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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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 2, 2015	2014_159178_0030	T-121-14	Resident Quality Inspection

Licensee/Titulaire de permis

McKenzie Health
10 TRENCH STREET RICHMOND HILL ON L4C 4Z3

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

MacKenzie Health
10 TRENCH STREET RICHMOND HILL ON L4C 4Z3

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

SUSAN LUI (178), NITAL SHETH (500), SARAH KENNEDY (605), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 1, 2, 3, 4, 5, 8, 9, 10, 11, 2014.

The following Critical Incident Intake was inspected concurrently with this inspection:
T-706-14.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), registered dietitian (RD), social worker (SW), director of infection control and continuance quality improvement (CQI), director of facility services (Maintenance), registered staff, personal support workers (PSWs), residents, family members of residents, resident council president and representatives, family council representative.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
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

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

21 WN(s)
14 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2014_168202_0009	178
O.Reg 79/10 s. 9. (1)	CO #001	2014_168202_0007	178

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.
Observations on December 2, and December 8, 2014, determined that the raised toilet seat in the bathroom for resident #009 was not properly secured to the toilet and as a result could tilt and swivel if used by a resident. This fact was confirmed by the home's director of CQI on December 8, 2014, who attempted but was unable to secure the seat to the toilet.
Interviews with registered staff and PSWs confirmed that the unsecured raised toilet seat should be reported to the nurse in charge, who would then submit a requisition to maintenance to have it fixed. Staff interviews and record review confirm that a maintenance requisition was not submitted until December 8, 2014, after the problem was communicated to the staff by the inspector. Staff interviews also confirmed that only one resident residing in the room uses the toilet, and that resident does so only with the assistance of two staff members and a "sit to stand" mechanical lift.
On December 9, 2014 the home's CQI manager confirmed that the seat had been removed, as it could not be secured, and it was replaced by a raised seat which fits securely. Observations confirmed that the seat had been replaced and fit securely. [s. 5.]

Additional Required Actions:

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

WN #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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff involved in the different aspects of care of the resident collaborate with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Record review and staff interview confirm that staff did not collaborate with each other in the implementation of resident #018's plan of care

Review of the resident #018's Medication Administration Record (MAR) confirmed that an identified medicated cream is to be applied to the resident's lower legs twice daily. Interview with the registered staff member assigned to the resident confirmed that this task had been delegated to the resident's assigned personal support worker (PSW), and that the registered staff member believed that the PSW was applying the medicated cream every day as directed. The registered staff member signed the MAR to indicate that the cream was applied at 0800 on Dec 1, 2, 3, 4, and 5, 2014. However interview with the assigned PSW on December 5 confirmed that the PSW did not apply the

resident's medicated cream on December 4, or for the past few days because the PSW felt that the resident did not require it because the resident's legs were not red. [s. 6. (4) (b)]

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

Observation conducted on December 1, 2014, at 12:00 p.m., revealed that resident #026 was served fluids with regular consistency, and that resident #025 was served cranberry juice.

A review of a plan of care for above mentioned residents revealed that resident #026 is to be provided nectar thick fluids (fluid thickness as per power of attorney's [POA's] request) and resident #025 is to be provided 250 ml of fibre added apple juice at lunch.

Interview with the registered nursing staff and the food service manager confirmed that resident #026 should be provided with nectar thick fluids as requested by the POA, and resident #025 should be provided with fibre added apple juice at lunch as set out in their individual plans of care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

A review of resident #011's plan of care revealed that the resident has decreased/impaired vision related to cataracts, and staff is to ensure that eyeglasses are clean, appropriate and being worn by the resident.

Interview with an identified PSW confirmed that the resident is not wearing eye glasses.

Interview with the registered nursing staff member confirmed that the resident has eye glasses for reading but the resident is not using them at the present time. The registered nursing staff member confirmed that the plan of care should be revised, as the resident does not use the eyeglasses at present, and that the plan of care should reflect resident's current condition. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
-staff involved in the different aspects of care of the resident collaborate with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,
-the care set out in the plan of care is provided to the resident as specified in the plan,
-the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, are kept locked and secure.
On December 1, 2014, at 10:55 a.m. the door leading to the patio from the 3 east lounge was observed to be unlocked. There were no staff or residents observed in the lounge or in the hallway outside the lounge.
On December 1, 2014, at 1:00 p.m. the door leading to the patio from 3 east lounge was observed to be unlocked.
The Director of Infection Control and Quality Management was informed and arranged for the door to be locked.
A discussion with the Administrator revealed the door had been checked and found to have a malfunctioning locking system. A requisition was forwarded to the maintenance department and the locking system was repaired.
On December 1, 2014, at 16:00 p.m. the door leading to the patio from the 3 east lounge was noted to be locked and secure. [s. 9. (1) 1. i.]

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 all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be kept locked and secure, 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 kept clean and sanitary.

Interview with resident #006, revealed that the sink and washroom in the resident's room, and the floor in the dining room are not properly cleaned, especially when the regular house-keeping staff is not working.

Observations conducted on December 1, 2014, at 10:00 a.m., revealed that in the shower/tub room #521, the shower chair/commode rim was soiled with feces, the toilet contained urine, gloves were on the floor, and white paper debris was on the floor. Observation conducted on December 8, 2014, at 10:00 a.m, revealed that the shower chair/commode rim and the toilet were soiled with feces.

Interview with an identified PSW confirmed that the shower chair is dirty and the staff who provided a shower to the resident should have cleaned it with wipes. The PSW confirmed that the toilet needs to be cleaned by the housekeeping staff.

Interview with the coordinator of environmental services (housekeeping and laundry) confirmed that the above mentioned furnishings should be cleaned by the staff. [s. 15. (2) (a)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.
Resident interview, staff interview, and an audio recording provided by the resident confirm that on August 17, 2014, an identified PSW did speak to resident #006 in an aggressive manner. While providing care, the PSW refused to converse with the resident at times, and responded aggressively to the resident at other times.
The resident stated that this PSW had been communicating with him/her in this manner for months, and that it made the resident feel humiliated. The resident stated he/she found it so uncomfortable, that at times the resident would wait until the next shift to request care, rather than interact with the identified PSW. [s. 19. (1)]

2. The licensee has failed to ensure that resident #012 is protected from abuse.
On May 22, 2014 resident #012 was forced to have a shower after the resident had verbalized to the PSW that he/she was tired and didn't feel like he/she wanted a shower. The PSW transferred the resident onto the commode chair, which resulted in bruising on resident #012's both arms above the wrists.
Resident #012 stated that he/she was very upset due to the incident and was not able to sleep that night. The resident reported the incident the following morning to the registered staff on day shift. An investigation was initiated by the home which resulted in the termination of the PSW staff member.
An interview with the DOC confirmed that the incident involved physical and emotional abuse of the resident by the PSW. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action is taken in response to every incident of abuse and neglect.
Resident interviews, staff interviews and record review confirm that on August 16, 2014, resident #006 reported to the home's DOC that the resident had been spoken to rudely and given the "silent treatment" by an identified PSW. At the time, the resident provided a tape recording of the interaction, which the DOC listened to. During interview, the DOC stated that on the tape the DOC heard the PSW refusing to speak to the resident, and when resident #006 would ask questions the PSW was abrupt and rude, providing only one word answers. The DOC stated that he/she considered the behaviour to be abusive because by refusing to respond appropriately to the resident, the PSW was neglecting the resident.
Immediate action was not taken to remove the resident from this PSW's care. Resident and staff interview confirm that the PSW cared for the resident on at least one shift after the resident complained about the identified PSW's behaviour. [s. 23. (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 appropriate action is taken in response to every incident of abuse and neglect, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff occurred, did immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA).
Staff interviews, resident interview and record review confirm that on August 16, 2014, resident #006 informed the home's DOC that the resident had been spoken to rudely and ignored at times by an identified PSW. The resident provided a tape recording of the interaction and it was listened to by the DOC. In an interview during this inspection, the DOC stated that he/she considered the PSW's behaviour on the tape to be neglectful, as the PSW was not responding appropriately to the resident. Record review and interview with the home's administrator confirmed that the recording of the PSW's interactions with the resident could be viewed as "borderline verbal abuse", and as a result, a disciplinary suspension was issued to the identified PSW.
Management staff confirm that the Director under the LTCHA was not informed of the resident's allegations of verbal abuse and of the results of the home's investigation of the incident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff occurred, did immediately report the suspicion and the information upon which it was based to the Director under the LTCHA, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

On December 1, 2014, an interview with resident #005 revealed that staff are not always asking if the resident requires assistance with brushing teeth and that staff only provide assistance once or twice weekly. On December 8, 2014, the resident revealed that his/her teeth were not brushed on the evening of December 6, 2014, nor on the morning of December 8, 2014. Review of the resident's minimum data set (MDS) assessment revealed that the resident is not cognitively impaired.

A review of the electronic flow sheet for resident #005 indicated that hygiene care was initialed as having been completed at the end of the night shift on December 6, 2014 by staff #016. During an interview with staff #016 on December 10, 2014, the staff member stated that he/she had cleaned resident #005's dentures and swabbed the resident's mouth. However, resident interview and record review confirms that resident #005 does not have dentures. This resident did not receive oral care to maintain the integrity of the resident's oral tissue.
An interview with the home's director of CQI confirmed that residents are to receive oral care twice daily. [s. 34. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An interview held with three Residents' Council representatives revealed that the licensee does not respond within 10 days of receiving concerns or recommendations from the Residents' Council.
Review of the minutes of the Residents' Council meeting held October 23, 2014, revealed that the response from the licensee was dated November 14, 2014, which was greater than 10 days. Review of the minutes of the Residents' Council meeting held November 20, 2014, revealed the response from the licensee was dated December 3, 2014, which was greater than 10 days.
Interviews with the Administrator and Program Manager confirmed that the licensee did not respond to the Residents' Council within 10 days of being advised of their concerns or recommendations. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff receives retraining annually relating to the following:

* The Residents' Bill of Rights
* The home's policy to promote zero tolerance of abuse and neglect of residents
* The duty under section 24 to make mandatory reports
* The whistle-blowing protections afforded by section 26.

Record review and interview with the DOC confirmed that in 2013, 102 staff out of a possible 151 did not receive the mandatory annual education related to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the whistle-blowing protections afforded by section 26. The DOC confirmed that education for 2014 has not been completed as of yet. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff receives retraining annually relating to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the whistle-blowing protections afforded by section 26, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.
Observations on December 4, 2014, confirmed that the licensee failed to ensure the medication cart was kept locked when not in use.
On December 4, 2014, the inspector observed a cart unattended in the 4th floor hallway. No staff was present in the hallway. The inspector was able to open all drawers of the medication cart, and obtain access to multiple drugs. Approximately two minutes later an identified registered staff member returned to the cart. The staff member expressed surprise that the cart was unlocked, and stated that the cart should lock automatically when the drawers are closed. The staff member was unable to lock the cart even when pressing the electronic "LOCK" button on the cart. The staff member changed the batteries in the cart, but the cart still would not consistently lock when the "LOCK" button was pressed. This fact was confirmed by two other identified registered staff members. The cart was then locked in the medication room for safekeeping. Interview with the home's DOC revealed that a technician had been called and would be coming to service the cart that evening. The DOC stated that until the cart was serviced, the home's staff would be instructed to double check the lock and not leave the cart unattended if it was not locked. [s. 130. 1.]

2. Observations and staff interviews confirm that on December 5, 2014, a tube of medicated prescription cream labeled with a resident's name was found within the cushions of a sofa in the 5th floor west hall lounge.
On discovering the tube of medicated cream in the lounge, an inspector informed an identified personal support worker (PSW), who confirmed that he/she had misplaced the resident's medicated cream the previous day, and had been looking for it.
Interviews with the identified PSW and the DOC confirmed that the tube of cream should have been returned to the registered staff after the PSW had finished applying it to the appropriate resident, and that the cream should be stored within the locked treatment cart. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
Staff interviews and record review confirm that the medicated cream prescribed for resident #018 was not administered in accordance with the directions for use specified by the prescriber. Review of the resident's Medication Administration Record (MAR) confirmed that an identified medicated cream is to be applied to the resident #018's lower legs twice daily. Interview with the registered staff member assigned to the resident confirmed that this task was delegated to the resident's assigned PSW. On December 5, 2014, the assigned PSW informed the inspector that he/she did not apply the identified medicated cream to the resident's legs on December 4, and has not applied the cream for the past few days. The PSW's reason for not applying the cream was that the resident's legs were not red. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive annual retraining in infection prevention and control as required under subsection 76 (4) of the Act.

Review of the home's training records for infection prevention and control revealed that 23.3% of the direct care staff did not receive training in infection prevention and control in 2013.

Interview with the lead for the home's infection prevention and control program confirmed that the home was not able to provide training to all direct care staff in infection prevention and control in 2013. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive annual retraining in infection prevention and control as required under subsection 76 (4) of the Act, to be implemented voluntarily.

WN #14: 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. (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 staff participate in the implementation of the infection prevention and control program, as evidenced by the following observations:

a) On December 2, 2014, the following unlabeled personal care items were observed in the shared bathroom for room 308B:
two combs, a denture cup, hair shampoo and hair spray.

b) On the morning of December 5, 2014, an environmental services staff member was observed wearing gloves while emptying garbage from the 5th floor Soiled Utility Room into a large bin. The staff member then proceeded with the large bin to the elevator, pressed the elevator button and left the unit via the elevator, all without removing gloves or performing any hand hygiene. The staff member proceeded to perform the same duties on the 4th floor, all without changing gloves or performing any hand hygiene. [s. 229. (4)]

2. Observation conducted on several occasions revealed that an environmental services staff member pushed the button to use the elevator wearing same gloves that had been used to push the garbage cart and to remove garbage from the floor.
Interview with the identified environmental staff member confirmed that he/she should remove dirty gloves before pushing the button to use the elevator.

Interview with the lead of the infection prevention and control program confirmed that to prevent the spread of infection in the home, dirty gloves should be removed before pushing the button to use the elevators.
The home's lead for the infection prevention and control program also confirmed that all residents' personal care items should be labeled if they are stored in a shared washroom. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #15: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' rights to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity are fully respected and promoted.

Observations conducted on December 1, 2014, at 12:30 p.m., revealed that while an identified PSW was feeding two residents, the PSW used each resident's clothing protector to wipe each resident's mouth.

Interview with the registered nursing staff and food service manager confirmed that when feeding a resident the staff should use paper napkins to wipe the resident's mouth, in order to maintain the resident's dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that resident's right to be properly cared for in a manner consistent with his or her needs is fully respected and promoted.

Interview with resident #018 confirmed that the resident's chosen method of bathing is a bed bath and the staff use water from the sink in the resident's washroom to provide the bed bath. The resident stated that the water from this sink is usually cold in the evening when the resident is bathed, and also at night time.

Interview with resident #006 confirmed that the water is cold from the sink in the washroom at 4:00 a.m., and at night.

Interview with an identified PSW confirmed that the water in the evening time is cold while the PSW provides a bed bath to resident #018.

The inspector measured water temperature in resident #018's room on December 10, 2014, at 9:25 a.m. Initially, when the hot water ran, the temperature was 38.8 degrees Celsius and then it dropped down within 5 minutes to 35 degrees Celsius. On December 11, 2014, at 9.15 a.m., the water in the 5 west shower room measured 22 degrees Celsius, and in the washroom sink in room #427, the hot water was initially 34.2 degrees Celsius, but after 4.5 minutes it reached 40 degrees Celsius.

A review of water temperature audits performed by the home between October and December 2014, indicated that the water temperature in several resident rooms and tub rooms was found to be under 40 degrees Celsius.
Interview with the administrator confirmed that 40-49 degrees Celsius is the acceptable range for the water temperature in the home, and if it is out of this range it is not acceptable. The administrator made a maintenance request regarding the water being cold in room #427 on December 4, 2014, which was not addressed until December 10, 2014. [s. 3. (1) 4.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response is provided to the Family Council within 10 days after receiving advice related to concerns/recommendations.

On December 5, 2014, an interview with the Family Council representative revealed that the licensee responds orally to concerns or recommendations at the council meetings which take place on a monthly basis. The meeting minutes from October 1, 2014, reveal that issues brought forward included: putting cups by the ice machine, setting up a family support group and adjusting dessert portion sizes. The licensee did not respond in writing within 10 days after receiving these concerns/recommendations.

On December 5, 2014, an interview with the Administrator revealed that they attend every meeting and they respond orally at the following meeting after the concern was brought forward. The Administrator was not aware that the home was required to respond in writing within 10 days of concerns or recommendations being made. It was confirmed that the licensee did not respond in writing within 10 days of receiving the concerns/recommendations addressed at the October 1, 2014, meeting. [s. 60. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition and hydration programs include a system to measure resident's height upon admission and annually thereafter.

A review of resident #006 and #007's plan of care revealed that the residents' heights are not recorded in 2013.

Interview with the registered nursing staff and RD confirmed that the home is supposed to measure residents' heights on admission and annually thereafter, however the home did not measure the residents' heights in 2013. [s. 68. (2) (e) (ii)]

WN #18: 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:
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).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, providing residents with any eating aids and assistive devices, required to safely eat and drink as comfortably and independently as possible.

Observation conducted on December 1, 2014, at 12:00 p.m., revealed that resident #027 was served lunch on a regular plate. Resident #011 was not provided a built up and curved spoon for dessert.

A review of a plan of care (diet sheet) for the above mentioned residents indicates that resident #027 requires a rimmed plate and resident #011 requires two built up and curved spoons at meal times.

Interview with the registered nursing staff and the food service manager confirmed that the above mentioned residents should have been provided with the identified assistive devices to maintain their independence for eating. [s. 73. (1) 9.]

2. The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Observation conducted on December 1, 2014, at 12:30 p.m., revealed that resident #009 was served the dessert and resident #028 was served the main course on the table without feeding assistance available.

A review of a plan of care for the above mentioned residents revealed that resident #009 requires extensive assistance for eating and resident #028 requires total assistance throughout the meal.

Interview with the registered nursing staff and the food service manager confirmed that residents should not be served food until the feeding assistance is available to the residents. [s. 73. (2) (b)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Family Council was sought in how to carry out the satisfaction survey.

On December 5, 2014, an interview with a Family Council representative revealed that the Family Council member could not recall a discussion at the Family Council meetings regarding how to carry out the satisfaction survey.

On December 5, 2014, an interview with the Administrator revealed that there is no documentation to support that the licensee sought advice from the Family Council regarding how to carry out the satisfaction surveys. [s. 85. (3)]

2. The licensee has failed to ensure that the advice of the Residents' Council was sought in developing and carrying out the satisfaction survey.

A review of the Residents' Council minutes failed to identify any documentation indicating that the licensee had sought the advice of Residents' Council regarding the development and carrying out of the satisfaction survey.

An interview with the Administrator confirmed that the licensee did not seek the advice of the Residents' Council in developing and carrying out the 2013 satisfaction survey. [s. 85. (3)]

3. The licensee has failed to ensure that the licensee made available to the Residents' Council the results of the 2013 satisfaction survey in order to seek the advice of the Council.

A review of the Residents' Council meeting minutes failed to locate any documentation to indicate that the 2013 satisfaction survey was shared with the Residents' Council.

An interview with the Administrator confirmed the results of the satisfaction survey were not shared with the Residents' Council. [s. 85. (4) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (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 and the pharmacy service provider, meets at least quarterly 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. 115 (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 and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Staff interviews and record review confirm that an interdisciplinary team which included the aforementioned members, met to evaluate the effectiveness of the medication management system on April 24, 2014 and October 1, 2014. A meeting had been scheduled between these two dates, but was canceled due to an outbreak in the home, and was not rescheduled.
The home's CQI manager stated that the interdisciplinary team will be meeting again in December for the purpose of evaluating the effectiveness of the medication management system. [s. 115. (1)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.
Observations of a medication cart on the 4th floor on December 4, 2014, revealed a non-drug related item stored in the narcotic drawer of the medication cart. A metal tool was observed inside a plastic ziplock bag in the narcotic drawer of the cart. An identified RPN confirmed that the tool is used by the gastrointestinal physician for two residents' G-tubes, and had been stored in the cart for safekeeping.
The identified RPN and the DOC both confirmed that this tool was not a drug or drug related supply and should not be stored in the narcotic drawer. The tool was removed by the DOC. [s. 129. (1) (a)]

Issued on this 26th day of January, 2015

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

Original report signed by the inspector.