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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 16, 2014	2014_188168_0014	H-000554-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

LISA VINK (168), BERNADETTE SUSNIK (120), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582), KELLY HAYES (583), LEAH CURLE (585), VIKTORIA SHIHAB (584)

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): May 20, 21, 22, 23, 26, 27, 28, 29, 30, 2014, and June 3, 4, and 5, 2014.

This Inspection Report contains findings of non-compliance identified during inspections conducted concurrently with the Resident Quality Inspection. Concurrent Complaint Inspections include: H-000168-14, H-000418-14, H-000266-14, H-000399-14 and H-000296-14, concurrent Critical Incident Inspections include: H-000223-14 and H-000672-14, and concurrent Follow Up Inspections include: H-000391-13, H-000390-13, H-000388-13, H-000387-13, H-000175-14, H-000176-14, and H-000174-14.

During the course of the inspection, the inspector(s) spoke with the acting President/Director of Finance, Director of Care (DOC)/Chief Nursing Executive, Assistant Directors of Nursing (ADOC), Resident Care Coordinators (RCC), Medical Director, Executive Secretary, Food Services Manager (FSM), Food Service Supervisor (FSS), Housekeeping/Laundry/Security Supervisor, Manager of Engineering and Maintenance, Registered Dietitian (RD), Human Resources Supervisor, Infection Control staff, Therapeutic Recreation staff, Private Duty Caregivers, Social Service Workers, Resident Property Clerk, Cooks, Occupational/Physiotherapy Aide, maintenance and housekeeping staff, dietary aides, registered nursing staff, personal support workers (PSW's), residents and family members.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, reviewed documents including but not limited to: menus and production sheets, policies and procedures, meeting minutes, clinical records, logs and services reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Not every resident was protected from abuse.

Staff interview and record review identified that in 2014, resident #87 was pushed by resident #86. This resident to resident contact resulted in resident #87 sustaining a fall and injury. Resident #87 was not protected from abuse from resident #86. [s. 3. (1) 2.]

2. Not every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs.

A. Resident #88, who according to the plan of care had confusion, a decline in cognitive function and a diagnosis of dementia, was not cared for in a manner consistent with their needs on two consecutive days 2014. The resident, who staff reported was known to sleep in common areas, resist care and be independent with most physical aspects of care, positioned themselves in a lounge arm chair during the beginning of the day shift, and remained there until the day shift the following day. Staff interviews confirmed that medications and nourishment were offered, and attempts were made, by each shift, to provide care to the resident, although the care was consistently refused. The resident remained up in the chair without receiving assistance, or support with their activities of daily living, during the identified period of time. There was a noted change in the resident's condition, including pain, when assessed on the day shift of the second day. The physician was notified and interventions were put into place to manage the symptoms displayed before the resident was transferred and admitted to the hospital on the second day. Some of the staff who worked on the first day, reported that in hindsight, the resident was more lethargic than usual and difficult to rouse. The resident was not cared for in a manner consistent with their needs. (168)
B. The plan of care for resident #39 indicated that they were cognitively impaired, could not make concrete decisions, and due to constipation included a routine order for weekly enemas. Documentation for 11 consecutive days in 2014, identified the resident refused the weekly enemas stating that the surgeon ordered a hold on the order. The clinical record did not include a hold order from the surgeon or a physician. Registered staff did not verify with the surgeon if the enema was to be held, nor did they notify the physician of the refusal of the medication. On a specified date in 2014, the physician assessed the resident to have a distended abdomen. Interview with the staff confirmed that they did not consult the surgeon until suggested by the physician. The resident did not have a bowel movement for 16 days and was admitted to the hospital for treatment. The resident was not cared for in a manner consistent with their need. (528) [s. 3. (1) 4.]

3. Not every resident had their personal health information, within the meaning of the Personal Information Protection Act, 2004 kept confidential in accordance with the Act.

A. On May 20, 2014, Willow Grove staff indicated that unneeded papers could be placed in the recycling bin for disposal. It was then noted that documents, which contained resident personal health information was in the recycling bin.
B. On May 23, 2014, documents containing personal health information regarding

resident #54 were observed in the garbage bin during shift change on Oak Grove. Housekeeping staff were observed to empty the garbage bin into the general garbage container at 1432 hours.
C. On May 26, 2014, Oak Grove housekeeping staff confirmed that garbage and recycling materials collected from nursing stations were combined with other garbage and recycling materials without being shredded or other efforts to destroy the personal health information. (584) [s. 3. (1) 11. iv.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 resident is protected from abuse and that every resident has their personal health information, within the meaning of the Personal Information Protection Act, 2004 kept confidential in accordance with the Act, 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The written plan of care for each resident did not include the planned care for the resident.

A. Resident #14 was observed with a fastened front closing seat belt while up in the wheelchair on May 27, 2014, and June 3, 2014. The resident was able to release the belt on request. The plan of care did not include the use of the belt, which was confirmed during staff interview. (168)
B. In early April 2014, resident #14 experienced an increase in pain and use of as needed analgesic. As a result of this pain the physician reassessed the resident in mid April and ordered a routine analgesic to manage the pain, which was effective, as

confirmed by the resident. The plan of care reviewed on May 27, 2014, did not include a needs statement related to pain or interventions in place. Interview with staff confirmed that the management of pain symptoms was planned care for the resident and not included in the plan of care. [s. 6. (1) (a)]

2. The written plan of care for each resident did not set out clear directions to staff and others who provided direct care to the resident.

A. Residents #52 and #53 had their diets identified on the Menu Choices List as modified diabetic. This list was used to direct staff in the serving of meals. Their plans of care identified that they were to receive a modified diabetic, with additional restrictions. The plans of care did not give clear direction to staff regarding their nutritional care needs. A review of the therapeutic menu confirmed that a the required diet was available for the residents. (584)
B. The plan of care for resident #18, updated on April 23, 2014, specified supervision at meals and staff to provide oversight, encouragement or cueing. The printed and accessible Health Care Record Display had a revision date of July 25, 2013. The eating assistance intervention indicated the resident was independent, without staff assistance or oversight. On May 26, 2014, during the noon meal the resident was served lunch in bed and left unattended. The plan of care, available for staff did not give clear direction. [s. 6. (1) (c)]

3. Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Resident #16 had a Minimum Data Set (MDS) quarterly assessment August 5, 2013, which indicated occasional incontinence of bladder. The assessment of November 3, 2013, identified that the resident was incontinent of bladder, had inadequate control, with multiple daily episodes, and that there was no change in urinary continence when compared to the status of 90 days ago. Interview with the RCC, responsible for MDS, confirmed that the resident had a change in bladder continence during the identified time period and that the assessments were not consistent with each other. (168)
B. Resident #18 was known to demonstrate responsive behaviours which was confirmed by staff. The plan of care identified the behaviours and interventions in place. Review of the MDS assessments for mood and behaviour patterns for November 17, 2013, February 15, 2014, and March 19, 2014, identified that the

resident had a change in indicators of depression, anxiety and sad mood as well as behavioural symptoms during the specified time period, however staff consistently coded no change in status over the 90 days, or since last assessment. Interview with staff confirmed that the resident had a change in status including deterioration, and that the identified assessments were not consistent with each other. (168)
C. Resident #19 had their seat belt restraint discontinued on June 4, 2014. The restraint assessment completed on June 3, 2014, indicated the resident required the belt due to high risk and frequent falls, declining health and poor decision making. A progress note on June 4, 2014, indicated the resident no longer required a seat belt, which was agreed to by the family, discontinued by the physician, and changed in the plan of care. Interview with registered staff confirmed the two assessments related to the use of the restraint were not consistent. (583) [s. 6. (4) (a)]

4. Not all care set out in the plan of care was provided to the resident as specified in the plan.

A. The plan of care for resident #61 indicated that they were on a specialized diet, to provide fluids, pureed soup and to allow half portions of pureed entree for pleasure when alert. During the lunch meal on June 3, 2014, the resident was alert and talking in the dining room. The resident was provided with two fluids and fed a Boost pudding. Care was not provided to the resident as specified in the plan as the resident was not offered the half portion of pureed entree or the pureed soup as per the plan of care. (156)
B. The plan of care for resident #60 indicated they were to receive a restricted diabetic, with additional restrictions diet. The home’s menu cycle did not include menus for a restricted diabetic, with the additional restrictions. On May 27, 2014, the dietary aide reported that the resident was provided with a low sodium diet, with diabetic desserts, or water was added to regular juice. The Medication Administration Record (MAR) indicated that the resident was not to receive artificial sweeteners or diet pop. The direction was to provide regular foods with sugar but just in smaller portions. On June 3, 2014, during the lunch meal, the dietary staff reported that they followed the low sodium diet on the therapeutic menu for the resident. Nutritional care was not provided as per the plan of care. (156)
C. The plan of care for resident #15 indicated that the resident was to be included in all decision making regarding care and that any changes to the usual routine, including staffing, were to be communicated to both the resident and the family. Interviews conducted with front line and registered staff who provided care to the resident, revealed that assessments of the resident's care routine were conducted on

two specified dates. Two staff members confirmed that the resident, substitute decision maker (SDM) and family were informed in advance, of the first assessment, however they were not notified of the second assessment, which included participation by a staff member, who was not consistently involved in the resident's care routine. (582)
D. The plan of care for resident #31 indicated they were on a pureed textured diet. During the lunch meal on June 3, 2014, they received puree textured green beans and pureed macaroni and beef casserole stirred together with low calorie pancake syrup. All items were mixed together in a bowl and placed in front of the resident. The staff reported that the syrup was added as the resident would not eat otherwise. The plan of care did not include this intervention nor to stir the meal together. Staff did not provide care as per the plan. (156)
E. During the lunch meal on June 3, 2014, resident #62 was provided with puree pasta and puree green beans with pancake syrup. The plan of care did not include the addition of the syrup to the entree. Staff did not provide care as per the plan. [s. 6. (7)]

5. The resident was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. The plan of care, available on May 22, 2014, for resident #16 identified the intervention of a bladder retraining, restorative care program. Interview with staff confirmed the resident was no longer on the program, for approximately one year, and was now routinely toileted, but not on a retraining or restorative care program. Quarterly assessments reviewed for the past three quarters, identified the level of continence, elimination patterns and supplies used, however not a bladder retraining or restorative program. The plan of care was not revised with changes in care needs. (168)
B. Resident #78's nutritional assessment completed on March 26, 2014, indicated that their nutrition risk increased from medium to high. A risk related to nutritional care was identified in the Registered Dietitian's (RD) assessment indicating that the resident usually slept through breakfast. In a review of the May 2014 Food and Fluid Intake form identified the same issue, noting that the resident slept through breakfast and did not consume breakfast for 23 days in May, 2014. The plan of care was not revised to include missed morning meals as a risk, therefore no specific goals or interventions were identified related to regularly missing meals. The RD confirmed that the plan of care was not updated to include the change in care needs related to

missed meals. (583)
C. The plan of care for resident #18 indicated that due to altered skin integrity staff were not to apply incontinent wear, to use dry flow pads only, that briefs were on hold and to change as frequently as needed. It was observed on May 27, and 28, 2014, that the resident was wearing a brief. Interview with staff confirmed the use of the brief as the areas of altered skin integrity had improved. It was confirmed that due to the change in care needs briefs were no longer contraindicated for the resident, however the plan of care was not revised to reflect this change in status. (168)
D. The plan of care for resident #10 related to mouth care, identified both upper and lower dentures. The resident was observed to be edentulous. Interview with the resident and PSW staff confirmed that the resident no longer wore dentures and did not have access to them. The plan of care for mouth care was not updated to reflect this change in status. (528)
E. In 2013, resident #12 had an unwitnessed fall with minor injury. Review of October 2013, MDS assessment identified the resident was a high risk for falls and supporting assessments indicated that they were responding to interventions in the plan. The plan of care was not updated to include a risk for falls or corresponding interventions until May 23, 2014. Interview with registered staff confirmed that a risk for falls and interventions were not included in the plan of care. (528)
F. The plan of care for a specified resident indicated they were to receive total assistance from two staff for toilet transfers. The resident and staff confirmed the toilet was no longer used, the resident had a catheter and used briefs for containment. The resident stated that briefs were changed twice a day and PSW staff reported they were changed on request. The plan of care was not revised to reflect the change in toileting status. (584) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 written plan of care for each resident includes the planned care for the resident and 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. Not every restrained resident in the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

A. Resident #31 was identified in the plan of care and observed to use a side fastening seat belt when in the wheelchair.
i. On May 21, 2014, at 1200 hours the side fastening seat belt was loose and could be pulled away from the resident's body to approximately mid thigh. Interview with registered staff confirmed that the restraint was applied too loosely and should be two fingers breadth from the resident's body.
ii. On May 23, 2014, at 1550 hours the seat belt was loose and could be pulled away from the resident's body to approximately mid thigh. Interview with direct care staff and registered staff confirmed that the restraint was applied too loosely and should be two fingers breadth from the resident's body. (528)
B. On May 21, 22, 23, and 26, 2014, resident #19 was observed in their wheelchair wearing a side fasting seat belt, which was identified to be a restraint, that was applied incorrectly. On May 21, 23, and 26, 2014, the belt was applied allowing a squeezed fist between the resident's abdomen and the belt. On May 22, 2014, the belt was applied allowing four fingers between the resident's abdomen and the belt. Interview with registered staff on May 26, 2014, confirmed that the belt was not applied as per specifications. The staff identified training had been provided on the application of seat belts and the expectation was no greater than two fingers space present between the abdomen and the seat belt once applied. (583)
C. Resident #19 had a seat belt restraint and required repositioning every two hours when the device was in use according to the home's policy and the plan of care. On May 23, 2014, the resident was observed from 1040 hours until 1430 hours. The resident was not repositioned during the specified period of time. Interviews with registered and PSW staff working confirmed that the seat belt was not released nor was the resident repositioned from 1040 hours to 1430 hours. (583)
D. On June 3, 2014, during the noon meal, resident #76 was observed in a wheelchair with a front fastening seat belt which was not applied correctly. The belt was loose extending three to four inches away from the resident's abdomen. PSW staff confirmed that the belt could not be tightened due to the design of the device, and for this reason a blanket was placed on the footrest, to prevent sliding down in the chair. The PSW identified that this concern, of the loose fitting belt, was reported to registered staff. (120) [s. 30. (1) 3.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: 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 licensee did not comply with the conditions to which the license was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system. This required each resident's care and services 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, be reassessed along with Resident Assessment Protocol (RAPs) by the team using the MDS Full Assessment by the 14th day following the determination that a significant change had occurred.
For all other assessments:
a) The care plan must be reviewed by the team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of the VB2.
b) RAPs must be generated and reviewed and RAP 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 was subject.
A. The following residents had incomplete or late Assessment Protocols (APs) completed:
i. Resident #16 had an assessment completed with an ARD of November 3, 2013, however AP's were not completed until December 3, and 4, 2013. A second assessment was completed with an ARD of February 1, 2014, however some AP's

were not completed until February 22, 2014. (168)
ii. Resident #87 had an assessment completed with an ARD of January 21, 2014, however AP's were not completed until February 24, 2014. (168)
iii. Resident #86 had an assessment completed with an ARD of November 11, 2013, however AP's were not completed until January 19, 2014. A second assessment was completed with an ARD of February 9, 2014, however some AP's were not completed until March 9, 2014. (168)
iv. Resident #15 had an assessment completed with an ARD of November 6, 2013, however AP's were not completed until December 19, 2013. A second assessment was completed with an ARD of February 4, 2014, however AP's were not completed until March 26, 2014. (582)
v. Resident #14 had an assessment completed with an ARD of May 9, 2014, however AP's had not yet been completed when the clinical record was reviewed on June 3, 2014. Staff interview confirmed that the triggered AP's for the May 2014, assessment were not completed. (168)`
vi. Resident #10 had assessments completed in January 2014, and April 2014, which did not have AP's completed within 14 days of the ARD, which was confirmed during staff interview. (528)
vii. Resident #12 had assessments completed in December 2013, and March 2014, which did not have AP's completed within 14 days of the ARD, which was confirmed during staff interview. (528)
Staff interviewed confirmed that a monthly schedule was distributed which outlined what assessments were to be completed. This schedule included the time frames for completion of each section of the RAI MDS assessment. The RCC, who was responsible for RAI, confirmed that staff were to follow the scheduled time frames for the completion of the quarterly assessments, and that AP's would be recorded in the progress notes as PN-AP. [s. 101. (4)]

Additional Required Actions:

CO # - 006 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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. Not all residents were offered a minimum of three meals daily.

A. Resident #78 was observed in bed asleep on June 3, 2014, until 1100 hours. Registered staff confirmed that the resident did not go to the dining room for breakfast and was not offered a breakfast in their room. (583)
B. Resident #78 was identified at high nutritional risk. On May 27, 2014, at approximately 1045 hours, the resident was observed in bed asleep and staff confirmed that the resident was not offered breakfast. (156)
C. On May 26, 2014, resident #19 was not offered and did not receive breakfast. The plan of care nor progress notes included an explanation for the missed breakfast. Interview with registered and PSW staff on May 26, 2014, confirmed that the resident was not offered and did not receive breakfast. [s. 71. (3) (a)]

2. Not every resident was offered a minimum of a snack in the afternoon and evening.

A. On May 26, 2014, at 1940 hours, evening snacks and beverages had not yet been offered to residents on a specified unit. Interview with registered staff at 1945 hours, confirmed the process of distributing evening snacks and beverages was for registered staff to provide the nourishments to the residents, that fluids were offered to all residents, but snacks were only provided on request. The registered staff confirmed that not all residents were offered a snack in the evening. (583)
B. Discussion with a specified resident indicated that snacks were not consistently offered. A review of their intake records on May 27, 2014, for May 2014, identified that they did not consume evening snack on 25 of 27 days.
C. Interview with a PSW and resident #18 on a specified unit confirmed that evening snacks were usually not offered to residents. Intake records reviewed on May 27, 2014, for the resident identified that snacks were not taken 23 of 27 days in May 2014. (584) [s. 71. (3) (c)]

3. The evening meal was served before 1700 hours.

On May 26, 2014, at 1650 hours, residents in a specified dining room had already finished their soup course. Service of the main entree began at 1655 hours. It was confirmed with the dietary staff that the meal service was initiated at approximately 1640 hours. [s. 71. (6)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 evening meal is not served before 1700 hours, to be implemented voluntarily.

WN #6: 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,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods; O. Reg. 79/10, s. 72 (2).
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable; O. Reg. 79/10, s. 72 (2).
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

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. (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. The food production system must, at a minimum, provide for standardized recipes and production sheets for all menus and preparation of all menu items according to the planned menu.

A. On May 20, 2014, cooks reported that they did not track shortages on the production sheets. (156)
B. Menus did not always reflect what was being served.
On June 3, 2014, during the noon meal, dietary staff indicated that yogurt was available for those on thickened fluids, however, this was not indicated on the therapeutic menu to guide staff. (156)
C. Recipes were not always available or followed.
i.   On May 20, 2014, during an interview with the cooks, it was noted that the home had a cook-chill food production system. Food was prepared a day in advance and then re-heated for service the day of use. Staff indicated they 'just add water' to minced and puree texture foods and do not follow any recipes in the preparation. (156)
ii. On May 29, 2014, cooks confirmed that they do not consistently follow recipes. It was reported that they would just add tomato sauce to the pizza soufflé to puree it and did not follow a recipe, as they were not sure that there was one. They indicated crackers were not added to soup, instead they use mashed potatoes as a thickener. (156)
iii. Cooks reported that recipes were not followed for the quantity of ingredients used to add to textured recipes. The cooks reported that there were no recipes for minced and puree textures and that they were "still fixing the recipe books". (156)
iv. On June 3, 2014, during the noon meal dietary staff indicated that the regular chef salad included turkey and cheese as well as salad dressing. It was reported that the minced and puree texture chef salad did not include turkey or cheese but did include the dressing. Both the minced and puree texture salad appeared to be of a very watery consistency. A review of the recipe indicated that the chef salad was only to include iceburg lettuce, tomatoes and cucumbers; there was no mention of dressing, turkey or cheese. The minced and puree recipe indicated that the regular salad was to be minced and pureed however there was no information regarding adding or excluding any of the items noted on the regular chef salad recipe. The portion size of the regular texture chef salad was noted to be a #8 scoop, however, the therapeutic menu indicated that a #6 scoop was to be used. The home used salad tongs during the observed lunch meal on second floor on June 3, 2014, and not a scoop. (156)
v.   On May 26, 2014, during the dinner meal on a specified unit staff ran out of turkey

a la king before all residents who requested the entree were served a full serving. Dietary staff verified that the last resident served did not receive a full portion of the entree and there was no additional minced turkey a la king available. The resident received a substitution. (583)
vi. The snack menu was reviewed and evening snack supplies compared to the planned menu. On May 28, 2014, the snack storage areas were checked on Birch Trail, Rose Garden, Lilac Garden, Valley Trail, Tulip Garden and Balsam Trail. The planned evening snack was peach-apple sauce or crackers with cheese. Three of the six home areas had no cheese available. Two of the areas had three to five slices of cheese unlabeled in the fridge. Staff could not identify how long the cheese slices had been in the fridge. On the five areas with limited or no cheese, dietary staff confirmed that cheese was not available when they transported the snacks to the areas, from the kitchen, nor did they know what cheese was to be offered to residents. Each area had one pack (six individual containers) of strawberry-apple sauce, which differed from the planned menu, an insufficient quantity for the number of residents to be offered snacks. (584)
vii. On May 30, 2014, resident #78 requested pureed pizza with minced spring salad for lunch, however was served the pizza with minced carrot. Interview with the dietary staff confirmed that the resident received minced carrot because they ran out of minced spring salad. (583) [s. 72. (2)]

2. Not all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

A. Foods did not always appear appetizing and food quality may not have been preserved.
i. On May 21, 2014, during the lunch meal on a specified unit the puree mashed potatoes appeared very dry. Dietary and nursing staff reported the mashed potatoes served were dry. (585)
ii. On May 21, 2014, during the lunch meal on a specified unit the puree tuna for the tuna sandwich appeared to be a nectar thick consistency. (585)
iii. On May 26, 2014, during the lunch meal, second sitting, on a specified unit, it was noted that sandwiches were not panned/portioned separately for each sitting. The pan of sandwiches was used for the first sitting and then the remaining sandwiches in the pan were used for second sitting. The quality of the sandwiches would be compromised and dried out. (156)
iv. On May 27, 2014, it was noted that the soup was in the steam table at 1045 hours in a specified unit, which was the second dining sitting which began at 1230 hours, the

soup had an extended period of hot holding prior to service. (156)
v. On June 3, 2014, during the noon meal two residents received puree textured green beans and pureed macaroni and beef casserole with low calorie pancake syrup. Taste would be compromised with the mixture of foods. (156)
vi. On June 3, 2014, during the lunch meal the minced and puree texture salad appeared to be a very watery consistency. (156)
B. On May 26, 2014, during the lunch meal, the dietary aide reported that the thermometer was rinsed in water between taking temperatures of different food items, and had not been properly sterilized. The FSM reported on June 4, 2014, the expectation was that thermometers were to be sanitized with alcohol swabs. The FSM indicated that the home was in the process of developing a new thermometer sterilization policy for all staff to follow. (156)
C. Portion sizes indicated on the therapeutic menu were not always followed, resulting in the residents being not served the correct portion sizes, at times less than required/planned.
On June 3, 2014, during the noon meal service on a specified unit:
i. A #6 scoop was indicated for puree texture macaroni and beef casserole, however, a #10 scoop was used instead.
ii. A #8 scoop was indicated for minced pears, however, a #10 scoop was used instead.
iii. A #8 scoop was indicated for puree chef salad, however, a #16 scoop was used instead.
iv. A #8 scoop was indicated for puree pears, however a #10 scoop was used instead. (156) [s. 72. (3) (a)]

Additional Required Actions:

CO # - 008, 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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

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

Findings/Faits saillants :

1. The daily and weekly menus were not consistently communicated to residents.

A. On May 20, 2014, first floor South the posted puree daily menu was for Sunday, week two, however puree items served at lunch May 20, 2014, were from the Tuesday, week two menu. Interview with FSS on May 23, 2014, confirmed that the posted puree menu was to be the Tuesday, week two menu. (585)

B. On May 23, 2014, outside the dining room on one South and on May 28, 2014, outside the dining room on one North the regular weekly menus were not available. In each area the incorrect week of the menu rotation was posted. (583)
C. On May 20, 2014, the posted menus on Heritage Trail were all regular texture menus. The regular texture heading had a week one daily menu posted, the minced texture heading had a week two daily menu posted and the puree texture heading had a week three daily menu posted. (156) [s. 73. (1) 1.]

2. Not all foods and fluids were served at a temperature that was both safe and palatable to the residents.

The temperature range in which food-borne bacteria may grow, known as the danger zone was 4 to 60 degrees Celsius (°C). A poster found in the home on the third floor dining area on May 23, 2014, indicated the holding temperatures for cold items must be at 4 °C and hot food items must be 74 °C prior to service.
A. On May 26, 2014, during meal service on two specified units it was observed that one third of the hot foods, mainly the modified textures were placed on the servery counters as the steam tables were full.
i.   On one unit the temperature of the puree turkey a la king and puree peas, was measured immediately after being served to a resident without reheating. The puree turkey a la king was 45 °C and the puree peas were 43 °C.
ii. On the other unit the temperature of the cream soup, was measured immediately after it was served to a resident without reheating and was measured to be 53 °C. (583)
B. Several residents reported that food was not served at an appropriate temperature. (156)
C. On May 21, 2014, during the lunch meal on a specified unit regular texture chicken nuggets were probed at 50.9 °C, regular potatoes at 57.5 °C, and regular mixed vegetables were probed at 56 °C. (585)
D. On May 21, 2014, during the lunch meal on a specified unit all textures of ambrosia salad were above 4 °C. Regular texture salad was probed at 6.2 °C, minced was 10.5 °C, and puree texture was probed at 11.1 °C. All textures of pineapple were above 4 °C. Regular texture pineapple was 7.8 °C, minced was 12.9 °C, and puree texture was 11.9 °C. Regular texture fruit cocktail was 13.3 °C. The ambrosia salad, pineapple, and fruit cocktail were observed sitting on the counter at room temperature for 25 minutes prior to service with no observable method to keep them cold. (585)
E. On May 21, 2014, during the lunch meal on a specified unit all textures of coleslaw

were above 4 °C. Regular texture coleslaw was probed at 11.4 °C, minced was 7.3 °C, and puree texture was 5.0 °C. Puree texture tuna was probed at 6.9 °C. (585)
F. On May 26, 2014, during the lunch meal on a specified unit, second sitting, the pastrami on rye sandwiches were probed at 8.6 °C. It was noted that the home provided a tray of sandwiches for the first sitting and then used the remaining sandwiches in the pan for the second sitting in the adjoining dining room. The minced pastrami was probed at 7.3 °C and puree pastrami at 6.5 °C. The potato salad was probed at 4.5 °C, minced at 6.3 °C and puree texture was probed at 5.5 °C (156) [s. 73. (1) 6.]

3. Not all residents were provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A review of the clinical records for resident #18 identified that they had been assessed as a high nutritional risk by the RD due to a very low Body Mass Index, a history of reduced intake of foods and fluids and chewing difficulties. The plan of care directed staff to provide supervision at meals, specifying oversight and encouragement. On May 26, 2014, the resident was observed sleeping in bed, with a lunch tray in front of them, and no staff in attendance. On May 28, 2014, at 0916 hours, the resident was observed sleeping in bed, with a tray of food in front of them and a bolus of food in their mouth. Staff did not enter the room to observe the resident for 21 minutes. No encouragement was provided for 26 minutes. Staff interviews confirmed the resident regularly consumed meals alone in their room, without staff supervision or encouragement. This lack of supervision and encouragement, as per the plan of care, did not allow the resident to eat as safely as possible. (584) [s. 73. (1) 9.]

4. Proper techniques were not used to assist residents with eating, including safe positioning of residents who required assistance.

On June 3, 2014, during the lunch meal on second floor staff were observed feeding residents #62, #63 and #64 while standing.
i. The plan of care for resident #62 indicated that they required extensive assistance with eating, had difficulty chewing and was on a puree texture diet.
ii. The plan of care for resident #63 indicated that they were on a puree texture diet, had a chewing/swallowing impairment and was at risk for choking.
iii. The plan of care for resident #64 indicated that they were totally dependent on others for eating, received thickened fluids and was at risk for choking.
The feeding policy indicated that "staff should be sitting while feeding, maintaining eye

contact and talking to the resident that is being fed and assuring that the resident's head and neck are properly positioned for feeding". Proper feeding techniques were not used to assist residents with eating. (156) [s. 73. (1) 10.]

5. Not every resident who required assistance with eating or drinking was not served a meal until someone was available to provide the assistance required by the resident.

On June 3, 2014, during the lunch meal on second floor a lunch entrée was placed in front of resident #31 at 1255 hours. The resident was not approached or provided any assistance until 1325 hours, when the staff approached and said "you don't want to eat, ok" and took the food away. The resident did not consume any of the meal. (156) [s. 73. (2) (b)]

Additional Required Actions:

CO # - 010, 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance and that every resident who requires assistance with eating or drinking is served a meal when someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #8: 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 home was not kept clean and sanitary.

A. All serveries and galley kitchens were inspected for general sanitation either on May 26, or 27, 2014, and some were re-inspected on June 3, 2014. General sanitation issues were observed in the serveries, which included visible matter on many of the lower cabinet surfaces, in and around the garbage containers and on walls specifically under cork boards. A build up of debris or matter was observed in and around the stoves and refrigerators and along baseboards. In the galley kitchens, a build up of debris and caked on matter was noted behind stainless steel fridges, under some of the stainless steel corner sinks and around ice machines. The gray textured floors were stained pink from juice spills and/or were blackened from ground in dirt. According to dietary staff, the floors had not been scrubbed using a machine but were hand mopped, making it difficult to get the dirt and stains out of the textured floors. A cleaning schedule was found posted on the white refrigerators in each servery indicating that surfaces in the serveries such as cabinets and walls were to be cleaned once per week. In failing to clean spills and splatter when they occurred, a build up had become evident. Such surfaces require a daily cleaning to ensure minimal cross contamination from surfaces, to hands and to food.
B. Carpeting in the common areas, where televisions were located, of Pine Grove and Primrose Lane were observed to be stained. Residents were observed to receive snacks in these areas. The Housekeeping Supervisor confirmed the routine for carpets was to have them deep cleaned by an outside service provider twice per year and then only on request. Housekeeping staff had a small cleaning machines which can extract spills, however based on observations of housekeeping staff, the daily routine did not allow adequate time to clean carpets using the machines.
C. Furnishings located in common areas, where televisions were located, were noted to be stained or soiled. Two blue wing back chairs were stained in Primrose Lane, two red wing back chairs were soiled in Cedar Grove, one blue leather easy chair in the Birch had visible matter on it. Some of the furnishings required steam cleaning to remove the stains, a task that was not done on a daily basis by housekeeping. [s. 15. (2) (a)]

2. Not all furnishings and equipment was maintained in a safe condition and in a good state of repair.

A. The licensee entered into a contract with a repair service on January 2, 2013, to ensure that their ceiling lifts would be inspected and repaired as necessary. The

contract was subsequently canceled in May 2014, and an alternative repair service enlisted. During the transition between contractors, lift equipment that was in disrepair was not "locked out" or "tagged" out of service by staff as required. An evaluation of repair records and ceiling lift motors in the various home areas revealed that approximately 50 percent of the available ceiling lift motors were out of service due to broken clips, missing chargers, dead batteries, unresponsive remote controls or detached remote controls. Staff reported to use the lifts by manually manipulating the components, where remotes were not working and borrowing motors from other home areas as spare ceiling lift motors were not available. Mechanical floor lifts were only available in ten out of the sixteen home areas and were an alternative for use when a ceiling lift was not functional. However, staff would leave their home area to go in search of the lift in another area, taking time away from resident care.

The disrepair of each of motor was observed to have been documented by staff in the service provider’s request for service binder. Staff reported that the service provider visited several times per week to evaluate what motors needed to be repaired. The majority of requests were made in May 2014, and the repairs were still pending on June 3, 2014. Responses made by the service provider on most of the request forms included statements such as "will quote for repair" or "will quote for replacement". Two requisitions in particular, the first dated March 17, 2014, for a sling clip that broke off was seen by the contractor on March 25, 2014. The response was to get a quote for replacement. On April 15, 2014, a note was made that parts were on order. On May 1, 2014, another note indicated that parts were still on order and as of June 3, 2014, the lift was still in disrepair. A requisition, dated March 20, 2014, was made for a motor with a broken sling clip. No response was noted on the form by the contractor. Both of these motors were verified to be available to staff in Rose Garden and Heritage Trail without proper lock out or “out of service” tags on them. The home’s policy “Resident Handling: Lifts, Transfers and Repositioning, OHS/POL-5” required that "any unsafe equipment be removed from service and labeled immediately".

A tub lift chair in Maple was not working properly according to staff, however the request for service binder could not be located by staff to verify whether the disrepair was documented. The chair was observed in the tub room and did not have a lock out or "out of service" tag on it. The staff reported that they used a lift from another home area. The home was identified to have sixteen tubs but only ten tub lift chairs. The home’s policies “Maintenance Work Orders, MAI-POL/4” and “Preventive Maintenance, MAI-POL/6” addressed equipment maintenance issues. The latter policy identified that outside service contractors provided preventive maintenance but the policy did not address who was responsible for the care and maintenance of the

various lift equipment, especially when the service provider was not available or unable to provide the service. None of the above procedures identified what staff were to use when equipment was not available, either due to use by staff from another home area or was not safe for use.
B. Lower cabinet surfaces located in the serveries in each of the seven home areas in the South Tower were observed to be worn down to raw wood. Some of the surfaces were cracked or beginning to crack due to moisture penetration. The condition of these cabinets was previously identified and documented during an inspection in May 2013. To date, measures to address the condition of the cabinets were not instituted.

C. Over bed tables with rusty and peeling bases were observed in use in Heritage Trail, Valley Trail, Cedar Grove, and Lilac dining room and in an identified room.
The bottom of a cabinet unit located in the Oak Grove tub room was in poor condition, it appeared to have been damaged by repeated water exposure. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 012, 016 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not develop and implement procedures to address incidents of offensive and lingering odours.

Urine odours were previously identified and documented during an inspection conducted on May 2013. Pine Grove and Willow Grove were toured on May 20, 26, and June 3, 2014, and were noted to have offensive and lingering urine odours, especially Pine Grove. The units were reported to be home to residents with behaviours related to incontinence and furnished with wall to wall carpeting that was installed directly on top of concrete. The Housekeeping Supervisor confirmed deep carpet cleaning was performed by an outside service and was completed several times per year. Other cleaning methods included spot cleaning or the use of a small extractor by housekeepers, if they had sufficient time. None of these methods removed the urine that had penetrated down into the concrete or possibly into wall cavities. A policy was not developed to address issues related to various types of odours and available options to staff if regular cleaning was not effective in removing the odours. The Housekeeping Supervisor reported that a request was submitted to have the carpeting removed and replaced with smooth flooring, however no progress was evident since the last inspection. [s. 87. (2) (d)]

Additional Required Actions:

CO # - 013 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #10: 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. Residents were not evaluated in accordance with evidence-based practices with respect to bed rail use to minimize entrapment risk to the resident.

Resident #95 was observed in bed with two quarter rails in the raised elevated position on May 27, 2014. The bed was tested on July 30, 2013, and failed several zones of entrapment. The plan of care did not include any information regarding rail use. The RCC indicated that if there was no information in the plan, then no rails should be used. When the RCC was asked how decisions were made regarding rail use, a copy of the Restraint Assessment form was provided. The form did not include any specific guidance for staff with respect to evaluating residents for bed rail use . The RCC alone made final decisions regarding rail use, rather than an interdisciplinary review. The guidelines endorsed by Health Canada “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003”, created by the Federal Drug and Food Administration were not implemented or incorporated into the home’s existing restraint assessment. These guidelines were current best practices in the field of bed safety for adult hospital beds. [s. 15. (1) (a)]

2. Where bed rails were in use, steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Between July and November 2013, two staff members tested all the beds in the home, except those with a therapeutic air surface, for all seven zones of entrapment. Over 100 beds were found to be non compliant with the measuring guidelines provided by Health Canada. Some interventions were made where bed rails had been removed, however the majority of the bed rails were being used as per by the resident's plan of care or because staff left the bed rail in the raised position out of habit. No interventions were observed to be implemented for the residents who were observed with rails elevated while in bed, where the bed did not pass all zones of entrapment.
The following residents were observed lying in bed on May 26, or June 3, 2014:
i. Resident #90 was observed in bed with both quarter rails elevated. This model of bed was tested in 2013, and noted to pass. However, when the same model of bed was re-tested on May 27, 2014, the bed failed zones two and three. The plan of care did not include any information about the need to use bed rails.
ii. Resident #92 was observed in bed, on an air mattress, on June 3, 2014, with both quarter rails elevated. The plan of care included no information regarding rail use. The bed was tested in January 2014, and failed several zones of entrapment. No

interventions were employed to mitigate the failed zone issues.
iii. Resident #91 was observed in bed with quarter rails elevated. The plan of care included no information regarding rail use. The bed was tested in January 2014, and failed several zones of entrapment. No interventions were employed to mitigate the failed zone issues.
iv. Resident #94 was observed in bed with two three-quarter rails elevated and on an air mattress. There was approximately one inch between the top of the rail and the top of the mattress. The resident did not have any interventions to mitigate zone two and three entrapment risks, or to reduce the risk of rolling over the top of the rail. No rail height extenders, bolsters or gap fillers were observed in use. The plan of care did not identify rail use.

A common practice of leaving at least one bed rail in the raised position was being employed by PSW's during the inspection. Numerous beds, those that passed and failed entrapment zone testing, were seen with at least one rail elevated while residents were out of bed. When staff were interviewed, they reported that it was a habit to always leave the rails up for residents needing to transfer themselves into bed. Not all staff were aware of entrapment issues associated with the beds and that rails were only to be employed when indicated in the plan of care. Confirmation was made with one of the RCC's that if the plan of care did not include information regarding bed rails, it was due to the fact that they were assessed as not needing them. Based on the various plans reviewed for the above residents and the observations made, staff did not follow the plan of care and placed residents at risk.

Residents were provided with beds equipped with split rails in three rooms, all which failed several zones of entrapment. The management staff were not aware that these beds were still in use, as they thought they all had been removed.

Residents were provided with therapeutic air mattresses in ten rooms. The home did not have an adequate supply of gap fillers to ensure that these residents, if using rails, could have the zone two gaps, between the rail and mattress reduced.

Different beds had been purchased, moved and accepted into the home without adequate monitoring since they were tested in 2013. New mattresses were purchased and applied to beds, but mattresses were not matched to the bed frames and therefore could have been changed. The test results that were conducted in the past could no longer be used as a reliable source of information to determine the

status of the bed systems. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 014, 015 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. Not all hazardous substances were kept inaccessible to residents.

A. Iodine was found in resident rooms on May 26, 2014, in five rooms.
B. Spa room doors were left wide open with disinfectant inside drawers or out on shelving on May 26, 2014, in the Willow Grove tub room, Trillium shower room and Oak Grove tub room. A housekeeper in one home area revealed that she leaves the doors open for the floor to dry after mopping. [s. 91.]

Additional Required Actions:

CO # - 017 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #12: 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. Where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with all applicable requirements of the Act.

Section 49 of Regulation 79/10 noted "that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-falls assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls".
The home's policy for falls "NUR-POL/3 Falls Prevention and Management, last revised October 23, 2013" instructed staff to complete a falls assessment using the progress notes. Interview with the DOC and RCC confirmed the heading/titles for the falls and falls-serious injury progress notes was the tool used by the home for post-falls assessment and were based on the Falls Risk Assessment Tool (FRAT). A review of the FRAT and the home's progress note template for falls confirmed that the notes did not include all components of the FRAT and therefore was not a clinically appropriate assessment tool. (528) [s. 8. (1) (a)]

2. Where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

A. The home had a "Flow Sheet Policy, last review date of June 2013", which directed staff to complete the documentation on the flow sheet: "if you actually do the care".
i. Record review for resident #19 identified they required to be released from their seat belt restraint and repositioned every two hours. On May 23, 2014, the resident was observed and did not receive repositioning or removal of their seat belt between 1040 hours and 1430 hours. The Flow Sheets were reviewed at 1430 hours and included documentation that the resident was repositioned at 1200 hours and 1400 hours on May 23, 2014. Interview conducted with staff working May 23, 2014, day shift confirmed that the resident was not repositioned as documented on the Flow Sheet. (583)
ii. Staff interviews confirmed that on an identified evening shift in 2014, resident #88 refused care. The Flow Sheet, was signed for the evening shift, as "AM/HS care

provided as per resident care plan". Staff interviewed confirmed that they documented the completion of care, that was not provided on the specified shift. (168)
B. The home had a policy "Restraint, PASD, and Alternatives, NSG-NUR-POL/10, last revised October 23, 2013", which identified "an assessment must be completed each time the restraint/PASD is re-ordered. A separate assessment must be done for each type of restraint/PASD".
Resident #18 was observed to use a tilt wheelchair and two bed rails in the raised position when in bed as a PASD, which was confirmed by staff. A review of the clinical record identified that these devices were in place for over 12 months. The record reviewed for the past 12 months included a formalized assessment or reassessment of the bed rails in June 2013, and February 2014, and for the tilt wheelchair in June 2013, only. The assessments were not completed each time the devices were ordered, on a quarterly basis, as required, as confirmed by staff. (168)
[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 where the Act or this Regulation requires the licensee 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, is in compliance with and is implemented in accordance with all applicable requirements of the Act and is complied with, to be implemented voluntarily.

WN #13: 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. Not every person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

A. In 2014, a concern was reported to the DOC regarding residents living on an identified home area. The allegations were investigated by the home immediately, including multiple interviews with staff, residents and families. After a week long investigation the home did not find grounds to support abuse or neglect of residents, and investigation notes indicated that management would be monitoring the issue ongoing for three months. The DOC confirmed that the Director was not notified of the allegations or results of investigation. [s. 24. (1) 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 every person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #14: 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 plan of care was not based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

A. A review of records from March 1, 2014, until May 2014, did not include an assessment related to resident #76's sleep patterns and preferences. Food and fluid intake records identified the resident did not eat breakfast 14 of 31 days in May 2014, because they were sleeping. The plan of care did not identify that the resident regularly slept thorough breakfast. Interviews completed with staff confirmed that sleep patterns and preferences were not identified in the plan of care. (583)
B. A review of records from January 1, 2014, until May 2014, did not include an assessment related to resident #78's sleep patterns and preferences. Food and fluid intake records identified the resident did not eat breakfast 23 of 31 days in May 2014, because they were sleeping. The plan of care did not identify that the resident regularly slept thorough breakfast. Interviews completed with staff confirmed that sleep patterns and preferences were not identified in the plan of care. [s. 26. (3) 21.]

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 plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. Not every PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Subsection 33(4)3 of the Long Term Care Homes Act, 2007, identified that a personal assistance service device (PASD) may only be included in the plan of care if the use of the device was approved.
Resident #18 was observed to be using a tilt wheelchair and two raised bed rails while in bed. Interview with staff confirmed the use of the devices and that they were both PASD's. A review of the clinical record identified that the resident previously had approval for the devices, and had a written physician's order, as recently as December 2013. The resident was admitted to the hospital in 2014, and on readmission to the home the devices were not reordered by the physician, although continued to be used by the resident. Interview with staff confirmed the home's expectation that a physician's order be in place for a PASD. The PASD's for resident #18 including a tilt wheelchair and two bed rails were not currently approved for use. [s. 33. (3)]

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 PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident’s plan of care, to be implemented voluntarily.

WN #16: 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. Not all drugs were stored in a medication cart that was kept secured and locked.

On May 29, 2014, at 1154 hours, the medication cart was unattended and unlocked outside of the dining room. The registered staff was in the dining room with their back to the cart feeding a resident. The registered staff reported that they did not lock the cart and confirmed that it should have been secured. (156) [s. 129. (1) (a) (ii)]

2. Not all drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

A. On May 23, 2014, drugs were stored in medication rooms that did not comply with manufacturer's instructions for expiration dates, specifically:
i. In the medication storage room, on the second floor, South, one opened and used container of Vitamin B12, 1000mcg/ml was noted to be expired November 2013.
ii. In the medication storage room, on the fourth floor, two unopened containers of Docusate Sodium expired October 2013, and April 2014, and one opened and used container of probiotics expired November 2013.
iii. In the medication storage room, on the fourth floor, North, two unopened packages of Isopto Tears 1.0% expired March 2014, one unopened container of Docusate Sodium 100 mg expired April 2014, and one opened and used containers of Ferrous Sulfate expired February 2013.
Interview with registered staff confirmed that the medications were expired as per the manufacturer's instructions on the bottles/packaging. [s. 129. (1) (a) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all drugs are stored in the medication cart which is kept secure and locked and that all drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. When a resident was taking any drug or combination of drugs, including psychotropic drugs, there was not consistent monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A. Resident #86 had a physician's order for a medication as needed twice a day. The MAR's were reviewed for the months of February and March 2014. These records identified that the resident was administered the medication on at least 46 occasions during the identified time period, however the resident's response and effectiveness was only recorded 14 times, in the progress notes and/or the MAR's. Interview with registered staff confirmed that the effectiveness of medications would be recorded in the progress notes or the MAR. (168)
B. Resident #12 had a need for pain control and received a medication on January 17, and 20, 2014, February 14, and 27, 2014, and March 5, 2014. Records reviewed did not include an assessment or documentation of the effectiveness of the medication. Interview with registered staff confirmed that after the administration of the medication, the resident's response and the effectiveness of the drug was not monitored and documented. (528)
C. Resident #14 experienced pain and required the use of as needed analgesic in April 2014. On April 16, 2014, the physician reassessed the resident and ordered routine, twice a day analgesic, which was effective in pain management. From April 1, 2014, until April 16, 2014, the resident received the as needed analgesic 16 times as documented in the MAR. Review of the MAR and progress notes, for the same time

period, included the effectiveness of the medication only six times, which was confirmed during staff interview. Documentation of the resident's response and the effective of the medication was not consistently completed. (168)
D. Resident #20 received an anti-inflammatory for pain on November 11, 2013. Review of the records did not include an assessment or documentation of the effectiveness of the medication. Interview with registered staff confirmed that after the administration of the medication, the resident's response and the effectiveness of the drug was not monitored and documented. (528)
E. Resident #87 had a history of daily responsive behaviours and pain.
i. As an intervention to assist in the management of the behaviours, the physician trialed a variety of medications. For six identified months, the medications that were administered, as required, for behaviours were not consistently evaluated and the resident's responses were not always documented. Interview with registered staff confirmed 14 instances where a medication was administered and evaluation of the resident's response was not documented.
ii. From September 2013, to January 2014, the resident received routine anti-inflammatories. Review of records did not include documentation of routine weekly pain assessments to monitor their effectiveness by registered staff in the MAR or progress notes. Interview with the ADOC confirmed that if the pain assessments were not included on the MAR or progress notes they were not completed. (528)
F. Clinical record for resident #15 identified that an as needed analgesic was administered 29 times during November 2013, and the effectiveness was not documented seven times. The same medication was administered 25 times during February 2014, and the effectiveness was not documented six times. During May 2014, the medication was administered eight times, however the effectiveness was not documented on three occasions. Registered staff confirmed that the effectiveness was not recorded on the specified dates, and the documentation expectation regarding the resident's response to the medications, including a weekly pain assessment at 0800 hours and 2000 hours using the Numerical Rating Tool score, with findings on the MAR and in the progress notes. In November 2013, four out of eight pain assessments were not documented. In February and May 2014, two of eight assessments were not documented, which was confirmed by registered staff. (582) [s. 134. (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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is consistent monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #18: 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. (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. Not all staff participated in the implementation of the infection prevention and control program.

A. The home's policy "INF-POL/1 Routine Practices, last revised October 2013" indicated hand hygiene, either using alcohol based rub or hand washing with soap and water, was required before and after contact with any resident, their body substances or items contaminated by them, before and after performing invasive procedures, and between different procedures on the same patient.
i. On May 23, 2014, from 0740 to 0750 hours, medication administration was observed. Registered staff were observed to check capillary blood sugar before administering subcutaneous insulin to resident #37. The same staff member then handled and administered a narcotic tablet to resident #38. Hand hygiene was not observed before or after medication administration for resident #37 and #38. (528)
ii. During the lunch meal on May 20, 2014, a PSW was observed to scrape uneaten food off of a resident's plate, then continued to interact with a resident and touched

their walker with soiled hands. Interview with another PSW on May 23, 2014, identified the expectation to wash hands between tasks, such as scraping used dishes, then interacting with residents. Interview with registered staff identified that the practice was to wash hands after scrapping used dishes before interacting with residents.
iii. During the lunch meal on May 20, 2014, a dietary staff member was observed to scrape uneaten food off of a resident's plate, then rinsed their hands with water without using soap. The dietary staff continued to work, providing a resident with a clean utensil, pouring coffee, and serving dessert. The FSM confirmed on May 22, 2014, that the staff had completed the Food Handler Certification course though the local health unit, and the expectation that staff follow the course training. The course manual indicated hand washing expectation was to apply soap as part of the hand washing program. (585)
B. Personal hygiene items were identified on May 26, 2014, in common spaces such as tub and shower rooms. Unlabeled used hair brushes noted in Pine Grove shower room, Trillium Tub room and Tulip Garden shower room on May 20, 2014, and May 26, 2014. Unlabeled used deodorant sticks identified in Tulip Garden shower room and Cedar Grove tub room on May 26, 2014. A loose bar of used soap noted on top of the tub in the Primrose Lane tub room on May 20, 26, and June 3, 2014. Three used loose bars of soap were found on an open shelf in Cedar Grove tub room on May 26, 2014. The infection control designate reported the expectation for staff to return personal items to the resident's room or washroom after they were showered or bathed, but no specific policies could be provided regarding the expectation.
C. The tub, which was regularly used in an identified unit did not have any disinfectant inside the unit itself or a dispensing system connected to the unit on May 26, 2014, and June 3, 2014. The tub was observed to have just been used and no disinfection supplies were available. The spray bottle of disinfectant found on a shelf in the room was also empty. The disinfectant dispenser for the tub in a second unit was checked on May 26, 2014, and found to be empty of disinfectant. (120) [s. 229. (4)]

2. The pets living in the home or visiting as part of a pet visitation program did not have up to date immunizations.

On May 28, 2014, the home provided a copy of the most up to date vaccination records on file for the two visiting pets. The document identified that the pets were last immunized in 2011. Staff confirmed that there was one pet living in the home, however was unable to produce a record of annual vaccinations. According to the home's policy, "Pet Therapy (PRG POL/4)", animals used in visiting programs must be

fully vaccinated and records must be available upon request, as well live in pets must have up to date vaccinations and a record of testing for parasites or other infectious diseases. Staff confirmed that the home did not have up to date immunization records for all pets as part of the program. (582) [s. 229. (12)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #19: 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 resident did not receive individualized personal care, including hygiene care and grooming, on a daily basis.

On May 21, 22, and 23, 2014, resident #10 was observed to have visible facial hair on their chin and upper lip. The plan of care indicated they required extensive assistance with personal hygiene. On May 22, 2014, the resident indicated they were aware of the facial hair, did not like it, and wanted it removed. Interview with direct care staff confirmed that they did assist the resident to shave, however confirmed it had not been completed. [s. 32.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The resident was not bathed, by the method of their choice.

Resident #19 indicated their preference was to have a tub bath, but choice around bathing was not offered, and tub baths were not always provided. A review of the bath day schedule identified the resident's bath was May 26, 2014, during the morning shift. On May 26, 2014, the resident was not taken to the tub room during the morning shift. Staff interviewed at 1425 hours on May 26, 2014, confirmed the resident's preference for a tub bath, however a bed bath was provided. [s. 33. (1)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Staff did not use safe transferring and positioning devices or techniques when assisting residents.

Section 2 of the Long-Term Care Home Act, 2007, defines "staff", as persons who work at the home as employees of the licensee, pursuant to a contract or agreement with the licensee, or pursuant or contract or agreement between the licensee and an employment agency or other third party.

Resident #20 had third party private caregivers. Review of the plan of care and bedside signage indicated that the resident required a sit to stand lift and two person assist for safe transfers. Home staff confirmed the resident required two person assist for safe transfers and reported that the private caregivers did not follow verbal and posted instructions for safe transfers, often completed with only one person. Two private caregivers confirmed that they transferred the resident using one person assist and no lift, despite the safe transfer instructions provided by the staff in the home. [s. 36.]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with the President of Residents' Council and the Council Assistant confirmed that not all concerns or recommendations were consistently responded to in writing within 10 days.   Available Residents' Council Meeting Minutes were reviewed for the past five meetings and identified that the following issues were not responded to:
i.   During the April 2014, meeting a concern regarding incontinent products.
ii. During the February 2014, meeting a concern regarding towels.
iii. During the September 2013, meeting concerns regarding spicy and sweet food. [s. 57. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. Not every verbal complaint made to a staff member concerning the operation of the home had been investigated, resolved where possible, and responded to within 10 business days of receiving the complaint.

A. Resident #70 indicated that a sum money went missing from their room in 2014. The resident reported the loss to staff, however did not receive a response and was not informed of any internal investigation that took place. Two registered staff documented that the resident had reported the missing money and a progress note, indicated that the social work would follow up. Interviews completed with staff confirmed that the specified progress notes were shared with all areas of the home and administration automatically via the computer system. A review of the procedure related to theft or loss indicated that the Resident Property Clerk would receive the progress note for missing valuables, would complete an investigation and search, arrange for storage of valuables and keep an inventory file. The Social Worker and Property Clerk confirmed they both received notice of the missing money and that an investigation did not initially take place, nor was a response provided the to resident. Follow up action was initiated, after the inspector inquired about the complaint and process in place. The complaint was not investigated or responded to as required. [s. 101. (1) 1.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident’s written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The resident’s written record was not kept up to date at all times.

Resident #14 had a fall in 2013, and the Head Injury Routine (HIR) was initiated as per the falls procedure. The HIR record was not included in the residents’ record and could not be located as confirmed by registered staff on May 26, 2014. [s. 231. (b)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 71. (1)	CO #006	2013_188168_0016	156
O.Reg 79/10 s. 71. (1)	CO #002	2013_122156_0030	156
O.Reg 79/10 s. 82. (1)	CO #009	2013_188168_0016	168

Issued on this 11th day of July, 2014

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), BERNADETTE SUSNIK (120), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582), KELLY HAYES (583), LEAH CURLE (585), VIKTORIA SHIHAB (584)
Inspection No. / No de l'inspection :	2014_188168_0014
Log No. / Registre no:	H-000554-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 16, 2014
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
LTC Home / Foyer de SLD :	ST JOSEPH'S VILLA, DUNDAS 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Bakker

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To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
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.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that every resident, including #88 and #39, is cared for in a manner consistent with their needs.

Grounds / Motifs :

1. Previously identified as non compliant in May 2013, as a VPC.

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

A. Resident #88, who according to the plan of care had confusion, a decline in cognitive function and a diagnosis of dementia, was not cared for in a manner consistent with their needs on two consecutive days 2014. The resident, who staff reported was known to sleep in common areas, resist care and be independent with most physical aspects of care, positioned themselves in a lounge arm chair during the beginning of the day shift, and remained there until the day shift the following day. Staff interviews confirmed that medications and nourishment were offered, and attempts were made, by each shift, to provide care to the resident, although the care was consistently refused. The resident remained up in the chair without receiving assistance, or support with their activities of daily living, during the identified period of time. There was a noted change in the resident's condition, including pain, when assessed on the day shift of the second day. The physician was notified and interventions were put into place to manage the symptoms displayed before the resident was transferred and admitted to the hospital on the second day. Some of the staff

who worked on the first day, reported that in hindsight, the resident was more lethargic than usual and difficult to rouse. The resident was not cared for in a manner consistent with their needs. (168)
B. The plan of care for resident #39 indicated that they were cognitively impaired, could not make concrete decisions, and due to constipation included a routine order for weekly enemas. Documentation for 11 consecutive days in 2014, identified the resident refused the weekly enemas stating that the surgeon ordered a hold on the order. The clinical record did not include a hold order from the surgeon or a physician. Registered staff did not verify with the surgeon if the enema was to be held, nor did they notify the physician of the refusal of the medication. On a specified date in 2014, the physician assessed the resident to have a distended abdomen. Interview with the staff confirmed that they did not consult the surgeon until suggested by the physician. The resident did not have a bowel movement for 16 days and was admitted to the hospital for treatment. The resident was not cared for in a manner consistent with their need. (528) [s. 3. (1) 4.]
(168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_188168_0016, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to all residents, including residents #61, #60, #62, #31, and #15, as specified in the plans.

Grounds / Motifs :

1. Previously identified as non-compliant in May 2013, as a CO.

Not all care set out in the plan of care was provided to the resident as specified in the plan.

A. The plan of care for resident #61 indicated that they were on a specialized diet, to provide fluids, pureed soup and to allow half portions of pureed entree for pleasure when alert. During the lunch meal on June 3, 2014, the resident was alert and talking in the dining room. The resident was provided with two fluids and fed a Boost pudding. Care was not provided to the resident as specified in the plan as the resident was not offered the half portion of pureed entree or the pureed soup as per the plan of care. (156)
B. The plan of care for resident #60 indicated they were to receive a restricted diabetic, with additional restrictions diet. The home's menu cycle did not include menus for a restricted diabetic, with the additional restrictions. On May 27, 2014, the dietary aide reported that the resident was provided with a low sodium diet, with diabetic desserts, or water was added to regular juice. The Medication Administration Record (MAR) indicated that the resident was not to receive artificial sweeteners or diet pop. The direction was to provide regular foods with sugar but just in smaller portions. On June 3, 2014, during the lunch meal, the

dietary staff reported that they followed the low sodium diet on the therapeutic menu for the resident. Nutritional care was not provided as per the plan of care. (156)
C. The plan of care for resident #15 indicated that the resident was to be included in all decision making regarding care and that any changes to the usual routine, including staffing, were to be communicated to both the resident and the family. Interviews conducted with front line and registered staff who provided care to the resident, revealed that assessments of the resident's care routine were conducted on two specified dates. Two staff members confirmed that the resident, substitute decision maker (SDM) and family were informed in advance, of the first assessment, however they were not notified of the second assessment, which included participation by a staff member, who was not consistently involved in the resident's care routine. (582)
D. The plan of care for resident #31 indicated they were on a pureed textured diet. During the lunch meal on June 3, 2014, they received puree textured green beans and pureed macaroni and beef casserole stirred together with low calorie pancake syrup. All items were mixed together in a bowl and placed in front of the resident. The staff reported that the syrup was added as the resident would not eat otherwise. The plan of care did not include this intervention nor to stir the meal together. Staff did not provide care as per the plan. (156)
E. During the lunch meal on June 3, 2014, resident #62 was provided with puree pasta and puree green beans with pancake syrup. The plan of care did not include the addition of the syrup to the entree. Staff did not provide care as per the plan. [s. 6. (7)] (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_188168_0016, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that there is a written plan of care for each resident, including residents #52, #53, and #18, that sets out, clear directions to staff and others who provide direct care to the resident.

The plan shall be submitted electronically to Lisa.Vink@ontario.ca by June 30, 2014.

Grounds / Motifs :

1. Previously identified as non-compliant in May 2013, as a CO.

The written plan of care for each resident did not set out clear directions to staff and others who provided direct care to the resident.

A. Residents #52 and #53 had their diets identified on the Menu Choices List as modified diabetic. This list was used to direct staff in the serving of meals. Their plans of care identified that they were to receive a modified diabetic, with additional restrictions. The plans of care did not give clear direction to staff regarding their nutritional care needs. A review of the therapeutic menu confirmed that a the required diet was available for the residents. (584)
B. The plan of care for resident #18, updated on April 23, 2014, specified supervision at meals and staff to provide oversight, encouragement or cueing. The printed and accessible Health Care Record Display had a revision date of July 25, 2013. The eating assistance intervention indicated the resident was independent, without staff assistance or oversight. On May 26, 2014, during the noon meal the resident was served lunch in bed and left unattended. The plan of care, available for staff did not give clear direction. [s. 6. (1) (c)]
(168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_188168_0016, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that each resident, including residents #16, # 78, #18, #10, and #12, are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

The plan is to be submitted electronically to Lisa.Vink@ontario.ca by June 30, 2014.

Grounds / Motifs :

1. Previously identified as non-compliant in May 2013, as a CO.

The resident was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. The plan of care, available on May 22, 2014, for resident #16 identified the intervention of a bladder retraining, restorative care program. Interview with staff

confirmed the resident was no longer on the program, for approximately one

year, and was now routinely toileted, but not on a retraining or restorative care program. Quarterly assessments reviewed for the past three quarters, identified the level of continence, elimination patterns and supplies used, however not a bladder retraining or restorative program. The plan of care was not revised with changes in care needs. (168)
B. Resident #78's nutritional assessment completed on March 26, 2014, indicated that their nutrition risk increased from medium to high. A risk related to nutritional care was identified in the Registered Dietitian's (RD) assessment indicating that the resident usually slept through breakfast. In a review of the May 2014 Food and Fluid Intake form identified the same issue, noting that the resident slept through breakfast and did not consume breakfast for 23 days in May, 2014. The plan of care was not revised to include missed morning meals as a risk, therefore no specific goals or interventions were identified related to regularly missing meals. The RD confirmed that the plan of care was not updated to include the change in care needs related to missed meals. (583)
C. The plan of care for resident #18 indicated that due to altered skin integrity staff were not to apply incontinent wear, to use dry flow pads only, that briefs were on hold and to change as frequently as needed. It was observed on May 27, and 28, 2014, that the resident was wearing a brief. Interview with staff confirmed the use of the brief as the areas of altered skin integrity had improved. It was confirmed that due to the change in care needs briefs were no longer contraindicated for the resident, however the plan of care was not revised to reflect this change in status. (168)
D. The plan of care for resident #10 related to mouth care, identified both upper and lower dentures. The resident was observed to be edentulous. Interview with the resident and PSW staff confirmed that the resident no longer wore dentures and did not have access to them. The plan of care for mouth care was not updated to reflect this change in status. (528)
E. In 2013, resident #12 had an unwitnessed fall with minor injury. Review of October 2013, MDS assessment identified the resident was a high risk for falls and supporting assessments indicated that they were responding to interventions in the plan. The plan of care was not updated to include a risk for falls or corresponding interventions until May 23, 2014. Interview with registered staff confirmed that a risk for falls and interventions were not included in the plan of care. (528)
F. The plan of care for a specified resident indicated they were to receive total assistance from two staff for toilet transfers. The resident and staff confirmed the toilet was no longer used, the resident had a catheter and used briefs for containment. The resident stated that briefs were changed twice a day and

PSW staff reported they were changed on request. The plan of care was not revised to reflect the change in toileting status. (584) [s. 6. (10) (b)] (528)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_188168_0016, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Order / Ordre :

The licensee shall ensure that no resident of the home, including residents #31, #76 and #19, are restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

The home shall ensure that all physical devices in use are applied according to manufacturers specification and that each restrained resident is repositioned at least every two hours.

Grounds / Motifs :

1. Previously identified as non compliant in May 2013, as a CO.

Not every restrained resident in the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

A. Resident #31 was identified in the plan of care and observed to use a side fastening seat belt when in the wheelchair.
i. On May 21, 2014, at 1200 hours the side fastening seat belt was loose and could be pulled away from the resident's body to approximately mid thigh. Interview with registered staff confirmed that the restraint was applied too loosely and should be two fingers breadth from the resident's body.
ii. On May 23, 2014, at 1550 hours the seat belt was loose and could be pulled away from the resident's body to approximately mid thigh. Interview with direct care staff and registered staff confirmed that the restraint was applied too loosely and should be two fingers breadth from the resident's body. (528)
B. On May 21, 22, 23, and 26, 2014, resident #19 was observed in their wheelchair wearing a side fasting seat belt, which was identified to be a restraint, that was applied incorrectly. On May 21, 23, and 26, 2014, the belt was applied allowing a squeezed fist between the resident's abdomen and the belt. On May 22, 2014, the belt was applied allowing four fingers between the resident's abdomen and the belt. Interview with registered staff on May 26, 2014, confirmed that the belt was not applied as per specifications. The staff identified training had been provided on the application of seat belts and the expectation was no greater than two fingers space present between the abdomen and the seat belt once applied. (583)
C. Resident #19 had a seat belt restraint and required repositioning every two hours when the device was in use according to the home's policy and the plan of care. On May 23, 2014, the resident was observed from 1040 hours until 1430 hours. The resident was not repositioned during the specified period of time. Interviews with registered and PSW staff working confirmed that the seat belt was not released nor was the resident repositioned from 1040 hours to 1430 hours. (583)
D. On June 3, 2014, during the noon meal, resident #76 was observed in a wheelchair with a front fastening seat belt which was not applied correctly. The belt was loose extending three to four inches away from the resident's abdomen. PSW staff confirmed that the belt could not be tightened due to the design of the device, and for this reason a blanket was placed on the footrest, to prevent sliding down in the chair. The PSW identified that this concern, of the loose fitting belt, was reported to registered staff. (120) (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2014

Order # / Ordre no : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_188168_0016, CO #010;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that home meets the practice requirements of the Resident Assessment Instrument - Minimum Data Set (MDS-RAI) system, which requires each resident to have their care and service needs be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the last Assessment Reference Date (ARD) of the previous assessment, and any significant change in resident's condition, either decline or improvement, to 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.

The plan shall be submitted to lisa.vink@ontario.ca by June 27, 2014.

Grounds / Motifs :

1. Previously identified as non-compliant in May 2013, as a CO.

The licensee did not comply with the conditions to which the license was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system. This required each resident's care and services 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, be reassessed along with Resident Assessment Protocol (RAPs) by the team using the MDS Full Assessment by the 14th day following the determination that a significant change had occurred.
For all other assessments:
a) The care plan must be reviewed by the team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of the VB2.
b) RAPs must be generated and reviewed and RAP 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 was subject.

A. The following residents had incomplete or late Assessment Protocols (APs) completed:
i. Resident #16 had an assessment completed with an ARD of November 3, 2013, however AP's were not completed until December 3, and 4, 2013. A second assessment was completed with an ARD of February 1, 2014, however some AP's were not completed until February 22, 2014. (168)
ii. Resident #87 had an assessment completed with an ARD of January 21, 2014, however AP's were not completed until February 24, 2014. (168)
iii. Resident #86 had an assessment completed with an ARD of November 11, 2013, however AP's were not completed until January 19, 2014. A second assessment was completed with an ARD of February 9, 2014, however some AP's were not completed until March 9, 2014. (168)
iv.   Resident #15 had an assessment completed with an ARD of November 6, 2013, however AP's were not completed until December 19, 2013. A second assessment was completed with an ARD of February 4, 2014, however AP's were not completed until March 26, 2014. (582)
v. Resident #14 had an assessment completed with an ARD of May 9, 2014, however AP's had not yet been completed when the clinical record was reviewed on June 3, 2014. Staff interview confirmed that the triggered AP's for the May 2014, assessment were not completed. (168)`
vi. Resident #10 had assessments completed in January 2014, and April 2014, which did not have AP's completed within 14 days of the ARD, which was confirmed during staff interview. (528)
vii. Resident #12 had assessments completed in December 2013, and March 2014, which did not have AP's completed within 14 days of the ARD, which was

confirmed during staff interview. (528)
Staff interviewed confirmed that a monthly schedule was distributed which outlined what assessments were to be completed. This schedule included the time frames for completion of each section of the RAI MDS assessment. The RCC, who was responsible for RAI, confirmed that staff were to follow the scheduled time frames for the completion of the quarterly assessments, and that AP's would be recorded in the progress notes as PN-AP. (168) (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant:
2013_188168_0016, CO #007;
2013_122156_0030, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that all residents are offered a minimum of three meals daily and a snack in the afternoon and evening.

The plan is to be submitted to carol.polcz@ontario.ca by July 4, 2014.

Grounds / Motifs :

1. Previously identified as non-complaint in May 2013, and May 2014, as a CO.

Not all residents were offered a minimum of three meals daily.

A. Resident #78 was observed in bed asleep on June 3, 2014, until 1100 hours. Registered staff confirmed that the resident did not go to the dining room for breakfast and was not offered a breakfast in their room. (583)
B. Resident #78 was identified at high nutritional risk. On May 27, 2014, at approximately 1045 hours, the resident was observed in bed asleep and staff confirmed that the resident was not offered breakfast. (156)
C. On May 26, 2014, resident #19 was not offered and did not receive breakfast. The plan of care nor progress notes included an explanation for the missed breakfast. Interview with registered and PSW staff on May 26, 2014, confirmed that the resident was not offered and did not receive breakfast. (583)

Not every resident was offered a minimum of a snack in the afternoon and evening.

A. On May 26, 2014, at 1940 hours, evening snacks and beverages had not yet been offered to residents on an identified unit. Interview with registered staff at 1945 hours, confirmed the process of distributing evening snacks and beverages was for registered staff to provide the nourishments to the residents, that fluids were offered to all residents, but snacks were only provided on request. The registered staff confirmed that not all residents were offered a snack in the evening. (583)
B. Discussion with a specified resident indicated that snacks were not consistently offered. A review of their intake records on May 27, 2014, for May 2014, identified that they did not consume evening snack on 25 of 27 days.
C. Interview with a PSW and resident #18 on an identified unit confirmed that evening snacks were usually not offered to residents. Intake records reviewed on May 27, 2014, for the resident identified that snacks were not taken 23 of 27 days in May 2014. (584) (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 04, 2014

Order # / Ordre no : 008

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_122156_0030, CO #003; 2013_188168_0016, CO #008;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that:
a) recipes are available for all food items including textured modified foods.
b) recipes are followed.
c) foods are not prepared too far in advance of meal service.

The plan is to be submitted to carol.polcz@ontario.ca by July 11, 2014.

Grounds / Motifs :

1. Previously identified as non-compliant in May 2013, and October 2013, as CO's.

The food production system must, at a minimum, provide for standardized recipes and production sheets for all menus and preparation of all menu items according to the planned menu.

A. On May 20, 2014, cooks reported that they did not track shortages on the production sheets. (156)
B. Menus did not always reflect what was being served.
On June 3, 2014, during the noon meal dietary staff indicated that yogurt was available for those on thickened fluids, however, this was not indicated on the therapeutic menu to guide staff. (156)
C. Recipes were not always available or followed.
i. On May 20, 2014, during an interview with the cooks, it was noted that the home had a cook-chill food production system. Food was prepared a day in advance and then re-heated for service the day of use. Staff indicated they 'just add water' to minced and puree texture foods and do not follow any recipes in the preparation. (156)
ii. On May 29, 2014, cooks confirmed that they do not consistently follow recipes. It was reported that they would just add tomato sauce to the pizza soufflé to puree it and did not follow a recipe, as they were not sure that there was one. They indicated crackers were not added to soup, instead they use mashed potatoes as a thickener. (156)
iii. Cooks reported that recipes were not followed for the quantity of ingredients used to add to textured recipes. The cooks reported that there were no recipes for minced and puree textures and that they were "still fixing the recipe books". (156)
iv. On June 3, 2014, during the noon meal dietary staff indicated that the regular chef salad included turkey and cheese as well as salad dressing. It was reported that the minced and puree texture chef salad did not include turkey or cheese but did include the dressing. Both the minced and puree texture salad appeared to be of a very watery consistency. A review of the recipe indicated that the chef salad was only to include iceburg lettuce, tomatoes and cucumbers; there was no mention of dressing, turkey or cheese. The minced and puree recipe indicated that the regular salad was to be minced and pureed however there was no information regarding adding or excluding any of the items noted on the regular chef salad recipe. The portion size of the regular texture chef salad was noted to be a #8 scoop, however, the therapeutic menu indicated that a #6 scoop was to be used. The home used salad tongs during the observed lunch meal on second floor on June 3, 2014, and not a scoop. (156)
v. On May 26, 2014, during the dinner meal on an identified unit staff ran out of turkey a la king before all residents who requested the entree were served a full serving. Dietary staff verified that the last resident served did not receive a full

portion of the entree and there was no additional minced turkey a la king available. The resident received a substitution. (583)
vi. The snack menu was reviewed and evening snack supplies compared to the planned menu. On May 28, 2014, the snack storage areas were checked on Birch Trail, Rose Garden, Lilac Garden, Valley Trail, Tulip Garden and Balsam Trail. The planned evening snack was peach-apple sauce or crackers with cheese. Three of the six home areas had no cheese available. Two of the areas had three to five slices of cheese unlabeled in the fridge. Staff could not identify how long the cheese slices had been in the fridge. On the five areas with limited or no cheese, dietary staff confirmed that cheese was not available when they transported the snacks to the areas, from the kitchen, nor did they know what cheese was to be offered to residents. Each area had one pack (six individual containers) of strawberry-apple sauce, which differed from the planned menu, an insufficient quantity for the number of residents to be offered snacks. (584)
vii. On May 30, 2014, resident #78 requested pureed pizza with minced spring salad for lunch, however was served the pizza with minced carrot. Interview with the dietary staff confirmed that the resident received minced carrot because they ran out of minced spring salad. (583)

(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 009 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.

Grounds / Motifs :

1. Previously identified as non compliant in May and October 2013, as CO's.

Not all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

A. Foods did not always appear appetizing and food quality may not have been preserved.
i. On May 21, 2014, during the lunch meal onan identified unit the puree mashed potatoes appeared very dry. Dietary and nursing staff reported the mashed potatoes served were dry. (585)
ii. On May 21, 2014, during the lunch meal on an identified unit the puree tuna for the tuna sandwich appeared to be a nectar thick consistency. (585)
iii. On May 26, 2014, during the lunch meal, second sitting, on an identified unit, it was noted that sandwiches were not panned/portioned separately for each sitting. The pan of sandwiches was used for the first sitting and then the remaining sandwiches in the pan were used for second sitting. The quality of the sandwiches would be dry and compromised. (156)
iv. On May 27, 2014, it was noted that the soup was in the steam table at 1045 hours in an identified unit, which was the second dining sitting which began at

1230 hours, the soup had an extended period of hot holding prior to service. (156)
v. On June 3, 2014, during the noon meal two residents received puree textured green beans and pureed macaroni and beef casserole with low calorie pancake syrup. Taste would be compromised with the mixture of foods. (156)
vi. On June 3, 2014, during the lunch meal the minced and puree texture salad appeared to be a very watery consistency. (156)
B. On May 26, 2014, during the lunch meal, the dietary aide reported that the thermometer was rinsed in water between taking temperatures of different food items, and had not been properly sterilized. The FSM reported on June 4, 2014, the expectation was that thermometers were to be sanitized with alcohol swabs. The FSM indicated that the home was in the process of developing a new thermometer sterilization policy for all staff to follow. (156)
C. Portion sizes indicated on the therapeutic menu were not always followed, resulting in the residents being not served the correct portion sizes, at times less than required/planned.
On June 3, 2014, during the noon meal service on an identified unit:
i. A #6 scoop was indicated for puree texture macaroni and beef casserole, however, a #10 scoop was used instead.
ii. A #8 scoop was indicated for minced pears, however, a #10 scoop was used instead.
iii. A #8 scoop was indicated for puree chef salad, however, a #16 scoop was used instead.
iv. A #8 scoop was indicated for puree pears, however a #10 scoop was used instead. (156) (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 010 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that the home has a dining and snack service that includes, at a minimum, food and fluids being served at a temperature that is both safe and palatable to the residents.

Grounds / Motifs :

1. Not all foods and fluids were served at a temperature that was both safe and palatable to the residents.

The temperature range in which food-borne bacteria may grow, known as the danger zone was 4 to 60 degrees Celsius (°C). A poster found in the home on the third floor dining area on May 23, 2014, indicated the holding temperatures for cold items must be at 4 °C and hot food items must be 74 °C prior to service.
A. On May 26, 2014, during meal service on two identified units it was observed that one third of the hot foods, mainly the modified textures were placed on the servery counters as the steam tables were full.
i. On an identified unit the temperature of the puree turkey a la king and puree peas, was measured immediately after being served to a resident without reheating. The puree turkey a la king was 45 °C and the puree peas were 43 °C.
ii. On an identified unit the temperature of the cream soup, was measured immediately after it was served to a resident without reheating and was measured to be 53 °C. (583)
B. Several residents reported that food was not served at an appropriate temperature. (156)
C. On May 21, 2014, during the lunch meal on an identified unit regular texture chicken nuggets were probed at 50.9 °C, regular potatoes at 57.5 °C, and regular mixed vegetables were probed at 56 °C. (585)
D. On May 21, 2014, during the lunch meal on an identified unit all textures of ambrosia salad were above 4 °C. Regular texture salad was probed at 6.2 °C, minced was 10.5 °C, and puree texture was probed at 11.1 °C. All textures of pineapple were above 4 °C. Regular texture pineapple was 7.8 °C, minced was 12.9 °C, and puree texture was 11.9 °C. Regular texture fruit cocktail was 13.3 °C. The ambrosia salad, pineapple, and fruit cocktail were observed sitting on the counter at room temperature for 25 minutes prior to service with no observable method to keep them cold. (585)
E. On May 21, 2014, during the lunch meal on an identified unit all textures of coleslaw were above 4 °C. Regular texture coleslaw was probed at 11.4 °C, minced was 7.3 °C, and puree texture was 5.0 °C. Puree texture tuna was probed at 6.9 °C. (585)
F. On May 26, 2014, during the lunch meal on an identified unit, second sitting, the pastrami on rye sandwiches were probed at 8.6 °C. It was noted that the home provided a tray of sandwiches for the first sitting and then used the remaining sandwiches in the pan for the second sitting in the adjoining dining room. The minced pastrami was probed at 7.3 °C and puree pastrami at 6.5 °C.

The potato salad was probed at 4.5 °C, minced at 6.3 °C and puree texture was probed at 5.5 °C (156) (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2014

Order # / Ordre no : 011

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that resident #18 is provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Grounds / Motifs :

1. Previously identified as non compliant in May 2013, as a VPC.

Not all residents were provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A review of the clinical records for resident #18 identified that they had been assessed as a high nutritional risk by the RD due to a very low Body Mass Index, a history of reduced intake of foods and fluids and chewing difficulties. The plan of care directed staff to provide supervision at meals, specifying oversight and encouragement. On May 26, 2014, the resident was observed sleeping in bed, with a lunch tray in front of them, and no staff in attendance. On May 28, 2014, at 0916 hours, the resident was observed sleeping in bed, with a tray of food in front of them and a bolus of food in their mouth. Staff did not enter the room to observe the resident for 21 minutes. No encouragement was provided for 26 minutes. Staff interviews confirmed the resident regularly consumed meals alone in their room, without staff supervision or encouragement. This lack of supervision and encouragement, as per the plan of care, did not allow the resident to eat as safely as possible. (584) (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 20, 2014

Order # / Ordre no : 012

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall re-surface all wood surfaces located in the South Tower serveries where the surfaces have lost their original seal of varnish.

The surfaces shall be made impervious to moisture, smooth and easy to clean.

Grounds / Motifs :

1. Previously identified as non compliant in May 2013, as a VPC.

Not all furnishings and equipment was maintained in a safe condition and in a good state of repair.

Lower cabinet surfaces located in the serveries in each of the seven home areas in the South Tower were observed to be worn down to raw wood. Some of the surfaces were cracked or beginning to crack due to moisture penetration. The condition of these cabinets was previously identified and documented during an inspection in May 2013. To date, measures to address the condition of the cabinets were not instituted.
C. Over bed tables with rusty and peeling bases were observed in use in Heritage Trail, Valley Trail, Cedar Grove, and Lilac dining room and in an identified room.
The bottom of a cabinet unit located in the Oak Grove tub room was in poor condition, it appeared to have been damaged by repeated water exposure.
(120)
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 013

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall prepare and submit a plan which will summarize how and when urine odours will be managed within the home, specifically in Pine Grove and Willow Grove home areas.

The plan is to be submitted to bernadette.susnik@ontario.ca by July 31, 2014.

Grounds / Motifs :

1. Previously identified as non-compliant in May 2013, as a VPC.

The licensee did not develop and implement procedures to address incidents of offensive and lingering odours.

Urine odours were previously identified and documented during an inspection conducted on May 2013. Pine Grove and Willow Grove were toured on May 20, 26, and June 3, 2014, and were noted to have offensive and lingering urine odours, especially Pine Grove. The units were reported to be home to residents with behaviours related to incontinence and furnished with wall to wall carpeting that was installed directly on top of concrete. The Housekeeping Supervisor confirmed deep carpet cleaning was performed by an outside service and was completed several times per year. Other cleaning methods included spot cleaning or the use of a small extractor by housekeepers, if they had sufficient time. None of these methods removed the urine that had penetrated down into the concrete or possibly into wall cavities. A policy was not developed to address issues related to various types of odours and available options to staff if regular cleaning was not effective in removing the odours. The Housekeeping Supervisor reported that a request was submitted to have the carpeting removed and replaced with smooth flooring, however no progress was evident since the last inspection. (120) (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

Order # / Ordre no : 014 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The licensee shall complete the following:
1. All residents shall be assessed using an interdisciplinary team approach which at a minimum shall include the RCC, a physiotherapist or Occupational therapist and a registered nurse.
2. All plan of care shall include the completion of a bed rail use assessment incorporating the guidelines identified in the document titled “Clinical guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003”.
3. All PSW's shall receive education on the hazards of bed side rail use.

Grounds / Motifs :

1. Previously identified as non compliant in May 2013, as a CO.

Residents were not evaluated in accordance with evidence-based practices with respect to bed rail use to minimize entrapment risk to the resident.

Resident #95 was observed in bed with two quarter rails in the raised elevated position on May 27, 2014. The bed was tested on July 30, 2013, and failed several zones of entrapment. The plan of care did not include any information regarding rail use. The RCC indicated that if there was no information in the plan, then no rails should be used. When the RCC was asked how decisions were made regarding rail use, a copy of the Restraint Assessment form was provided. The form did not include any specific guidance for staff with respect to evaluating residents for bed rail use . The RCC alone made final decisions regarding rail use, rather than an interdisciplinary review. The guidelines endorsed by Health Canada "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Drug and Food Administration were not implemented or incorporated into the home's existing restraint assessment. These guidelines were current best practices in the field of bed safety for adult hospital beds. (120) (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 015 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The licensee shall complete the following:
1. Resident bed systems shall be re-evaluated to determine current status of entrapment zones and the results and changes made to the bed documented.
2. A schedule shall be developed to ensure that each bed is re-evaluated at least yearly and at times when a change is made to the bed system.
3. Interventions shall be implemented for those residents where a bed system failed one or more zones of entrapment and those interventions documented in their plan of care.

Grounds / Motifs :

1. Previously identified as non compliant in May 2013, as a CO.

Where bed rails were in use, steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Between July and November 2013, two staff members tested all the beds in the home, except those with a therapeutic air surface, for all seven zones of entrapment. Over 100 beds were found to be non compliant with the measuring guidelines provided by Health Canada. Some interventions were made where bed rails had been removed, however the majority of the bed rails were being used as per by the resident's plan of care or because staff left the bed rail in the

raised position out of habit. No interventions were observed to be implemented for the residents who were observed with rails elevated while in bed, where the bed did not pass all zones of entrapment.
The following residents were observed lying in bed on May 26, or June 3, 2014:
i. Resident #90 was observed in bed with both quarter rails elevated. This model of bed was tested in 2013, and noted to pass. However, when the same model of bed was re-tested on May 27, 2014, the bed failed zones two and three. The plan of care did not include any information about the need to use bed rails.
ii. Resident #92 was observed in bed, on an air mattress, on June 3, 2014, with both quarter rails elevated. The plan of care included no information regarding rail use. The bed was tested in January 2014, and failed several zones of entrapment. No interventions were employed to mitigate the failed zone issues.

iii. Resident #91 was observed in bed with quarter rails elevated. The plan of care included no information regarding rail use. The bed was tested in January 2014, and failed several zones of entrapment. No interventions were employed to mitigate the failed zone issues.
iv. Resident #94 was observed in bed with two three-quarter rails elevated and on an air mattress. There was approximately one inch between the top of the rail and the top of the mattress. The resident did not have any interventions to mitigate zone two and three entrapment risks, or to reduce the risk of rolling over the top of the rail. No rail height extenders, bolsters or gap fillers were observed in use. The plan of care did not identify rail use.

A common practice of leaving at least one bed rail in the raised position was being employed by PSW's during the inspection. Numerous beds, those that passed and failed entrapment zone testing, were seen with at least one rail elevated while residents were out of bed. When staff were interviewed, they reported that it was a habit to always leave the rails up for residents needing to transfer themselves into bed. Not all staff were aware of entrapment issues associated with the beds and that rails were only to be employed when indicated in the plan of care. Confirmation was made with one of the RCC's that if the plan of care did not include information regarding bed rails, it was due to the fact that they were assessed as not needing them. Based on the various plans reviewed for the above residents and the observations made, staff did not follow the plan of care and placed residents at risk.

Residents were provided with beds equipped with split rails in three rooms, all

which failed several zones of entrapment. The management staff were not aware that these beds were still in use, as they thought they all had been removed.

Residents were provided with therapeutic air mattresses in ten rooms. The home did not have an adequate supply of gap fillers to ensure that these residents, if using rails, could have the zone two gaps, between the rail and mattress reduced.

Different beds had been purchased, moved and accepted into the home without adequate monitoring since they were tested in 2013. New mattresses were purchased and applied to beds, but mattresses were not matched to the bed frames and therefore could have been changed. The test results that were conducted in the past could no longer be used as a reliable source of information to determine the status of the bed systems. (120) (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 016

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that summarizes what immediate and long term measures will be implemented to ensure that serveries and galley kitchens are kept clean and sanitary.

The plan shall include who will audit the serveries and galley kitchens for cleanliness and how often.

The plan shall be submitted bernadette.susnik@ontario.ca by July 31, 2014.

Grounds / Motifs :

1. The home was not kept clean and sanitary.

A. All serveries and galley kitchens were inspected for general sanitation either on May 26, or 27, 2014, and some were re-inspected on June 3, 2014. General sanitation issues were observed in the serveries, which included visible matter on many of the lower cabinet surfaces, in and around the garbage containers and on walls specifically under cork boards. A build up of debris or matter was observed in and around the stoves and refrigerators and along baseboards. In the galley kitchens, a build up of debris and caked on matter was noted behind stainless steel fridges, under some of the stainless steel corner sinks and around ice machines. The gray textured floors were stained pink from juice spills and/or were blackened from ground in dirt. According to dietary staff, the floors had not been scrubbed using a machine but were hand mopped, making it difficult to get the dirt and stains out of the textured floors. A cleaning schedule was found posted on the white refrigerators in each servery indicating that surfaces in the serveries such as cabinets and walls were to be cleaned once per week. In failing to clean spills and splatter when they occurred, a build up had become evident. Such surfaces require a daily cleaning to ensure minimal cross contamination from surfaces, to hands and to food.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 29, 2014

Order # / Ordre no : 017

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee shall:
1. Educate all staff, particularly housekeeping and PSW's with respect to keeping hazardous substances inaccessible to residents. This includes substances labeled as disinfectant.
2. All hazardous substances identified in identified rooms are to be stored in an area that is inaccessible to residents.

Grounds / Motifs :

1. Previously identified as non-complaint in May 2013, as a VPC.

Not all hazardous substances were kept inaccessible to residents.
A. Iodine was found in resident rooms on May 26, 2014, in five rooms.
B. Spa room doors were left wide open with disinfectant inside drawers or out on shelving on May 26, 2014, in the Willow Grove tub room, Trillium shower room and Oak Grove tub room. A housekeeper in one home area revealed that she leaves the doors open for the floor to dry after mopping. (120) (120)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 20, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 16th day of June, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LISA VINK

Service Area Office / Bureau régional de services : Hamilton Service Area Office