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
Dec 22, 2014	2014_207147_0026	H-001421-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

TALL PINES LONG TERM CARE CENTRE
1001 Peter Robertson Blvd. BRAMPTON ON L6R 2Y3

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

LALEH NEWELL (147), CATHIE ROBITAILLE (536), DARIA TRZOS (561), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 21, 22, 23, 24, 27, 28, 29 a nd 30, 2014

H-001364-14
H-001159-14
H-000252-14
H-001392-14
H-000405-14
H-000076-14
H-000369-14
H-000587-14
H-001307-14
H-001246-14
H-001312-14
H-000576-14
H-001396-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Supervisors of Care (SOC), Facility Services Supervisor, Registered staff, Behavioural Supports Ontario (BSO), Social Worker, Clinical Dietitian, Dietary Services Supervisor, Dietary Aides, Cook, RAI (Resident Assessment Instrument)Specialist, Personal Support Worker(PSW), Resident and Family Council spokespersons, Residents and Families.

The following Inspection Protocols were used during this inspection:

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

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

- **11 WN(s)**
- **8 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. 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 failed to ensure that resident #023 and resident #206 had the right to live in a safe environment.

On an identified dated in October 2014, the LTC inspector went into shower room and found the shower room door to be open approximately one inch, the light was on and the privacy curtain was pulled. Resident #023 then called out from behind the curtain, and no staff were observed to be in the shower room with the resident. Upon entering the room, the inspector observed resident sitting on the lift chair suspended at an unsafe height over the shower cubicle and did not have the required seatbelt on, and did not have access to the call bell. The inspector came out to advise RN who then proceeded to get the Personal Support Worker (PSW) responsible for the resident, who had just taken another resident into another spa for a bath. The PSW then returned to shower room to complete resident #023's care. The PSW confirmed that she was responsible for resident #023's care and that the resident was able to be left alone in the bathroom unattended and had not yet been showered. The PSW was asked if any resident should be left with feet raised off of the floor, no seatbelt in place, and with no call bell. The PSW only shook her head in response to the question. The PSW was also asked, if she had forgotten about resident #023 as she was about to start another bath. The PSW once again only shook her head in response to the question.
B) Inspector then asked a second PSW to check on resident #206 who had been left in the other tub room. The PSW went into the tub room and quickly exited. The inspector then went to the tub room to check on resident #206 and noted resident sitting on the toilet while in mechanical lift. The resident appeared to be sleeping. Inspector stayed with resident #206 for several minutes before PSW staff returned.
C) Resident # 023's plan of care states the resident is to have two nursing attendants to provide total assistance using the sit/stand lift and can be left unattended and will call if finished. The Supervisor of Care confirmed that resident #023 could be left alone however, should have been toileted in the resident's own bathroom and given the call bell. Resident # 206's plan of care states the resident is to have two person mechanical lift, total assistance for entire process and to ensure safety. Interview with the Supervisor of Care confirmed if a resident's care plan does not state that a resident can be left unattended while in the bathroom, one staff should remain with resident who is in a mechanical lift. [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 all residents had the right to live in a safe environment, 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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care provided clear direction to staff who provided direct care to the resident.

Clinical documentation for resident #300 stated "DO NOT SERVE puree bread (dislikes)". This instruction was in the care plan used by registered staff, the kardex used by personal support workers (PSW's), and included in a written progress note by the Registered Dietitian. On October 24 and 27, 2014 the resident's diet list in the Castlemore servery indicated the resident "disliked pureed bread". This was confirmed by

the dietary aide who served meals to the resident on October 24 and 27, 2014. A PSW reported that the resident's kardex stated "DO NOT SERVE puree bread". The RD confirmed the resident was not to be served pureed bread, and the resident's diet list in the servery was not updated and did not provide clear direction to all staff providing direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure the care set out in the plan of care was provided as specified in the plan.

Resident #300 had a plan of care which stated "DO NOT serve pureed bread, as the resident dislikes them". On October 27, 2014, during lunch meal service in the Castlemore Crescent dining room, the resident was served puree bread. This was confirmed by the PSW assisting the resident. Registered Dietitian confirmed the resident was to not receive puree bread as the plan of care indicated the resident disliked pureed bread. [s. 6. (7)]

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

Resident #002 had a plan of care to receive nectar thickened drinks, On October 24, 2014, during lunch meal service in the Castlemore Crescent, resident #002 was observed receiving nectar thickened fluids. The PSW assisting the resident confirmed the resident received nectar thickened fluids. Other PSWs reported the resident required honey thick fluids. This instruction was confirmed that document they used to provide direction for care, known as the kardex, indicated the resident was to receive honey thickened fluids. Registered nursing staff confirmed the resident's plan of care indicated they were to receive honey thickened fluids. (585) [s. 6. (7)]

4. The licensee has failed to ensure that provision of care set out in the plan of care was documented.

Resident #041 had a respiratory infection and was placed on droplet precautions in June 2014. The written plan of care was reviewed and indicated that the respiratory infection and interventions in place for the resident were not documented in the written plan of care. The registered staff confirmed that the staff omitted to document the infection in the written plan of care. [s. 6. (9) 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 the resident's plan of care provided clear direction to staff who provided direct care to the resident, the care set out in the plan of care was provided as specified in the plan and that provision of care set out in the plan of care was documented, 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 home's policy for residents to self-administer medications was complied with.

Resident #207 had an order for self-administration of their inhalers. The policy [Medication-Administration-Self Policy No: LTC9-05.12.02] last updated April 14, 2014 identified that for those residents' who self-administered medications, the RN/RPN will review medications with the resident every three months, sign on the 3-month medication review sheet and complete the Self-Medication Checklist. A chart review was completed on resident #207 chart and there were no medication checklists noted in the clinical record. This was confirmed by the RN and the Supervisor of Care. [s. 8. (1)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #300 had surgery on an identified date in July 2014. The physician had prescribed an order for pain medication to be given every 4 to 6 hours when needed. The health records indicated that the resident received two doses on two different dates after the surgery. The progress notes indicated that the resident was assessed for pain and did not show any signs of pain or discomfort.
According to the (Medication Administration Record) MAR the next dose of the pain medication was given to resident later in the evening. There are no documented evidence to show that the resident exhibited a change in health, specifically in relation to pain as a result of the surgery.
The home's policy on Pain Management Program revised in March 2011 and interview with the DOC indicated that the pain assessment must be completed utilizing a clinically appropriate instrument and documented in Point Click Care (PCC). The DOC confirmed that the staff were required to use a Pain Assessment Tool under the Assessment Tab in Point Click Care (PCC) to assess for pain and confirmed that that was not done for this resident. The staff did not follow the Pain Management Program and did not comply with the policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. The home's "Weight Monitoring Program", revised April 2011, was not complied with.

A) The home's Weight Monitoring Program included a paper "Monthly Weight Schedule" to be completed by PSWs and Registered Staff. The schedule stated that 'residents must be re-weighed by the Registered Staff if there is a weight loss/gain of 2.2 kg or more from the previous month. This must also be documented in a progress note and communicated to the Dietitian".

i) In September and October 2014, resident #002 had their recorded weight documented on the "Monthly Weight Schedule".
From September to October 2014, documentation indicated resident #002 lost 3.8 kg, and triggered for a significant change in weight of 6.9% in one month, 8.9% in three months, and 11.1% over six months. The Monthly Weight Schedule form for October 2014 and progress notes did not indicate a re-weigh was completed by Registered Staff. A PSW reported the form did not contain a documented re-weigh of the resident. Registered staff confirmed there was no documented re-weigh of the resident.

ii) In September and October 2014, resident #013 had their recorded weight on the "Monthly Weight Schedule". These weights were also documented in the electronic medical records.

From September to October 2014, documentation indicated resident #013 lost 5.0 kg, and triggered for a significant weight change of 10.2% over three months, and 10.2% over six months. The Monthly Weight Schedule form for October 2014 and progress notes did not indicate a re-weigh was completed by Registered Staff. Registered Nursing staff confirmed that the form did not contain a documented re-weigh of the resident, there was no documentation in a progress note indicating a reweigh occurred, and that no referral was made to the Dietitian. The Dietitian confirmed they did not receive a referral from nursing staff for the resident's weight loss.

B) The home's Weight Monitoring Program stated the PSW was to weight residents at 'monthly intervals consistent with the schedule', and that the resident 'will be re-weighed on the same shift if there is a variance, and 'registered nursing staff will verify the re-weigh'.

i) On October 24, 2014, the "Monthly Weight Schedule" in the Castlemore Court tub room was reviewed and indicated that all residents in the home area already had recorded weights under the November 2014 weights column. One PSW reported that weights were taken in advance for all of the residents between October 22 and 24, 2014, and that weights would be entered electronically on November 1, 2014. Registered Nursing staff, the Supervisor of Care, and the Registered Dietitian for the home area stated the home's schedule for recording monthly weights was within the first seven days of the month, and not a week prior to the beginning of the month.

Improper practices in recording and documenting weights impacted the quality of information for staff to conduct accurate assessments of residents triggering for significant weight loss. (585) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with food and fluids that are safe and adequate in quantity.

A) The pureed food served to residents was not safe.

i) On October 24, 2014, during lunch meal service, in the Castlemore Crescent dining room, pureed beets and puree quiche were served to residents. The beets appeared runny, and were observed pooling on the plate. The puree quiche was noted to be sticky. Both foods created a risk for choking.

ii) On October 27, 2014, during the lunch meal service in Mayfield Court and Castlemore Crescent dining rooms, pureed caesar salad was served to residents. The salad was runny, and was observed pooling on the plate. The Food Service Supervisor confirmed that puree textures should be served as a cohesive form, and should not run. Both foods created a risk for choking.

B) Pureed food was not served to residents in an adequate quantity.

i) Resident #013 was identified as experiencing significant weight loss in October 2014, and followed a regular, puree diet. On October 27, 2014, during lunch meal service on Castlemore Crescent, a dietary aide was observed providing one #10 scoop of puree tortellini to resident #013, as well as all other residents in the home area receiving pureed tortellini. The therapeutic menu indicated that individuals receiving a pureed meal were to receive two #10 scoops of tortellini. The dietary staff reported they only provided one #10 scoop to all residents. The cook confirmed that residents were to receive two #10 scoops of tortellini. The Registered Dietitian confirmed they relied on foods being served at the correct portions as indicated in therapeutic menu when assessing resident's food intakes when triggered for weight loss. [s. 11. (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 residents were provided with food and fluids that are safe and adequate in quantity, to be implemented voluntarily.

WN #5: 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 failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On an identified date in April 2014 resident #101 had a fall and sustained an injury attempting to open the servery door on the third floor, Wildfield home area. The servery door on Wildfield was observed on October 28, 2014 to be open and unlocked, interview with the staff state the push button lock on the top half of the servery door was not functional and the staff are instructed to lock the handle on the bottom half of the door from the inside. The staff also confirm that the servery door has not been in a good state of repair for the past six months.
Interview with the Facility Services Supervisor related to the servery doors in the home, confirm that the home is aware of the risk associated with the servery doors not being maintained in a safe condition and are in the process of fixing all the servery doors in the home. At the present time only two out of six servery doors have been converted to key pad doors (Humber Court and Castlemore Court). [s. 15. (2) (c)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the staffing plan must provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

Interview with the Supervisor of Care (SOC), review of the home's Falls Tracking by Time, 2014 and Falls Monthly Tracking, 2014 audit reports related to resident falls, indicated that there was a spike in the number of falls with significant injury to residents (an average of 44.5 falls between January – June, 2014 with 24 falls occurring between 1500 to 1700 hours) around the afternoon shift change. A review of staffing completed by the home confirmed that all staff on the unit were attending shift report and were not monitoring the care and safety needs of the residents on the unit. Since July 2014 the home has implemented a practice to ensure that one PSW stays on the unit during shift report to monitor the residents, the home has also ensured that there is an increased number of activity staff on the units during this time to engage residents in a variety of activities. [s. 31. (3) (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 the staffing plan must provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee failed to ensure that every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

Interview with the home's Falls Management Committee Chair and review of the home's 2013 and 2014 Falls Monthly Tracking audit indicted that the home had an average of 44 falls per month and 43 falls per month respectively.
Further review of falls for resident #101, #102, #103, #104, #105 and #106 show that each resident had multiple falls resulting in significant injuries.

Review of the Falls Management Committee minutes between February to October 2014 show the committee did monitor, track, analyze and evaluate the number of falls on a monthly basis, and made recommendations to improve the the falls program by implementing different education sessions to the staff, residents and visitors. However, review of the falls incident audits show that there has been no significant improvement seen to the care, services and the falls program, as the number of falls in all of the home areas continue to be high on a consistent basis. [s. 84.]

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 licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home, to be implemented voluntarily.

WN #8: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the person who applied the device and the time of application is documented.

Resident #106 had a fall on an identified dated in September 2014 and sustained an injury. Interview with SOC, the staff on the unit and review of the clinical record including physician orders confirmed that prior to the fall staff were to place resident in a wheelchair and apply a seatbelt restraint at mealtime and as needed (PRN) when resident was fatigued.
Staff on the unit confirmed that on multiple occasions during the shift, they would place the resident in a wheelchair and apply the seatbelt restraint every time. This was done when the staff felt the resident was exhibiting signs of fatigue such as becoming unsteady on her feet. [s. 110. (7) 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 every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the person who applied the device and the time of application is documented, to be implemented voluntarily.

WN #9: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has a 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.

Resident #028's written plan of care required one person limited assistance to use the toilet room (transfers on/off toilet) and supervision and needed one person extensive assistance. The interview with the resident indicated that in February of 2014 resident rang a call bell as the resident needed assistance with toileting.
After waiting some time for assistance resident struggled to transfer from bed onto the wheelchair independently. A PSW that provided direct care to the resident responded to the call bell after approximately several minutes, came into the room and according to the resident responded in a rude way. The resident felt that the resident was not treated with courtesy and respect. The investigation report and the Supervisor of Care confirmed that the PSW should have assisted the resident with the transfer. The licensee did not ensure that the resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality. [s. 3. (1) 1.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, that strategies are developed and implemented to respond to these behaviours.

Review of progress notes for a four week period identified that resident #203 had numerous behaviours identified.

A review of the plan of care which the home refers to as the care plan for resident #203, did not include any interventions for these behaviours identified. This was confirmed by the Director of Care. [s. 53. (4) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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 menu items were served using methods to preserve appearance and taste.

A) On October 27, 2014, during lunch meal service in the Castlemore Crescent and Woodhill Court dining rooms, sub sandwiches were on the menu. The subs did not appear visually appealing as were served on a white hot dog bun, and contained three slices of meat and a slice of cheese. Further review indicated that the sub recipe stated that condiments, including mayonnaise, mustard, ketchup, and/or relish were to be served. The dietary staff in both home areas stated and confirmed that they had the condiments available in the servery, but were not offered during meal service to enhance the taste of the food.
B) On October 27, 2014, during lunch meal service in the Castlemore Crescent and Woodhill Court dining rooms, puree Caesar salad was served. The salad was not visually appearing as it was watery and pooled on the plate. A thick dollop of Caesar salad dressing was placed on top of the puree salad and did not look appealing. (585) [s. 72. (3) (a)]

2. The licensee has failed to ensure that foods and fluids were served to prevent contamination.

A) On October 27, 2014, during lunch meal service in the Castlemore Crescent and Woodhill Court serveries, one dietary aide was observed rubbing their nose with their hand, then continued serving meals to residents. Another dietary aide was observed scratching their scalp and neck, and continued serving meals to residents. The Food

Service Supervisor confirmed that hand hygiene should be performed after staff touch their hair or face.
B) On October 28, 2014, in the evening, on Castlemore Crescent, three PSW's were distributing the evening snacks and fluids. During the snack pass, the PSW's were observed taking dirty cups and napkins from residents, then continued to serve other residents snacks. One of the PSWs was observed repositioning a resident and providing full assistance to feed a resident, and continued to provide snacks to residents without performing hand hygiene. All of the PSW's confirmed they did not perform hand hygiene between tasks. The Food Service Supervisor confirmed that hand hygiene should be performed after staff touch soiled dishes and serving residents at snack times.
C) The home's policy, "Routine Practices – Hand Hygiene, LTC 8-03.1", revised June 10, 2013, stated "staff should perform hand hygiene "between each resident contact" "before and after feeding a resident", and "before preparing, handling, serving, or eating food and/or beverages". [s. 72. (3) (b)]

Issued on this 5th day of January, 2015

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

Original report signed by the inspector.