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
Feb 11, 2015	2014_191107_0028	T-000052-14	Resident Quality Inspection

Licensee/Titulaire de permis

University Health Network
550 UNIVERSITY AVENUE TORONTO ON M5G 2A2

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

LAKESIDE LONG TERM CARE CENTRE
150 DUNN AVENUE TORONTO ON M6K 2R6

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

MICHELLE WARRENER (107), MARILYN TONE (167)

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 16, 17, 18, 2014, January 5, 6, 7, 8, 2015

Critical Incident Inspection T-000451-13 was inspected during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members and friends of residents, the Executive Director, Director of Care, Social Worker, Dietary Manager, Maintenance Manager, Office Manager, Environmental Services Manager, Registered Dietitian, registered nursing staff (Registered Nurse (RN), Registered Practical Nurse (RPN)), front line nursing staff (Personal Support workers (PSW)), front line housekeeping, laundry and dietary staff (Cook, Dietary Aides).

The inspector also observed resident care, meal service, food production systems, laundry and housekeeping services, reviewed clinical health records for identified residents, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

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

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for residents provided clear direction to staff and others who provided direct care to the residents in relation to shaving.

A) The plan of care for resident #014 directed staff to shave the resident; however, the plan did not identify how frequently staff were to shave the resident. The resident was observed with visible facial hair on December 16, 2014 at 1504 hours, January 5, 2015 at 1520 hours, and January 6, 2015 at 0913 hours. Documentation in the resident's flow sheets identified the resident was shaved daily some weeks; however, was not documented as being shaved on other days/weeks. One staff interviewed stated the resident required shaving only on certain days; however, another staff interviewed stated the resident required daily shaving. Flow sheets indicated the resident was sometimes being shaved daily. The resident's plan of care did not provide clear direction to staff providing care on the required frequency of shaving.
B) The plans of care for residents #019, #020, #046, #047, #048 did not provide clear direction for staff providing care related to shaving. The residents' plans of care provided direction related to grooming; however, did not provide direction related to facial hair. The residents were noted to have long facial hair on December 16, 2014, and January 6 and 7, 2015. PSW staff and registered nursing staff interviewed provided different

responses on how the residents were to be groomed. The home's policy, (05-07-05 Personal Hygiene/Grooming Facial Grooming/Cosmetics), directed staff to assist residents as required and to respect the wishes of the resident in relation to removal of facial hair. The residents' plans of care did not specify the residents' wishes and did not indicate if the facial hair was to be removed and frequency of removal. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.
A) Resident #001 had a plan of care that identified the resident wore dentures and required staff assistance for removing and inserting the dentures. RAI-MDS coding completed for almost a one year period, identified the resident had lost some or all of their natural teeth and that the resident did not have or wear dentures. Dentures were also not identified in the other coding in the RAI-MDS assessments. PSW staff providing care to the resident, and the RPN for the home area where the resident resided, confirmed the resident had not been wearing dentures for as long as they could remember. The resident had dentures available in their room; however, the resident did not wear the dentures. The resident was unable to voice their preferences to the inspector when asked about the dentures. The RAI-MDS assessment coding was not consistent with the interventions identified on the resident's plan of care and staff were not consistently implementing the strategies identified on the plan of care. It was unclear from interviews and documentation why the resident was no longer wearing their dentures or if they were required. [s. 6. (4) (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 with ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident (s. 6(1)(c)) and 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 that their assessments are integrated and are consistent with and complement each other (s.6(4)(a)), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

A) Call bells located at the bedside in rooms 1150-1, 2119-1, 2128-1, 2133-1 were not functioning when the inspector tried to activate the system (on December 16, 17, 2014). The lights in the rooms and outside the rooms did not activate and the pager system was not activated to alert staff when the call bell button had been pressed. Staff confirmed with the inspector that the cords for the call bells were not working and did not allow the system to be accessed to alert staff of concerns.
B) Staff conducted an audit of all the call bells in the home on December 17, 2014 as requested by the inspector, and identified 17 malfunctioning call bells (would not activate the resident-staff communication system). The cords were replaced by the home after they were identified as malfunctioning.
C) Call bells in the spa room on the second floor did not have cords attached and could not be reached if residents were in wheelchairs (too high) or while they were in the tub/shower (too far away).
D) The cord on the call bell in the washroom of room 1138-1 detached from the system prior to the alarm sounding. Staff confirmed that if the cords were not attached securely they would detatch when pulled prior to activating the call bell system. [s. 17. (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 with ensuring that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included: any mood and behaviour patterns, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

A) During a review of the health file for resident #003, it was noted that the resident frequently had periods of: mood and behaviour patterns and identified responsive behaviours.
i. A review of the document that the home referred to as the care plan took place. This care plan was confirmed by the DOC to be the most current version of the plan. It was noted that although staff members interviewed confirmed that resident #003 was still displaying the above noted behaviours, the resident's care plan did not reflect that the resident had the inappropriate behaviours.
ii. The care plan did not identify all known potential triggers that could contribute to resident #003's behaviours. [s. 26. (3) 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 with ensuring that a plan of care must be based on, at a minimum, interdisciplinary assessment of mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, with respect to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a care conference of the interdisciplinary team that was providing the residents' care, was held at least annually for residents #003, #005 and #024, to discuss their plans of care and other matters of importance to the residents or their substitute decision-maker.
i. A review of the health file for resident #003 confirmed that a care conference was last documented as held for the resident in 2012. No other care conference information was found for the resident.
ii. A review of the health file for resident #005 confirmed that the last care conference documented as held for the resident was in 2012. No other care conference information was found for the resident.
iii. A review of the health file for resident #024 confirmed that the last care conference documented as held for the resident was in 2010. No other care conference information was found for the resident.
iv. During an interview with the Director of Care (DOC), they indicated that the care conferences should be documented in the electronic documentation system under the "Interdisciplinary Team Care Conference" tab. The DOC also indicated that some staff may still be using the paper care conference form that was previously used.
v. The Social Worker at the home confirmed that it was their duty to co-ordinate the scheduling of the annual care conferences. The Social Worker was not able to verify that any further care conferences took place for these residents.
vi. The DOC and the Social Worker were unable to provide any documentation or any other evidence to support that any further annual care conferences had taken place for the three identified residents. [s. 27. (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 with ensuring that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were bathed, at a minimum, twice a week by the method of their choice, unless contraindicated by a medical condition.
A) Resident #015 had a plan of care that required a shower twice weekly. For an identified week in 2014, documentation reflected a bed bath was provided with no other method of bathing on a second date that week. During interview, a PSW staff stated that if bathing was provided it would be recorded on the PSW flow sheets or on the weekly skin observation forms. Documentation on PSW flow sheets, skin observation forms or progress notes did not reflect a second bath was provided and did not reflect why a bed bath was provided instead of a shower. Staff stated if it was not recorded on any of the forms it likely was not completed.
B) Resident #045 had a plan of care that required a shower twice weekly. For an identified week in 2014, documentation on the PSW flow sheets indicated a bed bath was provided with no second bath/shower provided. Documentation on the skin observation forms and progress notes did not reflect the provision or refusal of a second shower or the reason for the bed bath versus the preferred shower.
C) Resident #017 had a plan of care that required a shower twice weekly. PSW staff interviewed stated the resident's spouse also wanted the resident to have showers.
For the week of:
An identified week in 2015 - nothing was recorded on the PSW flow sheets, bed bath was recorded once on the PSW skin observation form.
An identified week in 2014 - one bed bath recorded on the PSW flow sheets.
An identified week in 2014 - no bath recorded on the PSW flow sheets.
An identified week in 2014 - one shower on the PSW flow sheets.
An identified week in 2014 - one shower on PSW flow sheets.
Skin observation forms were not completed for the identified dates over a two month period. Staff stated if it was not recorded on any of the forms it likely was not completed.

D) Staff confirmed bathing was not completed on an identified date in 2014 due to reduced staffing levels. Documentation did not reflect a bath was offered on a different date for residents who requiring bathing that day. [s. 33. (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 with ensuring that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Resident #003 was noted to be physically and verbally aggressive. A review of the progress notes in the resident's health file and consultation notes from an outside agency confirmed that the resident was verbally and physically aggressive.
i. It was noted that there were a number of interventions suggested by the consulting agency and through meetings involving staff at the home to assist staff to manage the resident's behaviours, but these interventions were never entered into the the document that the home referred to as the care plan for resident #003. It was confirmed by staff that the care plan was used to direct staff related to the resident's care needs and should include any interventions related to resident care.
ii. It was also noted that resident #003's care plan did not include the need to provide any extra monitoring of the resident at times when potential triggers that could result in altercations with other residents were present. [s. 54. (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 with ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #7: 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,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu items were prepared according to the planned menu at the lunch meal December 16, 2014.
A) Not all menu items were prepared according to the planned menu texture, resulting in a coughing spell for resident #043. The pureed mushroom soup was not smooth and contained pieces of mushrooms. Resident #043 required a pureed texture menu and was coughing excessively after consuming the soup with the mushroom pieces. Staff assisting the resident with eating stated the resident seemed to be coughing due to the pieces of mushrooms in the pureed soup. The pureed vegetable salad was chunky and not smooth with pieces of vegetables visible. The texture of the pureed bread and pureed pineapple was not cohesive and the items were running into other items on the plate (also reduced nutritive value due to dilution with too much liquid).

The licensee has failed to ensure that all menu items were prepared according to the planned menu at the dinner meal January 6, 2015.
A) The planned recipe for calico corn required corn, green pepper, margarine, salt, sugar and pimento. The corn served to residents contained only corn. Staff confirmed the dish contained only corn and pureed creamed corn for the pureed texture (recipe required a purchased pureed corn product but the Nutrition Manager confirmed the recipe should have been revised to pureed creamed corn). The cook confirmed the recipe for the calico corn was not followed nor were concerns about the recipe communicated to the Nutrition Manager. During stage 1 of this inspection, residents had voiced concerns about bland food.
B) The planned recipe and cooking instructions for fish cakes required cooking the fish from a frozen state. Staff preparing the meal left the fish cakes sitting at room temperature for over 35 minutes, and had stated the fish was tempered in the refrigerator to thaw prior to cooking. The fish was not prepared according to the directions specified on the recipe and package directions. [s. 72. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring the food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a process was in place to report and locate residents' lost clothing and personal items.

A) The home provided a policy related to missing clothing, [HKLD-06-03-12], dated September 2013. The "Missing Clothing" policy included a form that was to be completed when a missing item of clothing was reported. Registered staff members interviewed confirmed that they were not aware of a form to be used to report missing clothing and indicated that they had never used such a form. A registered staff member interviewed was unable to locate any such form on their unit. The registered staff members interviewed indicated that they would call the laundry staff to let them know about the lost clothing, they would conduct a search on the home area and then check the lost and found in the basement. They were not aware of any process related to completion of a form or documentation of results of the search. During an interview with laundry staff it was confirmed that no form was currently being completed when an item of lost clothing was reported. There was no documentation related to the report of lost clothing, any actions taken or the outcome of the search. Laundry staff indicated that information was passed on to them through word of mouth. [s. 89. (1) (a) (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 with the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times. On December 18, 2014 at 1021 hours and again at 1126 hours, the door to the first floor clean utility room (room 1129) was unlocked and accessible to residents. The room contained a bottle of Zochlor Chlorine Disinfectant tablets (harmful if ingested), and four bottles of Isopropyl rubbing alcohol 70% (harmful or fatal if swallowed, according to the label). A PSW who entered the room while the inspector was there confirmed they were aware the lock on the door was not working correctly (did not consistently lock automatically when the door closed) and the area was accessible to residents. The maintenance log did not reflect that the faulty lock was reported for maintenance staff to fix the problem and the door was consistently left unlocked and accessible to residents. [s. 91.]

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 with ensuring that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that staff applied resident #016's seatbelt restraint in accordance with manufacturer's instructions. On December 16, 2014 at 1627 hours, a PSW was pushing the resident, who was seated in a wheelchair, through the hallway and the resident's wheelchair seatbelt had more than two fists space between the restraint and the resident. The PSW confirmed that the seatbelt was too loose and confirmed the resident was unable to undo the seat belt independently. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

A) During a review of the home's stock drug supply room located in the basement of the home, it was noted that there was a surplus (more that a three month supply) of stock drugs located in that room.
The surplus drugs included but were not limited to:
27 bottles of Almagel (350 mls. each), 28 bottles of Novasen 325 mg. (100 tabs each), 20 bottles of Vitamin B (90 tabs each), 35 boxes of Gravol Suppositories (10 each), 34 bottles of expectorant (250 mls. each), 25 bottles of Koffex (250 mls. each)
B) The DOC, who was present with the inspector when the storage room was reviewed, confirmed that there was more that a three month supply of stock drugs in the storage room. [s. 124.]

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 with ensuring that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken with respect to resident #014 under the nursing and personal support services program, including assessments, interventions, and the resident's responses to interventions, were documented.
A) Documentation on the PSW flow sheets identified the resident was not shaved over a seven day period. PSW staff interviewed stated that shaving was offered; however, refusals were not documented and the shaving provided was not documented during that time period.
B) The resident's plan of care required a shower twice weekly. Documentation on the PSW flow sheets identified the resident was offered a shower only once weekly during 5 identified weeks over a two month period. Staff interviewed stated the resident was offered the second shower; however, refusals were not documented. [s. 30. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee failed to ensure that staff used proper techniques to assist residents with eating at the lunch meal December 16, 2014.
A) Staff assisting resident #011 with eating was mixing the resident's food together (pureed marinated vegetables and pureed bread). Staff stated that sometimes the resident disliked an item so when it was mixed it was easier to feed the resident. The resident was unable to voice their preferences. The resident's plan of care did not direct staff to mix the resident's food together and the Nutrition Manager confirmed that this was not a proper feeding technique used at the home unless it was in the resident's plan of care.
B) The staff member assisting residents with eating was also not aware of what the food items were that they were feeding to resident #011. When asked what the items were, the staff replied, "I don't know. I'm just feeding." The Nutrition Manager confirmed that staff were to review the menu and communicate the menu choices to the residents they were assisting.
C) Proper techniques for assisting residents with eating were not used by the staff member assisting resident #011. [s. 73. (1) 10.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for the cleaning and disinfection of resident care equipment, such as tubs and shower chairs, in the second floor spa room at 1052 hours on December 16, 2014. A brown substance (appeared to be feces) was observed on the surface of the tub under the seat of the shower chair (sit in shower) and another brown substance was observed on the surface of the tub beside the seat. The tub was wet from use and the spa room (shower side) was empty with all the lights out (not currently in use). At 1522 hours the shower was observed (now dry) with the same areas of soiling. The RPN stated the home's policy was to clean and disinfect the tub after each use and confirmed with the inspector that the tub was visibly unclean after use. The home's policy, "INFE-02-01-07, version January 2013, directed staff to clean and disinfect the tub/shower after each use, including any equipment such as a shower chair or bath lift that had been used during the bath. [s. 87. (2) (b)]

Issued on this 12th day of February, 2015

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

Original report signed by the inspector.