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

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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
Mar 26, 2015	2015_297558_0001	T-1734-15	Resident Quality Inspection

Licensee/Titulaire de permis

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET NEWMARKET ON L3Y 2L1

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

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET NEWMARKET ON L3Y 2L1

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

BARBARA PARISOTTO (558), GORDANA KRSTEVSKA (600), JULIET MANDERSON-GRAY (607)

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): January 16, 19-21, 23, 26-30, 2015.

The following complaint was completed concurrently with the RQI: T-1343-14.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), the director of care (DOC), two assistant director of care (ADOC), environmental services manager (ESM), life enrichment manager (LEM), food service supervisor (FSS), maintenance supervisor, resident assessment instrument minimum data set (RAI MDS) coordinator, social worker, family service worker, physiotherapist (PT), nursing supervisors, wound care coordinator, registered nurses (RN), registered practical nurses (RPN), personal service workers (PSW), housekeepers, janitors, laundry aides, dietary aide (DA), family members and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
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
Skin and Wound Care

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
3. Every resident has the right not to be neglected by the licensee or staff. 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:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's 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 is fully respected and promoted.

a.) On January 28, 2015, resident #12 was sitting at an identified PSW work area eating breakfast and was observed eating without utensils. An interview with a PSW revealed that the resident should be using utensils and went to get utensils for the resident to use. An interview with the RN confirmed that the resident should have been provided utensils and that the resident was not treated in a dignified manner.

An interview with the ADOC confirmed that the home's expectation is that residents are to receive utensils for meals and confirmed that resident #12 was not treated in a dignified manner.

b.) An interview with a PSW revealed that staff attempted to assist resident #12 to get

ready for bed when the resident wanted to make a phone call. The staff member revealed that the resident was told it was too late to make a call.

An interview with the ADOC and DOC confirmed that the home's expectations is that the resident's right to make a phone call be respected and that the resident be treated with dignity. [s. 3. (1) 1.]

2. An interview with resident #11 revealed that a staff member made an inappropriate comment regarding the resident's size of bowel movement.

An interview with the identified staff member confirmed that an inappropriate comment was made regarding the resident's size of bowel movement, which upset the resident and confirmed the resident was treated in an undignified manner.

An interview with the ADOC and DOC confirmed that the staff member's comment was inappropriate and that resident #11 was not treated in a dignified manner. [s. 3. (1) 1.]

3. The licensee has failed to ensure that the resident's right not to be neglected by the licensee or staff is fully respected and promoted.

A review of resident #13's care plan identified the resident requires total assistance for all aspects of toileting activity and that the resident has the potential to be dry if toileted in advance by staff at specified times of day.

An interview with a PSW revealed that he/she made a report to a registered staff member regarding resident #13 who was often found sitting in urine-soaked clothing at the start of the PSW's shift at 5:00 p.m. and voiced concern of neglect of the resident. An interview with the identified registered staff member confirmed the PSW reported the above mentioned concern and the registered staff member also observed the resident to be wet.

An interview with the ADOC and DOC revealed they were unaware of this concern and indicated an internal investigation would be initiated for the alleged neglect. [s. 3. (1) 3.]

4. The licensee failed to ensure resident #11's right to participate in decision making was fully respected and promoted.

On a specific evening in August 2014, resident #11 was expecting a package to be

delivered. The package was given to the nurse supervisor by an identified PSW as the contents of the package would require a safety check by maintenance before use.
The nurse supervisor visited resident #11 to explain the home's policy and procedure and described the resident as very upset that the home was withholding the resident's personal property.
Interviews with the resident and the PSW revealed the nurse manager suggested a call be placed to the resident's spouse to assist with the situation and the resident responded that the spouse was unavailable.
An interview with the nurse supervisor confirmed a call was placed to the resident's spouse to inform the spouse of the situation. After informing the resident that the spouse had been contacted, the resident stated the supervisor had no right to call the resident's spouse.

An interview with the ADOC confirmed that resident #11's right to decision-making was disrespected when the evening nurse supervisor contacted the resident's spouse without consent from resident #11. [s. 3. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's 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 is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (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 there is a written plan of care for each resident that sets out the planned care for the resident.

A record review revealed that resident #10 had a wound assessment in January 2015, and identified an area of skin breakdown.

The resident's written plan of care did not identify the planned care for resident #10's wound and this was confirmed by the registered nurse. [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A record review of resident #12's MDS assessments and flow sheets revealed and staff interviews confirmed that the resident experiences frequent bowel issues.
A record review could not locate a dietary referral to assess the resident's bowel needs.

A review of the home's policy titled dietary services manual- nutritional care - continence care, policy #04-01-13 reviewed January 2007, revealed:
- on admission all residents will be assessed for individualized bowel and bladder protocols. When appropriate, residents will be referred to the dietitian.
- the dietitian in consultation with the interdisciplinary team will develop a nutritional care plan designed to address the resident's bowel and bladder needs. Each resident's nutritional care plan shall be carried out and communicated to the staff.

An interview with a registered staff member revealed that a referral should have been sent to the dietitian to assess the resident's bowel needs.

An interview with the ADOC confirmed that the home's expectation is when there is a change in a resident's bowel or bladders status a referral is sent to the dietitian. [s. 6. (4) (a)]

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

A review of the written plan of care for resident #06 states the resident uses a yellow day liner brief and staff may also use a blue large brief for incontinence.
Staff interviews revealed that the resident wears a yellow brief and this was documented in the PSW's assignment binder and the tena sheet.
An interview with a registered staff member indicated that the yellow day liner brief is different from a yellow brief and that the resident does not use a blue brief.

The registered staff member confirmed that the plan of care for resident #06 was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

4. A review of resident #02's January 2015, flow sheets revealed the resident received one tub bath and five bed baths.
A review of the plan of care revealed the resident prefers a shower once per week.
Interviews with the staff and resident revealed the resident prefers a tub bath once per

week.

An interview with the registered staff confirmed that resident #02's plan of care was not revised when the resident's bathing preference changed. [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 the resident's plan of care is reviewed and revised when the resident's care needs changed 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. 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 any plan, policy, protocol, procedure, strategy or system that the long-term care home has institute or put into place is complied with.

A review of progress notes written between January 6 and October 28, 2014, revealed that on several occasions resident #08 was missing a hearing aid.

On September 28, 2014, at 2:21 p.m., a progress note identified the family was upset upon discovering one of the resident's hearing aids was missing. The missing hearing aid was recorded in the unit daily record book. Record review revealed staff looked for

the hearing aide on September 28 and 29 and on September 30, 2014, the hearing aid was still missing. On October 26, 2014, the family delivered a hearing aid.
A review of the home's complaints binder did not locate documentation related to the complaint received on September 28, 2014.

A review of the home's policy dealing with complaints, NURS-03-05-01, last modified September 2011, states the charge nurse is to notify the DOC after meeting with the resident or family and that the DOC would investigate the circumstances leading to the complaint within 24hrs and complete the complaint form in detail.

An interview with an ADOC and DOC revealed they were unaware of this complaint and that the registered staff did not comply with the home's policy dealing with complaints. [s. 8. (1) (b)]

2. A review of MDS data for resident #12 revealed that the resident experienced a bowel condition.

A review of the home's policy titled – continence management program, resident care quality indicator, policy #RESI-10-04-01, version November 2013, revealed:
Staff will complete a continence assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. The assessment will include a thorough process for review of clinical health records, an interview of the resident and feedback from care staff. An assessment of the resident is completed:
- with any change in condition that may affect bladder and bowel continence.

A record review could not locate a bowel and bladder assessment using a clinically appropriate tool when the resident's bowel elimination status changed.

Interviews with the RAI MDS coordinator and the ADOC confirmed that resident #12 should have had an assessment when bowel elimination status changed. [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 that the long-term care home has institute or put into 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. 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 any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

An interview of resident #13 revealed the resident was rough-handled by a staff member. An interview with a PSW revealed that resident #13 reported to him/her that the resident was rough-handled. The PSW reported this to a registered staff member in addition to the PSW's concern relating to resident #13 being neglected as the resident was often found in urine-soaked clothing at the start of the PSW's shift.

An interview with the identified registered staff member confirmed that the PSW reported concerns relating to resident #13 being neglected but no concerns were brought forward relating to the resident being rough-handled. The registered staff member stated he/she was able to verify that resident #13's clothing was soaked with urine.The registered staff member reported the alleged neglect to the nurse supervisor.

An interview of the identified nurse supervisor revealed that the registered staff member did not report the alleged abuse and neglect, and that the home's expectation is that any alleged or suspected abuse or neglect be reported immediately.

An interview with the ADOC and DOC confirmed that the home's expectation is that any alleged, suspected or witnessed incident of abuse or neglect be reported immediately. [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 any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered staff within 24 hours of the resident's admission.

A record review for resident #05 revealed the resident was admitted to the home on an identified date and the admission skin assessment was conducted three days later, which identified an area of skin breakdown.

An interview with the ADOC confirmed that resident #05 did not have a skin assessment within 24 hours of admission. [s. 50. (2) (a) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds been assessed by a registered dietitian who is a member of the staff of the home.

A record review revealed in January 2015, resident #10's skin assessment identified an area of skin breakdown. A record review could not locate a referral to the dietitian.

The home policy titled skin care - clinical procedures - #03-01 date June 2010, states: Registered staff are responsible for assessing and obtaining information related to past skin issues, including but not limited to, current status: nutritional status including food intake and referral to the dietitian.

Interview with the wound care coordinator confirmed that it is expected that the registered staff on the floor would refer the resident who exhibits an area of skin breakdown to the dietitian. [s. 50. (2) (b) (iii)]

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 received a skin assessment by a member of the registered nursing staff within 24 hours of admission
- that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds been assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #6: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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 have received 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 to make mandatory reports under section 24
- The whistle-blowing protections

A review of the home's abuse training records identified that 8% of the staff did not receive training on abuse in 2014.
Interviews with two PSWs revealed that they did not receive abuse training in 2014.

An interview with the ADOC confirmed that not all staff received abuse training in 2014.
[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 have receive 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 to make mandatory reports under section 24
The whistle-blowing protections, to be implemented voluntarily.

WN #7: 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 secure and locked, and that complies with manufacturer's instructions for the storage of the drugs.

On January 23, 2015, the inspector observed a jar of prescription cream and a jar of cream marked analgesic ointment, unattended on a clean linen cart, in an identified hallway. The cart was accessible to residents.
An interview with a PSW revealed that creams should not be left on top of the cart unattended and accessible to residents.

An interview with ADOC and DOC confirmed that prescription ointments were not stored safely and securely. [s. 129. (1) (a)]

2. Observation of medication administration on an identified date, identified three eye drop bottles were opened but not dated.

An interview with the RPN confirmed that the medications were not dated and the expectation is that eye-drop bottles are to be dated when first opened. [s. 129. (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, drugs are stored in an area or a medication cart that is secure and locked, and that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #8: 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.

On January 20, and 21, 2015, at 9:30 a.m. and 10:30 a.m. respectively, clean linen carts and lifts were observed on both sides of an identified hallway, obstructing the hallway.

An interview with a PSW revealed that residents could not access the hand rail on either side of the hallway, which is a safety risk.

An interview with the ADOC confirmed that the home's expectation is that the hallways be kept clear of equipment to promote safe and secure environment for residents. [s. 5.]

2. On January 19, 2015, at 1:08 p.m. the inspector observed a clean linen cart sitting in an identified resident's room, unattended. A neutral disinfectant cleaner labeled do not drink was on the cart. Cognitively impaired residents reside in this home area. A PSW arrived to pick up the cart and revealed the clean linen cart should be stored in the utility room.

An interview with the ADOC confirmed that the disinfectant cleaner should be stored in a closed area and that the clean linen cart should be secured in the clean utility room. [s. 5.]

WN #9: 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's carpets are kept clean.

On January 26, 27, and 28, 2015, the inspector observed a large pink stain on the carpet by the fire doors on an identified home area. On January 27 and 28, 2015, the inspector observed a large orange stain on the carpet in the common area between the identified corridors.

Interviews with housekeeping staff revealed that carpet stains are spot cleaned with a chemical remover and if unsuccessful, the janitor will be notified to shampoo the area. The janitor would be informed verbally or through the housekeeping communication book kept at the nursing station.

Interviews with registered staff confirmed that if a carpet requires cleaning housekeeping will be notified verbally or through the housekeeping communication book.

An interview with the ESM revealed nursing would identify a stained carpet area in the housekeeping communication book, and the janitors would check the book daily, prioritize and complete the cleaning.

An interview with the deep cleaner revealed that a housekeeper or deep cleaner would clean the carpet stains if made aware of the stains through visual observation or through the housekeeping communication book. The deep cleaner confirmed that the identified carpet stains were not logged in the housekeeping communication book.

On January 30, 2015, the pink and orange stains remained on the carpet. [s. 15. (2) (a)]

WN #10: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

An interview with resident #11 revealed that the resident prefers to sleep in bed until 10:00 a.m.
An interview with a PSW revealed that the staff member was aware of the resident's sleep preference.
A review of resident #11's plan of care did not identify the resident's sleep patterns and preferences.

An interview with the MDS-RAI coordinator and the DOC confirmed that the home's expectation is that the resident's sleep patterns and preferences should be in the plan of care. [s. 26. (3) 21.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident receives individualized personal care, including hygiene care and grooming on a daily basis.

Observations revealed that on identified dates resident #12's left eye was matted and eyes glasses were unclean.
An interview with a PSW confirmed that the resident's glasses should have been cleaned before placing them on the resident.
An interview with a registered staff member confirmed that the home's expectation is that the staff should ensure that resident's eyes and glasses are clean at all times.

An interview with the ADOC confirmed that it is the home's expectation that residents are groomed twice per day and as needed and that eye glasses are cleaned before placing them on residents. [s. 32.]

WN #12: 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 each resident receives oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

An interview with resident #11 revealed that mouth care is not offered in the evenings.
An interview with a PSW confirmed that mouth care is not offered to resident #11 in the evenings because the resident does not ask.
An interview with a registered staff member revealed that mouth care is to be offered to residents in the mornings and in the evenings.

An interview with the ADOC confirmed that the home's expectation is that mouth care be offered to residents in the mornings and in the evenings. [s. 34. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident receives fingernail care, including the cutting of fingernails.

On identified dates resident #02 was observed to have long nails, that were not cut or trimmed, were visibly unclean and had worn out nail polish.

A review of the assigning master bath/shower record directs staff to provide fingernail care to the resident on each bath day.

A review of resident #02's flow sheets revealed that the resident did not receive fingernail care on the identified resident's bath days. Interviews with PSWs confirmed fingernail care was not provided. [s. 35. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is dressed in clean footwear.

On identified dates resident #04 was observed wearing unclean shoes. Staff interviews confirmed it is the role of the PSW to ensure residents' shoes are kept clean.

The resident's assigned PSW confirmed resident #04's shoes were unclean. [s. 40.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

An interview with resident #12 revealed that the resident's preferred bed time is 9:30 p.m. and staff often try to have the resident go to bed at 8:00 p.m. A review of resident #12's care plan identified the resident's preferred sleep rest pattern is 10:00 p.m.
A review of progress notes revealed that staff have tried to have the resident go to bed at 9:00 p.m. and the resident refused.

An interview with the ADOC confirmed that the home's expectation is that staff ensure that the resident's desired bed time is supported. [s. 41.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A review of resident #06's MDS assessment for December 2014, revealed that resident #06 is occasionally incontinent of bowel and bladder.

A review of the written care plan revised in January 2015, identified the resident with urinary incontinence and indicated a bowel and bladder assessment be completed when the resident experiences a significant change in status.
A record review revealed the most recent bladder and bowel assessment was completed in November 2013.
An interview with a registered staff member revealed the resident had a change in continence care needs in January 2015.

Interviews with the registered staff and ADOC confirmed an assessment using a clinically appropriate instrument should have been completed as resident #06's condition required. [s. 51. (2) (a)]

2. The licensee failed to ensure that each resident who is incontinent has an

individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment.

In November 2014, a clinical assessment revealed that resident #14 was continent of bowels and is not using incontinent products.

The MDS assessment completed in November 2014 revealed that the resident was frequently incontinent of bowels, used incontinent products and the assessment was categorized as a change in the resident's condition. The resident assessment protocol (RAP) on the same date revealed that during the observation period the resident had been frequently incontinent of stool requiring a brief for containment.

A review of the written plan of care could not locate the planned care for the resident relating to incontinence and use of incontinent product.

An interview with the RAI MDS coordinator and the ADOC confirmed that the resident's plan of care should include an individualized plan, to promote and manage bowel and bladder continence. [s. 51. (2) (b)]

WN #17: 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 response is provided in writing to the Family Council within 10 days of receiving advice related to concerns or recommendations made by the Family Council.

An interview with the Family Council chair revealed the Family Council raised a concern during the October 2014 meeting related to use of Skype by residents of the home. The chair indicated the LEM was to investigate and the ED to follow up on the concern. A record review of the Family Council minutes did not locate a written response to this concern.
At the next Family Council meeting in November 2014, a family member volunteered to address the concern. There was no scheduled Family Council meeting in December 2014.
Interviews with the Family Council chair and the ED could not confirm whether this concern was addressed and resolved at this point in time.

An interview with the ED confirmed a written response was not provided to the Family Council within 10 days of receiving the concern related to the residents' use of Skype in the home. [s. 60. (2)]

WN #18: 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).

Findings/Faits saillants :

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

On August 20, 2014, the Residents' Council president reviewed the annual customer/resident satisfaction survey questions and signed a document verifying the president's participation in the development of the survey. This document did not indicate the Residents' Council's advice was sought in carrying out the survey.

A review of Residents' Council minutes and interviews with the Residents' Council president, Residents' Council assistant and the ED could not confirm whether the Residents' Council's advice was sought in carrying out the survey. [s. 85. (3)]

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

On August 20, 2014, the Family Council chair reviewed the annual customer/resident satisfaction survey questions and signed a document verifying the chair's participation in the development of the survey. This document did not indicate the Family Council's advice was sought in carrying out the survey.

A review of Family Council's minutes and interviews with the Family Council chair could not confirm that the Family Council's advice was sought in carrying out the survey. [s. 85. (3)]

WN #19: 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 that procedures are developed and implemented to ensure that there is a process to report and locate residents’ lost clothing and personal items.

a.) An interview with resident #01 revealed personal linens went missing and was reported to a PSW. An interview with the identified PSW confirmed knowledge of resident #01's missing linens, and revealed the other PSWs and the registered staff were notified at that time.

Interviews with PSWs revealed when an item is reported missing, the PSW will search for the item in the resident’s room; may inform other PSWs on the home area to search their assigned residents’ rooms; may inform laundry and/or search the laundry’s lost and found; and will report it to the charge nurse.

An interview with a registered staff member revealed a form is initiated for missing laundry items and sent to the ESM.

A record review of the 2014 missing clothing/item forms did not locate the above mentioned item.

Interviews with a laundry aide and the ESM confirmed staff did not initiate a form to report the missing item.

b.) An interview with resident #11 revealed a personal laundry item went missing and was reported to a PSW.

Interviews with PSWs revealed when an item is reported missing, the PSW will search for the item in the resident’s room, may inform other PSWs on the home area to search their residents’ rooms, may inform laundry and/or search the laundry’s lost and found, and will report it to the charge nurse.

An interview with the identified PSW confirmed knowledge of resident #11’s missing laundry and that the missing item was not reported to the registered staff. [s. 89. (1) (a) (iv)]

WN #20: 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 failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date the inspector observed two pills on the floor in the hallway, by the medication cart on an identified home area. The registered nurse was not by the cart at the time of the observation.
An interview with the registered staff member confirmed that he/she should have remained with the resident until medications were swallowed.
A review of the home's policy titled the medication pass, policy #3-6, section 3, states administer medications and ensure that they are taken.

An interview with the ADOC and DOC confirmed that when staff administers medications the home's expectation is that the registered staff remain with the resident until they are swallowed. [s. 131. (2)]

WN #21: 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).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

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

a.) On January 19, 2015, the inspector observed unlabeled toothbrushes in the shared washrooms in four identified residents' rooms.

On January 20, 2015, the inspector observed an unlabeled toothbrush in the shared washroom in one identified resident's room.

b.) On January 19, 2015, and throughout the inspection, the inspector observed that there was no paper towel or toilet paper in the washroom of resident #27.

Interviews with PSWs revealed that the home's expectation is that residents' personal care items should be labeled upon admission and as needed and that residents should have toilet paper and paper towels in their washrooms.

An interview with a housekeeping staff revealed that toilet paper or paper towels are not placed in resident #27's washroom for identified reasons.

An interview with the ADOC confirmed that the home's expectation is that all residents' personal care items should be labeled on admission and as necessary and that all residents should have toilet paper and paper towel in their washrooms. [s. 229. (4)]

2. The licensee has failed to ensure that on every shift symptoms indicating the presence of infection in residents are recorded.

A review of progress notes revealed resident #09 experienced and was treated for an infection in October 2014.
A record review revealed and registered staff interview confirmed that the symptoms indicating the presence of infection were not recorded on two identified shifts during the infection period.

An interview with the ADOC confirmed the expectation is that there is a record of monitoring of symptoms of a resident with infection on every shift. [s. 229. (5) (b)]

3. The licensee has failed to ensure that all pets living in the home or visiting as part of a pet visitation program have up-to-date immunization.

A review of the home's pet vaccination records revealed that the pet vaccinations for two identified dogs did not have up-to-date immunizations that were due on July 12, September 7 and October 3, 2014.

An interview with the DOC and ED confirmed that home's expectation is that all pets who live or visit the home have up-to-date immunizations. [s. 229. (12)]

Issued on this 31st day of March, 2015

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

Original report signed by the inspector.