1. The menu cycle did not include menus for regular, therapeutic and texture modified diets for both meals and snacks.

A) Menus were not available for low sodium or vegetarian diets. The home policy on menu approval and the RD confirmed on May 9, 2013, that it was the expectation to have an individualized menu for residents on a low sodium or vegetarian diet.
i) The plans of care and current orders for residents #3006 and #7002 indicated that they were on a vegetarian diet, however, there was no therapeutic or individualized menus for a vegetarian diet for meals and snacks. Interview with resident #7002 identified that they did not have a separate menu and wished for more choices.
ii) The plan of care, diet sheets and order written by the RD on January 29, 2013, indicated that resident #3008 was on a low sodium diet. Registered staff confirmed on May 15, 2013, that the low sodium diet had not been discontinued, to her knowledge. The resident did not have a low sodium individualized menu.
iii) The menu cycle did not include alternate beverage choices at meals and snacks. As confirmed in an interview with the FSM on May 3, 2013, the current snack menu used by the home did not include beverage choices. [s. 71. (1) (b)]

2. Not all residents were offered a between-meal beverage in the morning.

A) On April 29, 2013, no between meal beverages were observed being offered between the breakfast and lunch meal on Tulip Garden between approximately 0940 hours until lunch. Interview with two staff and two residents confirmed that beverages were not offered mid morning, which was consistent with the food and fluid intake documentation.
B) On April 25, 2013, on Trillium and Maple Grove, the beverage cart was not observed being provided to the residents in the morning. Staff confirmed the beverage cart was not prepared nor served and that it was not served on a regular basis. Residents confirmed that the staff did not offer a beverage in the morning. [s. 71. (3)]

3. Not all planned menu items were offered and available at each meal.

The therapeutic menu for renal diets for the lunch meal May 15, 2013, indicated a pork sandwich was to be offered however, this was not prepared nor available to offer resident #5000. Staff confirmed that the pork sandwich was not available and the resident received a salmon sandwich instead. [s. 71. (4)]

Additional Required Actions:

CO # - 006, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

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

Findings/Faits saillants :

1. There were not standardized recipes and production sheets for all menus.

A) On May 09, 2013, it was confirmed by the FSM and the Nutritional Management Services regional manager that the home did not have standardized recipes for minced and pureed items for staff to follow. Recipes were also not available for all regular textured items.
B) On May 3, 2013, cooks indicated that they added gravy and barbecue sauce to the minced pork chops for taste but there was no recipe for consistency of the prepared product.
C) On May 9, 2013, there was no recipe for minced and puree beef. The cooks indicated that gravy would be added to the roast beef, and that sometimes they would mince and puree the same meal and then add applesauce or juice to pork and gravy to roast beef. The actions of staff influenced food quality and did not provide for a consistent product.
D) The recipe book was reviewed with the cook and was found to be incomplete.
i) The recipe for Greek salad indicated the following ingredients: romaine lettuce, olives, tomatoes and dressing. It did not include any quantities for items to guide the cooks in production.
ii) The macaroni and cheese recipe and cabbage and apple salad recipes did not indicate the yield that would be prepared to guide staff in food production.
iii) The January 22, 2012, Food Committee minutes included that the FSM "indicated that sometimes flavouring changes due to the cook of the day" and that "it could have been a different cook and they cook differently" when questioned regarding specific foods prepared in the kitchen. [s. 72. (2) (c)]

2. Not all menu items were prepared according to the planned menu.

A) Portion sizes were not followed according to the therapeutic menus. For example, on April 25, 2013, in Maple Grove, the therapeutic menu indicated that a #10 scoop was to be used for sloppy joe's, however, a #8 scoop was used instead, which was a larger portion than planned.
B) On May 3, 2013, in Heritage Trail, the therapeutic menu indicated that a #6 scoop was to be used for carrot fingers, a #8 scoop was to be used for apple raisin compote and a #16 scoop was to be used for puree breakfast sausage. A #10 scoop was used for all items, resulting in a smaller portion of carrots and apple raisin compote and a larger portion of sausage served.
C) On May 7, 2013, in Heritage Trail, the therapeutic menu indicated that a #16

scoop was to be used for baked beans, however, a #8 scoop was used, resulting in a larger portion served. The menu indicated that a #6 scoop was to be used for mashed potatoes and a #20 scoop for puree baked beans. A #10 scoop was used for both items, resulting in a smaller portion of potatoes and a larger portion of beans served.
D) On May 13, 2013, in Rose Garden, a #6 scoop was indicated on the therapeutic menu for minced beans and wieners; however, a #8 scoop was used, resulting in a smaller portion size served. [s. 72. (2) (d)]

3. Menu substitutions were not documented on the production sheets.

On May 3, 2013, the FSM confirmed that the home does not document menu substitutions on the production sheets. [s. 72. (2) (g)]

4. Not all food and fluids were prepared, stored, and served using methods which preserved taste, nutritive value, appearance and food quality.

A) The preparation of foods several days in advance of the meal being served decreased the food quality by changing the food characteristics including the appearance, texture, and flavour of the food. The nutritive value of the food was decreased and the susceptibility of food contamination during the production process was increased with so many steps in the process of food preparation.
i) On April 30, 2013, the FSS indicated the process for minced and puree textured items was to prepare textured items from products that were cooked during the last cycle (three weeks prior) and then frozen. The items were thawed, cooked, minced or pureed, cooled, packed/panned and then rethermed resulting in decreased quality and nutritive value. Preparation of frozen vegetables began two days in advance of the food being served. For example, on Friday, May 3, 2013, mixed vegetable were observed being panned in the kitchen for Sunday's lunch. The cook indicated that the process was to thaw the vegetables in the fridge, steam the vegetables, puree or ground, then cool, pack/pan and retherm (heat) on the day of service. The number of steps in the preparation of the vegetables resulted in compromised food quality and decreased nutritive value. Residents spoken to during the inspection indicated that they did not care for the texture of the minced and pureed vegetables and they lacked flavour.
ii) During the observed lunch meal on May 2, 2013, in Heritage Trail, the puree chicken appeared dried out and the pan was burned with black caking on side of pan resulting in compromised food quality. The inspector spoke with a resident eating

puree texture. The resident indicated that the pureed food did not have much flavour.
iii) On May 3, 2013, ham was prepared, ground, and cooled. The ham would be packed/panned the next day and served the following morning. The cooks indicated that the procedure was to cook the frozen pork, ground it warm, add gravy or sauce and then the product would be cooled, packed/panned, rethermed and served the next day for supper. The number of steps in the preparation of the ham resulted in compromised food quality and decreased nutritive value.
iv) On May 9, 2013, the cooking staff in the kitchen indicated that the roast beef was cooked and sliced today for lunch the next day for regular texture. Staff indicated that minced and pureed texture were prepared the day before from roast beef that had been cooked during the last cycle (three weeks prior), frozen, and then thawed for minced and pureed for lunch tomorrow. The beef would then go to the packing/panning room and then be reheated for residents on a minced and puree textured diet. The minced and puree cabbage roll casserole was already prepared from last cycle, frozen and then minced and pureed for the lunch today. The preparation of these items so far in advance and the number of steps in the preparation resulted in compromised food quality and decreased nutritive value.

B) Not all items were available to residents and food did not always appear appetizing.
i) During the morning beverage cart pass on Heritage Trail on April 25, 2013, only diet gingerale, water and cookies were on the cart, regular gingerale was not available.
ii) During the lunch service on May 3, 2013, the hamburgers appeared very thin. Regular syrup was not available for the pancakes, only diet syrup.
iii) During the lunch meal on May 2, 2013, in Heritage Trail, the puree chicken appeared dried out and the pan was burned with black caking on side of pan. The inspector spoke with a resident eating the puree texture meal, who indicated that the pureed food did not have much flavour.
iv) On April 13, 2013, the progress notes indicated that resident #4005 "came to supper would not eat the pork chops as it was too raw (he was not the only resident to mention this)".
v) On April 22, 2013, the pureed lunch meal on Cherry Lane did not look appetizing. The consistency of the pureed wieners, carrots and bread pudding was dry and crusted. The resident voiced concern regarding the texture and taste of the pureed food.

C) The Resident Council Food Committee minutes indicated many comments about the quality of the food.

i) The minutes on May 11, 2011, indicated that the vegetables, especially the carrots were hard.
ii) On April 11, 2012, the minutes noted that the vegetables were not always cooked right, they were too hard.
iii) Minutes of February 15, 2012, indicated that pork and Oktoberfest sausages were tough.
iv) November 12, 2012, minutes identified that omelettes were soggy on toast and buns, macaroni and cheese looked liked soup, and that salad and coleslaw was still not in nappies. The residents wanted the nappies for coleslaw as the juice was running into the tuna sandwich. According to the minutes it was "indicated that this issue has been addressed time and time again; and it should not be happening".
It was observed on April 30, 2013, in three home areas that nappies were not used for the coleslaw. Tulip and Rose Garden show plates did not include nappies for the coleslaw nor were they provided on plates served with coleslaw with sandwiches. On Valley Trail, the show plates had the coleslaw in a nappy however, residents were not served coleslaw in nappies. The juice from the coleslaw was observed running in to the sandwiches.
v) December 12, 2012, minutes identified that the turkey sausage, beef tips and mashed potatoes were too salty. [s. 72. (3) (a)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. Not all residents had a physician conduct a physical examination on an annual basis and a written report of the findings of the examination.

A) Resident #2060 did not receive an annual physical since January 23, 2010.
B) Resident #2061 did not receive an annual physical since January 23, 2010.
C) Resident #2062 did not receive an annual physical since 2009.
D) Resident #2063 did not receive an annual physical since 2008.
E) Resident #2064 did not receive an annual physical since February 10, 2010.
F) Resident #2065 did not receive an annual physical since January 10, 2011.
G) Resident #2067 did not receive an annual physical since August 3, 2011.
H) Resident #2066 did not receive an annual physical since August 17, 2011.
I) Resident #2067 did not receive an annual physical since February 21, 2011.
J) Resident #2068 did not receive an annual physical since November 14, 2009.
K) Resident #2069 did not receive an annual physical since September 8, 2011.
L) Resident #2070 did not receive an annual physical since November 12, 2011.
M) Resident #2071 was admitted in 2012 and has not received a physical.
The above findings were confirmed by the clinical record, registered nursing staff and Medical Director. [s. 82. (1) (a)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the Assessment Reference Date (ARD) of the previous assessment, and any significant change in resident's condition, either decline or improvement, be reassessed along with Resident Assessment Protocol (RAPs) by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred.
For all other assessments (quarterly, significant change in resident's health status):
a) The care plan must be reviewed by the interdisciplinary team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of VB2.
b) RAPs must be generated and reviewed and RAPs assessment summaries must be completed for triggered RAPs and non-triggered clinical conditions within seven days maximum of the ARD.

The licensee did not comply with the conditions to which the license is subject.
A) The following residents had incomplete MDS assessments.
i) Resident #4002, last had a full assessment completed on January 17, 2013. As of May 21, 2013, the current full assessment was incomplete for sections AB, A, B, C, D, E, F, G, H, I, J, L, M, N, O, P, Q and R, which was due April 17, 2013.
ii) Resident #4011, last had a full assessment completed on February 3, 2013. As of May 21, 2013, the current full assessment was incomplete for sections AA, AB, A, B, C, D, E, F, G, H, I, J, K, L, M, O, P, Q and R, which was due May 4, 2013.
iii) Resident #4010, last had a full assessment completed on February 4, 2013. As of May 21, 2013, the current full assessment was incomplete for sections AA, AB, A, B, C, D, E, F, G, H, I, J, K, L, M, O, P, Q and R, which was due May 5, 2013.
iv) Resident #4012, last had a full assessment completed on January 31, 2013. As of May 21, 2013, the current full assessment was incomplete for sections AB, A, B, C, D, E, F, G, H, I, J, L, M, O, P, Q and R, which was due May 1, 2013.
v) Interview with the RAI Coordinator confirmed that a chart was provided to staff which identified residents which were due to have their MDS coding and RAP's completed, along with the time frames for completion, on a scheduled basis. A list of outstanding assessments was forwarded to the ADON's on a weekly basis for follow

up. The "Active MDS Assessments" tab in Goldcare identified that over 40 residents had overdue, incomplete assessments as of May 21, 2013, which was confirmed by the RAI Coordinator.

B) The following residents had incomplete or late RAP's completed.
i) Resident #6011 most recent quarterly ARD was February 17, 2013, the RAPs were not completed until March 11, 2013.
ii) Resident #9863 most recent quarterly ARD was March 31, 2013, the RAPs were not completed until April 20, 2013.
iii) Resident #9709 most recent quarterly ARD was April 8, 2013, the RAPs were not completed as of May 2, 2013.
iv) Resident #9743 had an ARD of April 10, 2013, as of May 2, 2013, the following triggered RAPs were not completed: bowel condition, cognitive loss, pressure ulcer and social relationships.
v) Resident #0015 most recent quarterly ARD was April 13, 2013, the RAPs were not completed as of May 14, 2013. Previous ARD's include January 13, 2013, October 15, 2012, July 17, 2012 and April 18, 2012, however, no RAPs were completed as of May 14, 2013.
vi) Resident #4005 had a MDS assessment completed December 16, 2012. This assessment triggered the following RAPs to be completed: activities of daily living, behaviour, bowel condition, communication, urinary incontinence and mood. As of May 23, 2013, these triggered RAP's had not been completed.
vii) Resident #0883 most recent quarterly ARD was April 21, 2013, the triggered restraint RAP was not completed. The quarterly ARD dated January 21, 2013, did not have the triggered activities RAP completed.
viii) The nursing staff stated a schedule was sent out outlining what quarterly assessments were to be completed each month. The schedule included the time frames for completion of each section of the RAI MDS assessment. The RAI Coordinator confirmed that nursing staff were to follow the scheduled time frames for quarterly assessment completion. [s. 101. (4)]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. Where bed rails are used, residents had not been assessed and steps had not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment (one through seven); and other safety issues related to the use of bed rails, including height.

The home had their bed systems evaluated in accordance with current prevailing practices (Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", 2008) by an external company on January 24 and 25, 2013. The audit identified that over 60% of the beds failed more than one zone of entrapment related to either the rail type or mattress or both.
A mixed variety of manual and electric bed systems (which includes bed frame, bed rails and mattress type) were identified throughout the home during the inspection. In addition to the entrapment zones that were identified in the audit, additional safety risks were observed during the inspection.
A) Beds with therapeutic surfaces on the frames were not tested due to their compressible air filled design and were partially exempt from the Health Canada Guidelines. However, the guidelines did caution the need to evaluate the safety of the bed (including bed rail height) due to the inherent entrapment risks based on their design (soft edges, height and compressible nature). The benefits need to outweigh the risks. Many of these surfaces were observed in use during the inspection and safety risks identified. In four identified rooms, the air mattresses were thick and the surfaces were almost level with the tops of the raised bed rails. A resident sleeping on such a mattress could roll over top of the rail. The height of the rail on beds with therapeutic mattresses had not been addressed.
B) Numerous beds without corner mattress keepers to keep the mattresses from sliding side to side were identified. When beds without mattress keepers were tested, the mattresses easily slid off the frame of the bed, especially when the bed rails were in the down position. No visual amendments to bed systems were apparent other than gap fillers for beds where the mattress was too short for the bed frame.
The manager who is involved in the bed safety program was not able to provide any documentation to support what immediate steps have been taken to mitigate zone one through four entrapment risks. No documentation was provided that identifies when and how residents were assessed for compatibility with their bed system (appropriate rail, mattress and style of bed). [s. 15. (1) (a)]

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Not every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Resident #9925, who was unable to make own care decisions and with history of resistance and refusal to care was not provided personal care, from the supper hour on day in 2013, until the day shift on the next day. The resident, who required assistance with activities of daily living and continence care remained in the dining room, sitting upright in a dining chair during the period of time identified above. The usual routine would be for the resident to be provided evening care, changed, repositioned before retiring for the evening. Staff interviewed identified that attempts were made to care for the resident, however due to the response received no care, other than nourishment, was provided for approximately 14 hours. The plan of care indicated that staff were to accept the resident's right to refuse, however also identified that if there was ongoing refusal and care needed to be completed two staff may be needed. [s. 3. (1) 4.]

2. Not every resident was told who was responsible for their care.

Resident #2001 was not told of a change in their primary physician. During the month, following a hospitalization, the resident was not seen by a physician. When interviewed the Medical Director identified that there were changes implemented, in the home, which included changes in the physicians assignment providing medical care to residents. The resident was not notified of the change regarding their physician. This information was confirmed by the clinical record and interview with the Medical Director, who also identified that the re-organization of medial care, impacted residents in all home areas. [s. 3. (1) 7.]

3. Not every resident was afforded privacy in treatment.

On April 22, 2013, two residents were observed, in the Maple Grove dining room, to have administered eye drops, by the registered staff, at the table during meal service in the presence of other residents. [s. 3. (1) 8.]

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 are properly cared for in a manner consistent with their needs and told who is responsible for and is providing direct care, to be implemented voluntarily.

WN #10: 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. Not all required plans, policies, protocols, procedures or strategies, put in place were in compliance with the legislation.

A) The policy "Skin and Wound Care Management Program - NUR-POL/11, last revised February 12, 2013" indicated that staff were to send a note to the RD to assess residents with pressure or stasis ulcers. This document did not include the need to have the RD assess all residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds as required in O Reg. 79/10, section 50(2)(b)(iii). Interview with the front line nursing staff and nursing management confirmed that staff notify the RD when a resident has ulcers however not for all issues of altered skin integrity.
B) The home did not have a procedure in place to direct staff in medication administration for medication being left at the bedside. The ADON confirmed the home permits registered nursing staff to leave a dosage of scheduled medication at the bedside for specified residents when identified through a physician order and they have the ability to ingest their medication without direct supervision. It was also recognized that the medication had been dispensed by the registered staff and for this reason staff would sign the MAR, for the medications. It was the expectation that staff follow up and monitor to ensure the medication had been taken by the resident. The home did not have a policy in place to direct staff in the assessing, dispensing, signing, monitoring or evaluating residents who had their medication left at the bedside. [s. 8. (1)]

2. Not all required plans, policies, protocols, procedures, strategies or systems were complied with.

A) Review of "The Medication Pass, Section 12, Policy 12-5" identified that staff were to administer medication to residents ensuring they swallow them, then initial the square on the MAR that correspond to the date and time of the medication administered.
i) On May 1, 2013, at 1025 hours, 14 pills were observed in a paper medication cup along with 30 (milliliter) ml of lactulose and two puffers on the bedside table belonging to resident #9743. Review of the MAR indicated the resident was to receive the medications at 0800 hours, the record did not identify the ability to self-medicate. The registered staff was observed signing the medications for the 0800 hour pass at 1254 hours.
ii) Resident #6002 had a physician order for insulin every morning and evening. The

MAR sheets were not signed to indicate the resident received the insulin on April 26, 2013, at 1700 hours, and April 28, 2013, at 0800 hours. The resident did not have any medications for 0800 hours signed as being administered on April 28, 2013. The MAR documentation did not identify a reason for medication not to be administered.
iii) Resident #9709 had a physician order for a topical cream to be applied twice daily at 0800 and 1700 hours to the groins. The documentation on the MAR for April 2013, indicated the cream was applied/offered only ten of the sixty required times..
iv) Resident #9709 had a physician order for an ointment to be applied with each brief change. The MAR indicated the cream was applied 42 times for April 2013. It was not applied on April 5, 12, 21, and 26, 2013. The bladder function and bowel movement chart for April 2013, indicated incontinence 84 times with multiple occurrences each day.
v) Resident #6003 had a physician order for two medications at 0800 hours and 2000 hours. The MAR was not signed to indicate the resident received the medications at 2000 hours on April 19, 2013.
vi) Resident #9832 was late getting to the dining room on May 7, 2013. The noon medications were signed on MAR by the registered staff as given, however, the medication was found sitting in a cup on the dining room table. At the end of meal service, the resident entered the dining room, the meal was reheated and the registered staff pointed to the medication for the resident to take. The registered staff walked away and did not observe the resident take the medication. It was confirmed that the resident was not able to self-administer medications.
B) The policy "Physician's Medication Review 8-5" indicated that orders were to be pre-checked prior to physician review to verify diet order with current physician order. The last diet order for resident #3008 was written by the RD on January 2, 2013, which indicated a low sodium diet. The last Physician's Medication Review dated March 1 until May 31, 2013 and the current MAR, reviewed May 15, 2013, indicated a regular/regular diet. The plan indicated a low sodium diet and the registered staff confirmed on May 15, 2013, that the low sodium diet had not been discontinued to her knowledge. Staff did not follow the procedure for pre-checking medication reviews.
C) The policy "Menu Approval, FS-04-01-25" indicated that "all menu cycles must be approved by the home's Dietitian and reviewed by the Residents' Council. After the first rotation of the menu the NM and the Dietitian will meet to follow-up and evaluate the Dietitian comments/concerns, the resident and staff feedback". The menu approval was signed off by the RD on January 3, 2013, however, the changes suggested were not implemented on the current menu as of May 9, 2013. The RD indicated on May 9, 2013, that the expectation would be that the changes suggested

for the menu would be implemented by the FSM, and she assumed that they were completed [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 the programs and procedures in the home are compliant with the legislation and that staff are compliant with the homes programs, policies and procedures, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9. (1).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. O. Reg. 79/10, s. 9. (1).
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. Not all doors, as required, were kept closed and locked.

On May 1, 2013, in the Pine Grove home area, two doors, one to the stairwell and one to the exterior of the home, leading to an open area, were tested and found unlocked. Both doors did not have their red indicator lights lit which would be an indicator that the magnetic locking system was deactivated. None of the staff working in this home area were aware of the unlocked doors. The charge nurse was informed of the situation by the inspector who contacted maintenance staff. According to staff working in this home area, the doors were not monitored or tested by staff working in the home area. [s. 9. (1) 1. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors are kept closed and locked as per the regulations, to be implemented voluntarily.

WN #12: 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. Not all residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

Staff confirmed that resident #0986 received and consumed a casserole for the lunch meal May 14, 2013. The plan stated that the resident was allergic to one of the items in the casserole. The registered staff confirmed the allergy and that the resident normally did not eat the specified food however; was provided the entrée in error. Registered staff confirmed that the resident's allergic reaction would be to break out in hives. [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 are provided with food and fluids which are safe, to be implemented voluntarily.

WN #13: 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 :