included in the bowel management program.

B) In September 2014 at the Clinical Interdisciplinary Care Conference the nursing summary report had identified that resident #007 was experiencing constipation frequently and receiving treatment. However, the dietary summary completed by the food service supervisor did not address the bowel management problem including nutritional interventions and hydration protocols for the treatment of constipation. The staff did not collaborate with each other in the assessment of the resident and the plan of care was not developed and implemented to address the issues related to constipation. [s. 6. (4) (a)]

3. The licensee has failed to ensure that resident #061 received the care set out in their plan of care.

The plan of care for resident #061 directed staff to use a sit to stand lift for the resident. In May 2014 two PSWs did not use the lift to re-position the resident and instead lifted the resident at the axilla resulting in a significant injury. The clinical progress notes, critical incident and DOC confirmed this finding. [s. 6. (7)]

4. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) In May 2014 resident #061 sustained a significant injury. The plan of care was not updated to reflect the significant change in condition or the interventions recommended by the physiotherapist.

B) In July 2014 resident #061 developed an infection. The plan of care was not updated to reflect the change in condition or interventions to manage and prevent the infection.

C) In September 2014 resident #061 developed a virus. The plan of care was not updated to reflect the change in condition or the interventions to manage the infectious illness.

The plan of care was not updated to reflect the change in condition or the interventions for resident #061, which was confirmed by the clinical documentation and the DOC.

D) Resident #008 returned from hospital early November 2014 with a physician's order for Palliative Care and no oral food intake (Nothing Per Os - NPO). The nutritional care plan identified that the resident was to receive a regular diet with pureed texture. Staff interviewed and the physician's order confirmed the resident was NPO and was receiving treatment for hydration, the plan of care was not revised to reflect the changes until the end of November 2014. [s. 6. (10) (b)]

5. The licensee has failed to ensure that the resident #055 was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

A) The plan of care for resident #055 was not revised. The care set out in the resident's plan of care had not been effective in relation to unplanned weight gain and abnormal laboratory values. The resident's weight record indicated unplanned weight gain over a

period of three months. The plan of care in November 2014, stated "weight loss is not resident's goal, refer to eating focus for all dietary interventions". The interventions documented in the plan of care under "Weight Gain Focus" were not reviewed and revised since November 2007.

The dietary notes documented by the home's RD in the first week of November 2014 did not include an evaluation and effectiveness of strategies in relation to the resident's weight gain and abnormal laboratory values. The RD confirmed the resident's nutritional requirement i.e energy, protein was not reassessed. The energy, protein and fluid requirement was only assessed at the admission assessment. The care set out in the plan of care was not evaluated for the effectiveness and different strategies were not implemented to address the issues related to weight gain and abnormal blood values.

During this Resident Quality Inspection the resident's Substitute Decision Maker(SDM) approached one of the LTC Inspectors and expressed concerns regarding the resident receiving inappropriate high sodium and starchy food items from unknown sources. The SDM was concerned for the resident's frequent hospitalization and health status.

B) The progress notes from the first week of November 2014 indicated a dietary referral was made to the RD for resident #027 as the resident was refusing their nutritional supplement. The RD interview and the documentation in the progress notes confirmed the RD met with the resident on the same day. The RD reported that the nutritional supplement was discontinued when the resident felt it was affecting their bowel movement, as they were experiencing ongoing constipation. The June 2014 progress notes indicated the resident had weight loss in one month, low BMI and low blood count. The nutritional supplement was initiated by the RD to prevent further weight loss. However, after the supplement was discontinued during the first week in November 2014, the documentation did not reflect an assessment of the effectiveness of discontinuing the supplement on the resident's nutritional intake and weight changes. The RD confirmed that the resident's nutritional requirement i.e energy, protein and fluid was not reassessed prior to discontinuing of the supplement and different strategies were not implemented in the revision of the plan of care. [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 the following:
1. That there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; (c) clear directions to staff and others who provide direct care to the resident.
2. To ensure that staff and others involved in the different aspects of care of the resident collaborate with each other (a) in the assessment of the resident so their assessments are integrated and consistent with and complement each other; and (b) in the development and implementation of the plan of care.
3. To ensure (a) the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change; and (b) ensure that if the plan of care is being revised because care set in the plan has not been effective, the home shall ensure that different approaches are considered in the revision of the plan of care, 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 failed to ensure that the policy named "Resident Food and Fluid Intake Recording and Evaluation" CFS-11-16 and revised on August 2012 was complied with.

A) The home's policy stated that the PSW will record daily food and fluid intake of each

resident. All food and beverage intake for meals and snacks are recorded on the form using proper portion sizes consumed. The documented food and fluid intake record for resident #007, #008 and #027 were reviewed. The intake records for August, September, October and November 2014 were reviewed, and the daily flow sheets for the identified residents were found incomplete. Residents' had inconsistent documentation for their intake of food and fluids at meal time and nourishment pass.

B) The home's policy calls for the collaboration of the Nursing and Food Service department to monitor the food and fluid intake of residents and make timely referrals to address residents who were suspected to have sub-optimal food intake or nutrition-related problems. The procedure #3 directs the staff, attending physician, RN, RPN and RD would pay special attention to the following:

- An observed intake of less than 50 % of the usual intake for a period of 3 consecutive days.
- Residents with significant change in appetite.
- Residents with unexpected weight gain or loss.

The food and fluid intake record for resident #008 was reviewed. The resident's food and fluid intake was less than 50% of the usual intake for a period of nine consecutive days. The resident's fluid intake varied from 465 to 870 ml/day for nine consecutive days in November 2014. A referral to the RD was not initiated when the resident had a significant change in appetite and sub-optimal food and fluid intake. Staff interview and a review of the health record confirmed the resident had a significant change in oral intake. Interview with the RD confirmed a referral was not initiated and the change in resident's nutritional and hydration needs were not reassessed.

A review of the food and fluid intake records for the month of August, September, October and November 2014 indicated that resident #007 consumed less than 1,000 ml fluids/day over 50% of the time during these months. The RD confirmed that the referral for nutrition consultation was not initiated. [s. 8. (1)]

2. The licensee has failed to ensure that the policy named "Safe Resident Lifting and Transferring Practices" Number CNU-V-06 was complied with.

The policy directs staff to transfer residents according to assessment. The assessment completed for resident #061 directed staff to use a sit to stand lift to reposition the resident. Staff used a two person, under the axilla method of transfer instead of the

assessed method of the sit to stand lift. The resident sustained a significant injury as a result of the staff not complying with the policy. This was confirmed by clinical documentation and the DOC. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with., 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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

A tour of the home was completed on specific dates in November 2014 and December 2014 at which time the following maintenance and housekeeping related issues were observed and schedules had not been developed to address their repair.

A) The shower curtains located in the SPA rooms on 5 North, 5 South, 3 North, and 3

South had broken hooks, were torn and hanging off the rods.

B) The flooring in all Spa rooms on each unit in the home were soiled and stained.

C) The cloth chairs in resident rooms and lounge areas on 5 South, 4 North, 4 South, 2 North and 2 South had multiple stains. In addition, on 2 North and 2 South the chairs in resident rooms had the varnish worn off and the bare wood was exposed.

D) The Spa room on 2 North had two holes in the floor beside the lifts used for the jacuzzi. The holes were approximately three inches in diameter.

E) The hand washing sink in the hallway adjacent to the dining room in 5 North had the linoleum lifting off the edges of the counters and there was black mold around the grout of the sink. In 5 South the hand washing sink in the hallway adjacent to the dining room had cracked tiles under the sink and the wall was damaged were the base of the counter met the wall.

F) In the television lounge on 5 South there was a low back beige resident chair with brown stains on the seat. In room 516 there was a green high back resident chair with white stains on the seat.

G) In the lounge on 2 North, room 2NL2, the wall had a hole approximately six inches in length, and the dry wall was exposed.

H) The flooring between between specific rooms on the fourth floor were broken, cracked and missing pieces of tile.

I) The bottom of storage cabinet doors behind the jacuzzi in the Spa rooms on 3 South, 3 North, 2 South and 2 North were damaged exposing the particle board and had ragged edges.

J) On 2 South the tiles leading into the Spa room were broken.

K) On 2 North the handrail beside the resident lounge across from the nursing station was cracked, the wood was split and splintering.

The Facilities Manager confirmed there was no log of these repairs written down or no schedule for them to be fixed. The Facilities Manager also confirmed that the home

requires repairs, additional deep cleaning to ensure it is clean and sanitary, and the furnishings and equipment need to be maintained in a safe condition, and in a state of good repair for the residents. [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, (a) the home, furnishings and equipment are kept clean and sanitary; and (c) the home, furnishings and equipment are 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. 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the bowel management plan of care for resident #061, with respect to the resident's special treatments and interventions was developed based on an interdisciplinary assessment.

The progress notes for resident #061 were reviewed and noted the resident had periods of time where the resident had difficulties with their bowel movements and required

treatment. In September, July, and May 2014 the physician increased the resident's medications in response to the resident's constipation. The dietitian was not included in the assessment of the resident's constipation issues or in the plan of care. The clinical record, dietitian and DOC confirmed a referral to the dietitian had not been completed and there were no dietary interventions implemented to prevent constipation for the resident. [s. 26. (3) 18.]

2. The licensee has failed to ensure that a registered dietitian who is the member of the staff of the home completed a nutritional assessment for all residents when there was a significant change in the resident's health status and risks related to nutrition care.

A) The Minimum Data Set(MDS) Quarterly assessment for resident #027 was completed on November 10, 2014. Under Section K: Oral/Nutritional Status, subsection K4(c) was coded as the resident was leaving 25% or more of their food uneaten most meals. The Resident Assessment Protocol (RAP) triggered for Nutritional Status and it was not completed. The impact of the problem on the resident not consuming adequate nutrition and the risk factors were not addressed in the RAP summary. The nutritional care plan and the progress notes documented by the FSM on November 6, 2014 had identified the resident's BMI as 20.13. However, the resident's estimated nutritional requirements i.e energy, protein and fluid and the current intake was not reassessed. The RD did not complete the nutritional assessment and the strategies interventions were not care planned to address the issues.

B) The health record for resident #008 was reviewed, including the progress notes, food and fluid intake records, and the attending physician's notes from October 24, 2014, which stated slight decrease in weight, monitor for further weight loss. The progress notes dated November 5, 6, 7, 8, and 9, 2014 identified that the resident ate poorly most days and fluid intake varied between 450-500 millilitres (mls) per day. The documented food and fluid intake records for November 1 to 9, 2014 identified the resident ate less than 50% of their meals, refused their nutritional supplement and afternoon snack.

The home's policy "Resident Food and Fluid intake Recording and Evaluation", number CFS-11-16, and revised August 2012 directs staff to make timely referrals to address residents who are suspected to have sub-optimal food intake or nutritional problems. The policy stated the RD calculates energy and protein intake and determines appropriate interventions. The resident did not have a complete nutritional assessment by the RD when there was a significant change in the resident's health status and risks related to nutrition care. The review of the resident's clinical records and interview with RD

confirmed the resident's nutritional requirements, energy, protein and fluid intake were not calculated and reassessed. The RD reported resident's energy, protein and the fluid intake requirement was only assessed as part of the Admission Nutrition Assessment. The resident had low BMI, gradual unplanned weight loss, poor oral intake, risk for dehydration and was identified to be at moderate nutritional risk. The progress notes and staff interviews confirmed the resident had a significant change in health status, however, the resident's nutrition risk level was not reassessed by the RD.

C) The RD did not complete a hydration assessment for resident #008 when there was a significant change in hydration status and risks relating to hydration. The documented food and fluid intake records for a period of four months (August, September, October and November 2014) indicated the resident consumed most days less than 1500ml/day, and not meeting the minimum fluid requirement. The clinical record and interview with the registered nursing staff confirmed the resident had frequent Urinary Tract Infections (UTIs). The RD confirmed a referral was not made for an assessment, when there was a significant change in hydration status. For nine consecutive days from November 1 to 9, 2014 the resident's fluid intake was less than 900 mls/day. The resident did not have a hydration assessment before admitted to the hospital with a diagnosis of Urinary Tract Infection on November 10, 2014.

D) The RD did not complete a hydration assessment for resident #007 when there was a significant change in hydration status and risks relating to hydration. The MDS Annual Assessment for resident #007 was completed on September 27, 2014. The triggered Nutritional Status RAP summary had identified that the resident was consuming 1000-1100 ml fluid per day. However, the documented food and fluid intake records for a period of four months (August, September, October and November 2014) identified the resident's intake varies between 450-950 mls/day and not meeting the minimum 1500 ml/day fluid requirement. The resident was identified to be at risk due to low BMI, low hemoglobin and experiencing on going constipation. The resident did not have hydration assessment completed by the registered dietitian. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the residents' plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the residents': 18. Special treatments and interventions. In addition, to ensure that a registered dietitian who is the member of the staff of the home completed a nutritional assessment for all residents on admission and when there is a significant change in the resident's health status and risks related to nutrition care., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #061 was positioned using a technique that was safe.

In 2014 resident #061 was re-positioned in their wheelchair by two personal support workers (PSWs) using an under the armpit technique that resulted in the resident receiving a significant injury. The resident went to the hospital for assessment and treatment and returned the following day. The documentation that confirms the incident included the critical incident submitted to the Ministry of Health and Long Term Care (MOHLTC), clinical progress notes and the investigation completed by the management of the home. The DOC confirmed the staff did not use safe positioning techniques for resident #061. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents., to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure residents' #007, #008 and #027 were offered evening and afternoon snack and/or beverages between meals.

A) The documented food and fluid intake records for resident #007 were reviewed for August, September, October and November 2014. The documentation indicated that a snack in the afternoon and in the evening during the nourishment pass was not offered to the resident. The plan of care had identified the resident was at nutritional risk, potential for weight loss, and low Basal Metabolic Index (BMI). The plan of care also stated that the family of the resident had requested the resident to be awakened for the afternoon and bedtime snack if the resident was asleep.

B) Resident #008 who was identified to be at nutritional risk and had low BMI was not offered a snack during the evening snack pass. The resident was offered a nutritional supplement; however, the daily snack was not offered. A review of the documented food and fluid intake records for a 101 day period (August, September, October and nine days in November 2014) did not reflect that the food snack was consistently offered to the resident in the evening. The documented food and fluid intake records did not reflect that a choice of beverage was offered to the resident during the morning and the evening snack pass. The progress notes from the first week of November 2014, identified the resident ate poor at lunch and dinner.

C) Resident #027 was identified to be at nutritional risk, and low Basal Metabolic Index (BMI) and was not offered a snack during the afternoon and the evening snack pass. Documentation on the food and fluid intake records over a period of three months (August, September and October 2014) did not reflect that nourishment snacks were consistently offered to the resident in the afternoon and in the evening. Documentation on the food and fluid intake records for August, September and October 2014, indicated resident #027 was offered nutrition supplement; however, was not offered a choice of beverage during the morning and afternoon snack pass. The food and fluid intake records and the RD confirmed the resident was not consistently served beverages in between meals. [s. 71. (3) (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 all residents were offered, at a minimum, evening and afternoon snack and/or beverages between meals, to be implemented voluntarily.

WN #8: 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,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

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

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system provided for standardized recipes for all menus.

The recipes were reviewed and they were not consistent with the quantities of the menu

items specified on the production sheet report. The recipes were not scaled for the portions/servings required. In December 2014, the Braised Tofu with Chicken pieces recipe used by the cook had yield 100 servings; however, the production sheet had listed 108 servings (45 servings regular, 25 servings cut up, 18 servings minced and 20 servings pureed). The FSM confirmed that the Fall/Winter menus were recently implemented and all recipes were not adjusted. The cook preparing the minced and pureed food items was interviewed and confirmed that 30 servings of vegetables were prepared; however, the recipe used was for 20 servings. [s. 72. (2) (c)]

2. The licensee has failed to ensure that the food production system provided communication to residents and staff of any menu substitutions.

In November 2014, the posted daily and weekly Western Menu listed turkey sandwich plate and cucumbers with low fat dressing. Residents were served carrot salad instead of cucumbers with turkey sandwich. The FSM confirmed the menu substitution was made but the change was not made to the daily menu posted for resident viewing. [s. 72. (2) (f)]

3. The licensee has failed to ensure that all food and fluids are prepared, stored and served using methods that preserved taste, nutritive values, appearance and food quality.

A) On a specific date in November 2014 and December 2014 the food items served to residents at the lunch meal did not preserve the appearance, taste and quality. The meal served to residents receiving minced and pureed food did not appear to be appetizing and nutritious. On the same day in November 2014, the consistency of the minced chinese fried rice and the chicken was more of puree consistency, the appearance was glossy and sticky due to excessive use of thickening product. The minced entrees and vegetables were runny on the plate. The green beans were over cooked and discoloured.

B) On a specific date in December 2014, the minced chicken consistency was runny and had an excess amount of thickener added. The dietary aide was observed preparing thickened Octopus soup in a pot in the 2 South dining area. The staff observed to be preparing thickened soup with no directions, and measuring or weighing of the thickener did not occur. The consistency of the soup served to residents was lumpy and sticky.

C) On a specific date in December 2014, the cook was observed in the kitchen preparing minced and pureed food items. The recipes for minced braised tofu, chicken and

vegetables did not call for adding thickener. However, when the LTC Inspector questioned the staff if any thickener was added to the minced vegetables, the cook reported that five table spoons of instant mash potatoes and five table spoons of the thickener was added to the minced vegetables. The staff did not follow the recipe, which resulted in compromised food quality, altered flavour, texture and the nutrient content. The FSM confirmed that the expectation was for staff to follow the recipes when preparing all food items including minced and pureed food.

During Stage 1 of the Resident Quality Inspection (RQI), residents had complained to the LTC Inspectors about the food quality. The concerns voiced by the residents were that vegetables were often soggy, food was too fatty, and the food was salty. [s. 72. (3) (a)]

4. The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness.

A) On a specific day in November 2014, prior to the start of lunch service on the second floor dining room, pre-portioned and uncovered glasses of beverages i.e milk, nutritional supplement, juices, water, and yogurt were observed set up on the dining tables and the trays in the dining room. The dietary staff interviewed and reported the beverages were always set up on the tables at least 30 minutes prior to the meal service. The temperature of the milk and the nutritional supplement was warm. Both beverages were 3.4 degrees celsius above the standard for safe food. The hazardous foods were not stored and served using methods to prevent contamination and food borne illness. (159)

B) On a specific date in November 2014 the Long Term Care (LTC) Inspector observed the residents' individualized fluids already prepared and sitting on the dining room tables uncovered in the third floor dining room forty-five minutes prior to the start of the meal service. The fluids consisted of milk, juice, water and nutritional supplements. The dietary aide confirmed that they always prepare and place the residents' drinks on the tables before the meals. [s. 72. (3) (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:
1. All food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance, and food quality; (b) prevent adulteration, contamination and food borne illness
2. Ensure that the food production system must at a minimum, provide for standardized recipes and production sheets for all menus; communication to residents and staff of any menu substitutions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

On a specific date in November 2014 during the lunch meal service on 2 South and 2 North dining room the hot food temperatures were tested. Regular textured chicken strips and green beans were probed and they were cold and below the home's standard temperatures for hot food. The FSM removed the chicken strips and reheated them in the

microwave. The FSM confirmed the hot foods were to be served above 60 degree Celsius (140 degree Fahrenheit). [s. 73. (1) 6.]

2. The licensee had failed to ensure that residents were provided with any eating aid, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) On a specific date in November 2014 resident #052 was observed in the dining room during the lunch meal sitting at the table with their head down and eyes closed. The resident was observed with the meal served in front of them with no assistance with eating. The resident had to wait at least eight minutes for assistance until the staff member had finished feeding other residents. The physical assistance was provided only after the LTC Inspector intervened. The plan of care for the resident indicated under "Eating Focus" that they required extensive assistance with eating with a potential to restore function as ability to feed self with physical assistance due to cognitive impairment. The LTC Inspector observed that the resident was fed cold food. Interview with the PSW confirmed that staff was not readily available to assist the resident with eating. Resident #052 was identified to be at high nutrition risk.

B) On a specific date in November 2014 resident #053, and resident #054 was observed in the North dining room. They were served their lunch meal at approximately 1220 hours. The residents' sat with the meal in front of them with no assistance. After approximately ten minutes a staff member reminded resident #053 to eat. The staff person left the resident and went to feed another resident. The plan of care for resident #053 indicated under the "Eating Focus" that the resident required limited assistance with eating, and able to feed self with some assistance due to poor hand movement and cognitive impairment.

C) Resident #054 did not receive assistance until the LTC Inspector spoke with the registered staff and the PSW. The plan of care for resident #054 had identified that they required limited assistance with eating due to cognitive impairment.

Resident #053 and #054 were not provided the level of personal assistance they required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack serve that include at a minimum, food and fluids are served at a temperature that is both safe and palatable to the residents, and to ensure that residents are provided with any eating aid, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks

In December 2014 the LTC Inspector observed the following:

A) The hand washing sink in the hallway adjacent to the dining room in 5 North had the linoleum lifting off the edges of the counters and there was black mold around the grout of the sink.

B) The hand washing sink in the hallway adjacent to the dining room in 5 South had cracked tiles under the sink and the wall was damaged were the base of the counter met the wall.

The Facilities Manager confirmed there were no schedules developed to address the repair of the sinks. [s. 90. (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 procedures are developed and implemented to ensure that, (d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a policy was developed for the medication management system that ensured appropriate disposal of medication pouches after administering the medication to residents.

On a specific date in December 2014, during the noon medication administration pass on fifth floor, two registered nursing staff were observed disposing of the medication pouches, post administration of medication, into the common garbage. Packages of five residents were reviewed and it was noted the residents' names and the type and dose of medication they received were on the packages. The written policy for the current medication management system, specifically the disposal of packaging was reviewed and did not provide direction to the nursing staff about disposal of packages, post administration of medication. Three registered nursing staff and the DOC confirmed the policy did not include this information. [s. 114. (2)]

WN #12: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a hand hygiene program in accordance with evidence-based practices.

During the dining observation in November 2014, it was observed that hand hygiene practices were not carried out by staff while handling food. Staff were observed assisting residents with eating (resident #039 and #051), as well as handling soiled dishes. The staff then went to assist another resident #052 with no hand washing or sanitizing between the tasks.

The Administrator and DOC confirmed that staff were expected to wash or sanitize their hands in between feeding or providing care to residents. [s. 229. (9)]

Issued on this 22nd day of January, 2015

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

Original report signed by the inspector.