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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 15, 2016	2016_301561_0017	015619-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD OAKVILLE ON L6M 3L1

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

ALLENDALE
185 ONTARIO STREET SOUTH MILTON ON L9T 2M4

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

DARIA TRZOS (561), DEREGE GEDA (645), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)

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): June 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 2016

The following inspections were completed concurrently with the Resident Quality Inspection (RQI):
Critical Incident Inspections:
004772-15 - unsafe transfer
017069-15 - elopement of resident
014804-16 - fall of a resident

Complaint Inspections:
003956-15 - pain management
012912-15 - alleged emotional/verbal abuse
016988-15 - alleging refusing to allow residents to participate in programs
008142-16 - change in resident's status, transfer to hospital, family notification

During the course of the inspection, the inspector(s) spoke with the Administrator, the Administrative Assistant, Director of Nursing and Personal Care (DONPC), Resident Care Managers, Housekeeping/Laundry Supervisor, Building Operations Supervisor, Life Enrichment Supervisor, Life Enrichment Therapist, Nutrition Services Supervisors, Registered Dietitian, Social Worker, Employee Relations Specialist, Registered staff including Registered Nurses (RNs), and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Maintenance Workers, Housekeeping staff, Laundry personnel, Residents' Council members, President of Family Council, residents, and family members.

During the course of the inspection, the inspectors toured the home, observed the provision of care, observed the meal service, reviewed health care records, and reviewed relevant policies, procedures and practices.

The following Inspection Protocols were used during this inspection:

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2015_338147_0004	561
O.Reg 79/10 s. 72. (3)	CO #002	2015_338147_0004	107

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident’s pain.

Resident #085 had a history of medical condition. A record review indicated that the resident required the use of medication for the medical condition. A review of the resident’s written plan of care did not include interventions to manage the medical condition and the health record indicated that the resident had not received a formal assessment, despite the ongoing use of medications for the condition. Registered staff #328 confirmed that they were aware of the resident’s medical condition and confirmed that the resident had not received a formal assessment and was unsure if the monitoring of the residents condition was in their written plan of care.
The home’s policy indicated that the staff were expected to collaborate with resident to conduct an assessment using a clinically appropriate assessment tool. An interview with the DONPC confirmed that the resident required weekly assessments with the use of a clinically appropriate assessment tool and confirmed that the resident’s plan of care did not include the management and assessment strategies or interventions for resident’s medical condition.
(619) [s. 26. (3) 10.]

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, at a minimum, interdisciplinary assessment of the resident’s pain, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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:
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. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to 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.

The Personal Health Information Act states, 12. (1) A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian's custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal.

A) During this inspection a registered staff was observed throwing empty medication

pouches that contained residents' personal health information in the regular garbage. When interviewed, they had indicated that this was the home's process and after the medication pass was finished they would pour water into the garbage which would ensure that the personal health information was removed. Three other units were observed; empty medication pouches were being thrown out in the regular garbage and no water was poured into the garbage. Another registered staff was interviewed and indicated that the home's process was to throw empty pouches in the garbage and then housekeeping would pick it up from every home area. The DONPC was interviewed and indicated that the staff should be separating the pouches and be placing them in a separate container with water to ensure that the personal health information was removed.

B) On numerous occasions during stage two of the RQI, LTC Inspector observed the substation on Bronte and Halton home areas and observed binders containing residents' care plans and flow sheets sitting on the tables wide open. These documents were visible to anyone walking past the substation.

C) Nursing offices, that contained resident clinical health records and electronic documentation systems, were unsupervised with doors propped open and residents' clinical records accessible on multiple days throughout this inspection.

On June 16, 2016, the Halton House nursing office was left unattended with both doors open. Residents' clinical health records were accessible to anyone walking by the room, and resident personal health information was left open on the computer screen.

On June 17, 2016, the Trafalgar nursing office was left unattended with both doors propped open with the metal hook. Residents' clinical health records were accessible to anyone walking by the room.

On June 20, 2016, the Halton nursing office was left unattended with the doors propped open. Residents' clinical health records were accessible to anyone walking by the room.

On June 23, 2016, the Nelson nursing office was left unattended with the doors propped open. Residents' clinical health records were accessible to anyone walking by the room.

On June 23, 2016, the Bronte nursing office was left unattended by staff with the doors propped open. Residents' clinical health records were accessible to anyone walking by the room.

On June 23, 2016, the Trafalgar nursing office was left unattended by staff with the doors propped open. Residents' clinical health records were accessible to anyone walking by the room. (107)

The interview with the DONPC and the Administrator confirmed that the binders containing residents’ personal health information should not have been left on the tables and accessible to others. The residents' personal health information should not have been displayed on the computer screen while the door to the nursing station was left unattended and unlocked. The home currently does not have a policy addressing the storage of the residents' files but one is being drafted and will be implemented in the Fall of 2016. The draft policy called “Privacy and Protection of Personal Health Information” stated:
“Physical Security: a) paper charts and all resident information are kept in locked cupboards, cabinets, b) file cabinets are locked when not in active use, c) restricted access to offices where personal health information is held, d) resident charts and documentation is not to be left in unattended areas". [s. 3. (1) 11. 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 the following rights of residents are fully respected and promoted: 11. Every resident has the right to 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., to be implemented voluntarily.

WN #3: 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:
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. (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 licensee has failed to ensure that resident #070 was provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The plan of care for resident #070 directed staff to provide extensive assistance with eating. The resident did not receive staff assistance at the observed lunch meal June 13, 2016. The LTC Inspector observed the resident eating from their table mate's plate. Staff were not in the area of this resident's table and had not identified the concern. Resident #070 required a specific texture meal and was consuming a different texture sandwich from the table mate. The resident had a mouthful of this textured sandwich and staff had not identified the concern. The resident was also spitting their food during the meal. Extensive assistance and supervision were not provided as per the resident's plan of care. [s. 73. (1) 9.]

2. The licensee has failed to ensure that someone was available to provide the assistance with eating prior to serving resident #070 their lunch meal on June 13, 2016.

The resident had a plan of care that required extensive assistance with eating and the resident was served their meal prior to assistance being provided. The lunch meal began at 1215 hours, and the LTC Inspector observed resident #070 eating resident #049's food. Resident #070 required a specific texture meal and was eating their table mate's food which was a different texture. Staff were not supervising the residents during the meal and assistance had not been provided until the concern was identified by the LTC Inspector. [s. 73. (2) (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 residents are provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible and to ensure that someone is available to provide the assistance with eating prior to serving residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Resident #045's plan of care indicated that the resident was at high risk for falls and had a device in place to prevent resident from falling. Interviews with PSWs #323, #321, #327 and registered staff #320 confirmed that the device was in place to prevent resident's falls. The health care records were reviewed and the intervention was not documented in the written plan of care for resident. The written plan of care did not set out the planned care for the resident related to the use of the device. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #045 was observed having the call bell placed in a specific way and resident confirmed that this was their request. They also indicated that they had a fall because they needed to call for assistance and could not find the call bell; they tried to get up but fell. The health records were reviewed and indicated that the resident sustained a fall and the post fall assessment indicated that the resident was looking for their call bell and fell out of bed. The PSW #327 was interviewed and indicated that the call bell was within reach but not placed in the specific way the resident requested and that they were not aware of resident's preferences. The review of the written plan of care indicated that there was no clear direction to staff in relation to the placement of the call bell.
The registered staff #330 confirmed resident's preference for the placement of the call bell. The interview with the DONPC confirmed that the care plan was not clear. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of residents so that their assessments were integrated, consistent with and complemented each other.

A) Resident #036 was assessed as frequently incontinent of bladder on the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) completed in 2015. A Nurse-Continence Assessment was completed on an identified date in 2016 that reflected the resident was continent of both bowel and bladder and flow sheets for the same time period reflected the resident was frequently incontinent of bladder. During interview, registered staff #320 confirmed that the Nurse-Continence Assessment did not correspond with the documentation on the flow sheets and previous RAI-MDS assessment. PSW #321 and registered staff #336 stated that the resident was incontinent of bladder and the assessment was incorrect and did not correspond with the other assessments of the resident.

B) Resident #200's documentation on the "Dementia Observational System" (DOS) forms indicated the resident was sleeping in their bed at a specific hour on an identified date in 2015. Documentation on the Critical Incident System (CIS) related to an incident identified the resident did not return to the building during that specific hour. The home did not ensure that assessments were consistent in relation to the whereabouts of resident #200 during an incident on an identified date in 2015. [s. 6. (4) (a)]

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

A) Resident #030 was observed in bed during this inspection and the call bell was not within reach. The PSW #300 was interviewed and indicated that the call bell should have been placed within reach. The written plan of care was reviewed and indicated that the call bell must be within reach at all times.

B) Resident #189 was observed during inspection in their room resting in bed and the call bell was not within reach.
The written plan of care that was reviewed and indicated that the resident had a history of falls and had interventions in place including call bell to be within reach.
Interviewed registered staff #322 and confirmed that resident was at risk for falls and the call bell should have been placed within reach.

C) Resident #045's plan of care indicated that the resident was at high risk for falls and had a number of interventions in place to prevent the resident from falling.
Resident was observed on two different days during this inspection and two of the interventions were not in place.
The interviews with PSWs #321and #327 and registered staff #330 confirmed that the interventions should have been in place.The care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 there was a written plan of care for each resident that sets out the the planned care for the resident, to ensure there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of residents so that their assessments are integrated, consistent with and complemented each other, and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was in compliance with and implemented in accordance with applicable requirements under the Act.

The home's policy, "Identifying Residents at Risk for Altered Skin Integrity", policy number 17-03-01, directed staff to refer to the Registered Dietitian for stage two or higher pressure areas and only stage two skin tears greater than three centimeters (cm) and stage three skin tears. The home's "Annual Program Evaluation for 2015" directed staff to change the Skin and Wound Care policy to reflect this requirement. The directive in the policy is not consistent with the legislative requirement to have all residents exhibiting skin breakdown assessed by the Registered Dietitian.

The Registered Dietitian confirmed that staff do not make referrals for assessment by the Registered Dietitian unless the impaired skin integrity is a stage two or greater pressure area or a skin tear greater than three cm and/or stage three. [s. 8. (1) (a)]

2. The licensee has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The home's policy called "Falls Prevention and Management", policy number 19-01-05, approved May 2014, stated "initiate Head Injury Routine for all un-witnessed falls and witnessed falls that have resulted in a possible head injury".

Resident #045 had an un-witnessed fall on an identified date in 2016. Resident's health records were reviewed and the Head Injury Routine (HIR) documentation could not be found. RPN #320 was interviewed and indicated that HIR was to be completed after each un-witnessed fall even if a cognitive resident stated they did not hit their head. The DONPC confirmed that HIR was not initiated, but it should have been as indicated in the policy.(561)

B) The home's policy, "Wander Risk", policy number 01-05-01, directed registered staff to place an entry in the electronic Treatment Administration Record (eTAR) to check the device placement twice daily. A device was initiated for resident #200 on an identified date in 2015, after an incident. The electronic Medication Administration Record (eMAR) and eTAR were reviewed for the month in 2015, and did not include monitoring of the resident's device placement. The resident had another incident on an identified date in 2015. During interview, RPN #342 confirmed that the device was to be monitored twice daily on the eMAR or eTAR.

The policy also identified that staff were to: contact the resident's Substitute Decision Maker (SDM) to obtain consent for the device, complete paper work, document in Point Click Care in the user defined fields; develop a monthly process to audit the device; complete weekly testing of the device; and review of residents at risk at weekly Monday meetings.

Administrative Assistant #348 confirmed that staff did not contact the resident's SDM to obtain consent and the paper work was not initiated.

Resident Care Clerk #350 confirmed that staff did not complete weekly testing of the resident's device as per the home's policy. The device was recorded as being initiated on an identified date in 2015, with no further testing noted when the resident was transferred to another unit. The resident had incidents on two dates in 2015. During interview, staff #350 and #351 confirmed that none of the staff remembered hearing the device activate during an incident. It was unclear if the device was working or if staff did not hear it; however, the required testing of the device had not been completed as per the home's policy.

C) The home’s policy called “Transfer and Repositioning Techniques”, policy number 24-05-01, created February 2015 and revised April 2016, indicated that “PSW will ensure to immediately inform registered staff of any changes to resident status or safety concerns

about a residents transfer or repositioning ability".

On an identified date in 2015, resident #129 sustained an injury while being transported in the wheelchair by a PSW. The PSW did not report the incident to the registered staff immediately.
The interview with the DONPC and the Administrator confirmed that the PSW was expected to report such incidents to the registered staff immediately. (561)

D) The home's policy, "Resident Weight/Height Monitoring", policy number 10-01-08, directed staff to measure the resident's height on admission, and annually thereafter and to enter the heights into the electronic Point Click Care (PCC) system.

Not all residents had their height measured and recorded at least annually.
Several heights were missing from the home's PCC electronic records system during Stage 1 of this inspection. Registered staff #306 stated that sometimes residents' heights were also recorded in the paper "form 5" record in the residents' chart; however, this was not included in the home's Resident Weight/height Monitoring policy.

Resident #062 did not have a height recorded since 2012 on the PCC system and July 2014 on the form 5 record.
Resident #093 did not have a height recorded since March 2014 on both the PCC system and the form 5 record.
Resident #152 did not have a height recorded since in August 2014 on the PCC system and a height was not available on the form 5 record.
Resident #003 did not have a height recorded since in November 2014 on the PCC system and October 2014 on the form 5 record.
Resident #023 did not have a height recorded since in September 2009 on the PCC system and May 2013 on the form 5 record.
Resident #119 did not have a height recorded since in November 2014 on the PCC system, however, a height was recorded on the form 5 record in November 2015.
Resident #066 did not have a height recorded since 2012 on the PCC system, however, a height was recorded on the form 5 record in 2015.
Resident #082 did not have a height recorded since 2013 on the PCC system, however, a height was recorded on the form 5 record in 2015.
Resident #121 did not have a height recorded since 2014 on the PCC system, however, a height was recorded on the form 5 record in 2015.

Registered staff #347 confirmed that not all heights were being measured and recorded

in the PCC system annually, as per the home's policy.

E) The home's policy, "Safe Food Handling", policy number 10-04-03, directed staff to serve foods between 60-70 degrees Celsius (C) and to serve cold foods between 0-4 degrees C.

Food temperatures were not maintained at the observed lunch meal service June 22, 2016. Food temperatures were probed at the end of service to residents and were below 60 degrees C:
minced carrots 55.1 C
pureed scalloped potatoes 42.2 C
minced ham 49.6 C
minced beets 50 C
perogies 37 C

The pureed dessert loaf was left sitting out on the counter the entire meal service and was probed at 18 degrees C when served to residents.

Dietary Aide #343 confirmed the loaf was made with cream and was required to be kept cold. The Nutrition Services Supervisor #339 confirmed that the loaf should have been kept in the refrigerator until service time.

Not all items were fully under the heat lamp on-top of the re-therm cart and lids were not consistently kept on-top of the foods. Food temperatures were not consistently maintained until the end of meal service.

F) The home's policy, "Safe Food Handling", policy number 10-04-03, directed staff to record the dishwasher wash and rinse temperatures and to notify the supervisor/maintenance immediately should temperatures be outside the range. The policy identified a wash temperature range of 140-150 degrees Fahrenheit (F), and a rinse temperature of 176-194 degrees F.

Monitoring records for June reflected that temperatures were recorded outside of the required range on:
June 4, 2016, 0810 hours - rinse temperature 168 degrees F
June 14, 2016, 0815 hours - rinse temperature 174 degrees F
June 17, 2016, 1600 hours - wash temperature 152 degrees F, rinse temperature 162 degrees F

June 18, 2016, 0800 hours - rinse temperature 165 degrees F
June 19, 2016, 0745 hours - wash temperature 155 degrees F and rinse temperature 175 degrees F
June 20, 2016, 1530 hours - wash temperature 160 degrees F, rinse temperature 160 degrees F
June 21, 2016, 1615 hours - wash temperature 160 degrees F, rinse temperature 170 degrees F.

During interview with Nutrition Services Supervisor (NSS) #339 on June 22, 2016, the NSS stated that they had not been informed of the temperatures outside of the reference range and that staff had not communicated the issues to them. The NSS confirmed that staff were to report to them when dishwasher temperatures were outside of the reference range.
Maintenance records indicated that dishwasher temperatures had been checked in the identified home area and the NSS stated that the temperatures noted outside the reference range were likely due to monitoring errors (wrong timing) and not equipment malfunction.

G) The home's policy, "Prevention of Pressure Ulcers", policy number 17-02-01, directed PSWs to do a visual head to toe skin assessment on bath days and document all observations on the PSW Bath Assessment records and sign that the assessment was completed and findings were reported to registered staff. The policy also required registered staff to review the weekly Bath Assessment Record and sign off to indicate that a review had occurred and that appropriate intervention had been implemented.

Resident #119 required a shower twice weekly. Registered staff #322 and PSW #352 confirmed that the resident did not routinely refuse bathing. PSW Bath Assessment records were not completed for two baths weekly as per the home's policy, and registered staff were not consistently signing the Bath Assessment records. Bath Assessment records were not completed for several dates in 2016. PSW #352 stated that they felt confident the resident was receiving their bath; however, sometimes the PSW Bath Assessment sheets were not available for signature or a different staff member may be called in to complete the bathing and sometimes the bathing did not get recorded.

Registered staff were not consistently signing the PSW Bath Sheets as required in the home's policy. Registered staff had not signed any of the PSW Bath Assessment records for two of the months in 2016. Registered staff #322 confirmed that the PSW

Bath Assessment records were to be completed every shift. [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 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, is complied with and to ensure that 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, is in compliance with and implemented in accordance with applicable requirements under the Act., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered and available at the lunch meals June 13, 20, 22, 2016.

The planned menu stated that bread/butter would be offered to residents at the dinner and supper meals. At the observed meals, bread was and not offered to residents and pureed bread was not prepared or available, resulting in less than the minimum seven servings of grains (according to Canada's Food Guide) being offered to residents. On some days of the menu where the choice at both supper and dinner did not include a grain serving, residents may only be offered 4.5 servings of grains daily and the fibre and nutrient content of the menu would be reduced. Dietary Aide #343 confirmed that bread was only provided if specifically requested at meals and that pureed bread was not prepared and available on June 13, and 22, 2016. The Registered Dietitian confirmed that bread should be offered to residents at the dinner and supper meals as per the planned menu. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that planned menu items are offered and available at the lunch meals, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff released resident #148 from the physical device and repositioned the resident at least once every two hours.

The home's policy, "Minimizing of Restraining", policy number 19-02-01, directed PSW staff to check the resident in restraints hourly, to release the restraint and reposition the resident every two hours and at any other time based on the needs of the resident, and to document on the Restraint Flow Sheet. The policy also directed PSWs to document the time of restraint application, the resident's response to the restraint and time of removal of the restraint on the Restraint Flow Sheet.

Documentation on the resident's Restraint Flow Sheets for one of the months in 2016 reflected the resident was not always repositioned every two hours while the device was in place. The resident was not able to consistently remove the device and it had a restraining effect.

The Restraint/PASD Flow Sheet directed staff to code "A" when the device was applied; however, staff were not routinely documenting "A" after the resident's device was reapplied. During interview, PSW #302 stated that during the day shift flow sheets were completed with a "T" for toileted and that when the resident was toileted their restraint was reapplied after the toileting unless the records indicated the resident was sleeping. [s. 110. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff release the resident from the physical device and reposition the resident at least once every two hours, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

The home's policy, "Minimizing of Restraining Policy", policy number 19-02-01, directed registered staff to re-assess the need for the restraint on a quarterly basis with the Physician at the time of the quarterly medication review; to re-assess the resident's condition, effectiveness of the restraint, need for ongoing restraint, potential to employ a less restrictive restraint every eight hours or more frequently if warranted and document on the Restraint Flow Sheet. The policy also directed PSWs to document the time of application of the restraint, the resident's response to the restraint and the time of removal of the restraint on the Restraint Flow Sheet and to check the resident hourly and document on the Restraint Flow Sheet. The resident was also to be released from the restraint and repositioned every two hours and at any other times based on the needs of the resident and to document on the Restraint Flow Sheet.

Resident #148 required a restraining device. The order for the restraining device was not included on the quarterly medication reviews or on the resident's MAR. Documentation did not reflect that the restraint was being re-assesed quarterly as part of the quarterly medication review.

Registered staff #338 stated that staff monitor the effectiveness of the restraint every eight hours on the MAR; however, the restraint was not included on the MAR. Registered staff #324 confirmed that registered staff were to sign/initial the Restraint Flow Sheets every shift.

Registered staff were not consistently signing that they were re-assessing resident #148's restraint every eight hours on the Restraint/PASD Flow sheets. Registered staff signatures were missing for a number of shifts in 2016.

PSWs were not consistently recording on the Restraint Flow Sheet for resident #148. PSW #302 confirmed that PSWs were to document hourly on the restraint flow sheets while the restraint was in place.

The home's policy, "Minimizing Restraining Program Description", stated that each home had a Restraint and Falls Team (RAFT) Committee that met monthly to conduct reviews of all residents with orders for restraints/PASDs. The RAFT Committee was to include an evaluation of all residents with restraints/PASDs and make recommendations to discontinue use and that all documentation of each individual review would be completed in PCC.

Documentation in the clinical health record for resident #148 did not include any evaluation or RAFT team assessments. DONPC confirmed that there were meetings by the RAFT team that included resident #148; however, documentation related to resident #148 from those meetings was not included in the resident's clinical health record. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by resident’s, and those doors were kept closed and locked when they were not being supervised by staff.

On June 13, 2016, during the initial tour of the home at 1000 hours LTC Inspector touring the Sykes House area of the home, found an unlocked emergency exit door. The door, located on the second floor of the home led to an unmonitored stairwell, had a magnetic lock mechanism and a sign taped to it that stated “Please ensure door is closed, e-mail sent.”

Registered staff #315 indicated that the door was found unlocked on June 10, 2016, and that maintenance had been called and the door was presumed repaired. The registered staff also confirmed that this unit housed residents with mobility issues and or cognitive impairments that were potentially at risk of injury with the door unlocked.

Interview with the maintenance worker #346 indicated that the door was tested after being alerted to the issue on June 10, 2016, and that the door was secured at that point and confirmed that the lock needed repair again and would do it immediately.
LTC Inspector left the home area and returned at 1030 hours and checked the emergency exit door and found it unlocked again. Maintenance was called again and informed of the issue; the door was repaired a third time and upon checking at 1230 hours the issue had resolved.

The home's policy called “Door Security Policy”, policy number 01-05-02, last reviewed October 2014, stated “Doors leading to stairways and non-resident areas are always locked and are accessible to staff only”. Interview with DONPC confirmed that the staff failed to ensure that the magnetically locked emergency exit on the second floor of the home was secured. (619) [s. 9. (1) 2.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #133 required staff assistance for repositioning while up in their wheelchair. The home's "Turning and Repositioning Records" required registered staff to sign the sheets at the end of each shift. Registered staff #344 confirmed that they were required to sign the Turning and Repositioning Records at the end of each shift. The registered staff confirmed that documentation was incomplete on numerous shifts for an identified month in 2016 for resident #133. Registered staff signatures were also missing for numerous shifts in an identified month in 2016. [s. 30. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #036, who was incontinent, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Resident #036 had a documented decline in their continence of bowels noted at one of the 2016, RAI-MDS assessment.

The home's policy, "Continence Care and Bowel Management Program", directed staff to complete a continence assessment on admission and when there were any changes in condition that affected bladder or bowel continence, using the "Nurse-Continence Assessment" form on Point Click Care. A continence assessment using the Nurse-Continence Assessment was not completed when there was a change in the resident's level of bowel continence.

Registered Staff #336 confirmed a Nurse-Continence Assessment form was not completed after the decline in bowel continence and stated that staff only completed the RAI-MDS assessments to capture changes to the resident's level of continence.
An assessment of the resident's decline in bowel continence was not completed using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence. [s. 51. (2) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care for resident #200 included written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviour of wandering and exit seeking.

Resident #200 had an incident of responsive behaviour on an identified date in 2015. A device was put in place to address the responsive behaviour and resident was being monitored using the "Dementia Observational System" every half hour. The resident's written plan of care did not include the risk for responsive beahviour and did not include the strategies that were in place. The resident had another incident of responsive behaviour in 2015. The written strategies were not in place on the plan of care or included on the electronic MAR or electronic TAR as per the home's policy to ensure that staff were flagged to monitor the resident's device daily and to monitor the functioning weekly. The resident's device had not been monitored for placement or function after it was initiated in 2015. (107) [s. 53. (1) 2.]

WN #13: The Licensee has failed to comply with LTCHA, 2007, 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 failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Residents' Council minutes were reviewed for 2015 and 2016. There were concerns and suggestions identified by the Residents' Council in the minutes related to programs and services within the home. The written responses from the home related to the concerns and suggestions were not received by the Residents' Council until the subsequent monthly meeting. Resident #105, #133 and #140 were interviewed and confirmed that they received written responses to their concerns or suggestions at the next monthly meeting of the Residents' Council. The Residents' Council assistant and the Administrator were interviewed and confirmed that the written responses to the Residents' Council concerns and suggestions were not received by them within 10 days of receiving them. [s. 57. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies.

On June 20, 2016, on the Nelson home area the medication cart was observed, and the following items were found in the narcotic bin inside the medication cart:
-two rings
-earrings
-a necklace

The registered staff #325 was interviewed and was not aware of the legislative requirement. The DONPC confirmed that these items should not have been stored in the medication cart. [s. 129. (1) (a)]

Issued on this 23rd day of August, 2016

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

Original report signed by the inspector.