Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 14, 2015	2015_251512_0004	T-1642-15	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE INC
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

BLOOMINGTON COVE
13621 Ninth Line Stouffville ON L4A 7X3

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

TILDA HUI (512), JULIENNE NGONLOGA (502), JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 9, 10, 11, 12, 13, 16, 17, 18, 19, & 20, 2015.

Additional inspections related to the following Log#s were also completed during this inspection:
1) T-529-14, complaint,
2) T-841-14, critical incident,
3) T-960-14, critical incident,
4) T-1046-14, critical incident,
5) T-1539-14, critical incident.

During the course of the inspection, the inspector(s) spoke with the executive director, director of care (DOC), assistant director of care (ADOC), food service manager (FSM), recreation manager, recreation therapist, recreation therapist assistant, registered dietitian (RD), physiotherapist (PT), nurse practitioner (NP), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), cook, dietary aide (DA), handyman, housekeeping aide, laundry aide, residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observation in home and resident's areas, observation in care delivery processes, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity are respected and promoted.

Record review of resident #014 noted on an identified date, the resident's family member reported to the home that the resident was being treated in an identified manner by an identified staff member, and the resident also stated that he/she had an identified altercation with the same staff member. The DOC initiated investigation and filed a report to the MOH a day after receiving the complaint. The investigation did not demonstrate conclusive evidence for abuse of the resident against the staff member. However, there were evidence to suggest that the resident's rights to be treated with courtesy and respect was not upheld as a result of identified incidences.

Interview with the DOC confirmed the above mentioned identified incidences did occur involving the resident and the identified staff member, at which the resident's rights to be treated with courtesy and respect was not being respected and promoted. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident has the right to be protected from abuse.

Record review of resident #015 and #021 noted that on an identified date at an identified time, resident #021 was witnessed by staff making contact with resident #015 inappropriately in an identified common area. The residents were separated and assessment conducted on resident #015 with negative for injury. Both residents were monitored closely by team with no further identified issues. An investigation was initiated by the DOC during which it was identified that resident #021 has had previous incidents with inappropriate behaviors towards other residents in the home since admission. An identified authority was contacted and following investigation, it was identified that resident #021 had a history of an identified behavior. The home was not informed of the history.

Interview with the DOC confirmed that an identified altercation between the above mentioned identified residents did occur to resident #015 committed by resident #021 on an identified date. [s. 3. (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 the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity are respected and promoted, and to ensure that every resident has the right to be protected from abuse, 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. (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 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.

Observation made during the inspection period, and staff interview confirmed that resident #003 requires an identified mobility device.

Record review of the resident's written plan of care indicated that the use of the mobility device is not included. PSW and registered staff failed to collaborate with each other in the development of the written plan of care. [s. 6. (4) (a)]

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

Review of resident #010's written plan of care revealed that the resident is to have an identified device attached while in bed.

Observations made throughout the inspection period revealed that the resident did not have the identified device attached to his/her bed.

Interviews with two identified staff revealed that they were unaware that the resident is to have the identified device attached while in bed. Interview with the director of care (DOC) confirmed that it is the home’s expectation that staff follow interventions set out in the written plan of care as specified. [s. 6. (7)]

3. Observation made on an identified date during the inspection noted resident #024 eating egg salad sandwich, mixed green salad, wheat bread, and pear slices.

Review of the Dining Selection Tool for the unit indicated that staff are required to serve resident #024 sandwiches with no butter or mayonnaise.

Interview with an identified cook confirmed that all sandwiches served on that unit were prepared by mixing boiled eggs with mayonnaise, pepper, and salt; and the butter was spread on both sides of the whole wheat bread. The cook confirmed that the resident was not served a sandwich with no butter or mayonnaise as specified in his/her plan of care. [s. 6. (7)]

4. Record review of resident #003's plan of care indicated that the resident is at risk for falls related to his/her identified medical conditions and identified behaviors. The resident's written plan of care indicated that staff were to ensure that the resident was wearing his/her eye glasses while ambulated.

Observation made on two occasions during the inspection, revealed that the resident was wandering within his/her home area without wearing his/her eye glasses.

Record review indicated and staff interview confirmed that the resident had multiple falls on identified dates. The resident was not wearing his/her eye glasses prior to the above mentioned falls. On one occasion the resident bumped into an identified object while

ambulating in his/her room without eye glasses. The home's staff did not ensure that the resident was wearing his/her eyes glasses prior to the identified falls. [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 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, that the care set out in the plan of care is provided to the resident as specified in the plan, that the resident is 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's policy titled Fall Prevention and Management, Policy #VII-G-60.00, Revision date, May 2012, states the following: that the registered staff conduct the Fall risk Assessment in point-click-care (PCC) at the following times, as triggered by the MDS resident assessment protocol, when analysis of the triggered RAP indicate further assessment is needed, and within 24 hours of admission or readmission.

Record review of resident #010 revealed that the resident was triggered in MDS for multiple falls in the last 12 months. Review of the resident's assessment records revealed that the last time resident had a fall risk assessment done was upon admission 24 months ago.

Interview with an identified registered nursing staff confirmed that a fall risk assessment for the resident was not conducted since admission. Interview with the DOC confirmed that the home’s policy and expectation is that fall risk assessments are done on admissions, and when residents are identified to be at risk for falls. [s. 8. (1) (a),s. 8. (1) (b)]

2. Review of the home’s policy titled Handling of Medications Section 5, Policy # 5-1, Expiry and Dating of Medications indicated that a system is in place to ensure that an adequate and unexpired supply of medication is maintained for each resident. The procedure section of the policy stated that designated medications including eye drops must be dated when opened and removed from stock when expired.

Observation made during the inspection period in a medication cart of an identified unit, noted two eye drop bottles not dated with the date of opening for residents #031 and #032.

Interview with an identified registered nursing staff confirmed that the medications were not dated, and the home’s expectation is eye drops are to be dated when initially opened. Interview with the DOC confirmed that it is the home’s expectation that eye drops are to be dated when initially opened. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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 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.

Observation conducted during the inspection period at an identified time, on the ground level hallway, noted a first set of double doors leading to the kitchen and the maintenance workshop were left open. A second set of double doors from inside the first set of double doors leading to other service areas including a laundry room and staff lounge were also left open. There were key pads installed on the wall in front of the doors. The laundry room doors were observed open with drums of chemicals connected to the washing machines inside the room. There was no staff noted inside the laundry room at the time. The inspector waited for about three minutes and an identified laundry aide came into the room from another door. The laundry aide explained that the service doors were left open to allow staff to come in and out of the staff lounge during their breaks.

Interview with an identified maintenance staff stated that residents do attend programs at the Courtyard Café and the hair salon which were located inside the first set of double doors down the other end of the hallway. The staff stated that the residents were escorted by staff and/or family members most of the times when they come down the hallway.

Observation made two days after the initial observation, noted three residents in wheelchairs and one in regular chair sitting in the chapel which was located along the hallway in front of the first set of double doors. There was no staff nor volunteers noted in the room with the residents at the time of observation. The chapel doors were noted open as well as the set of double doors leading to the service areas.

Interview with the executive director confirmed that the residents were sitting there waiting to be transported back to the units after a religious program. The executive director stated that he/she often monitors the residents while he/she was sitting in his/her office which was located about ten feet away from the chapel, and his/her office has a window which opens into the hallway. The executive director confirmed that doors leading to the service areas were to be closed and locked and accessed by using the key pads on the wall. [s. 9. (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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home`s doors and windows are maintained in a safe condition and in a good state of repair.

1) Observation made during the inspection period at an identified time, noted the window's cranking handle in an identified resident's room not working. The handle can be turned to open the window up to six inches. However the open window cannot be closed by turning the handle. One side of the window screen was observed to be off the window frame. An identified registered nursing staff was informed and indicated that maintenance staff will be called to close the window and to repair the window's cranking device.

Interviews with an identified maintenance staff and the executive director who is the lead for the maintenance program revealed that the home is aware of the issue and is currently conducting a window audit throughout the building. On the date of interview, a total of 29 windows' cranking devices have been identified from the audit to be not working properly. The home has applied to their head office for funding and has received approval to purchase and install new cranking devices for these windows.

2) Observation made during the inspection period at an identified time, noted the second set of double doors on the ground level leading to services areas was not closing. It was left ajar with one door sitting on top of the other door. The doors were identified as fire doors and there was a key pad on the wall nearby to provide access.

Interview with an identified maintenance staff confirmed that the doors were not closing properly and that the doors should be kept closed and locked. The maintenance staff stated that he/she had tried to sand the doors down the day he/she was informed of the deficiency. The inspector returned two days later to check the doors, and the doors were aligned with each other and can be closed and locked. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident to staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation made during the inspection period at an identified time on an identified floor, noted an activity room with eight residents and one staff in the room in the middle of an activity program. The wall plate of a call bell was noted behind a cabinet on the wall beside the door.

Interview with two identified program staff confirmed that the call bell was inaccessible by residents at its current location. One of the program staff stated that the program staff had moved furniture around in the room recently and had put the cabinet at its current location without realizing that it was blocking the call bell. The second program staff indicated that the program manager was on leave until next week and he/she will inform the manager to follow up.

The inspector informed the executive director of the issue and the cabinet was moved to another location in the room the same day. The call bell is now accessible by residents. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home is equipped with a resident to staff communication and response system that is available in every area accessible by residents.

1) Observation made during the inspection period at an identified time, noted an activity room on the ground level labeled Courtyard Café has no resident to staff communication system installed. An area of patched paint was noted on a pillar in the middle of room, and two light tubes resembling call bell warning lights were noted on the opposite side of the pillar.

Interview with an identified registered nursing staff stated that the Courtyard Café has been used for a combination of staff and residents' events. The residents do come down to attend the residents' events, often supervised by staff. Interview with an identified maintenance staff confirmed that a call bell has been installed there before but removed.

2) Observation made during the inspection period at an identified time noted an end lounge on an identified floor with four residents in wheelchairs and one resident sitting in sofa chair listening to music. No call bell system was observed installed in the room.

Interview with an identified maintenance staff confirmed that a call bell was not installed in the identified end lounge. Interview with the executive director confirmed that a staff-resident communication and response system will be installed in the Courtyard Cafe on the ground level and the end lounge on the above mentioned floor. The executive director stated that both the Courtyard Cafe and the end lounge were located on the sections of the building planned for renovation in the near future. New electronic call bell system will be installed when the renovation is completed. In the meantime, a manual system will be implemented to meet legislative requirement. [s. 17. (1) (e)]

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 is equipped with a resident to staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, and that the system is available in every area accessible by residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when/if a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

Record review of residents #015 and #021 noted that on an identified date at an identified time, resident #021 was witnessed by staff having an identified inappropriate interaction with resident #015. The residents were separated by staff and assessment conducted on resident #015 with no injury. Both residents were monitored closely with no further identified issues. An investigation was initiated by the DOC and an identified authority was contacted.

Interview with the DOC confirmed that abuse did occur to resident #015 committed by resident #21 on an identified date and time as mentioned above. The critical incident report was submitted to the Ministry of Health and Long Term-Care (MOH) two days after the critical incident had taken place. The DOC confirmed that the home did not report to the Director immediately by using the after hour reporting phone number when the suspected abuse was brought to their attention. [s. 24. (1)]

2. Record review of resident #014 noted on an identified date, the resident's family member reported to the home that the resident was being treated in an identified manner by an identified staff member, and the resident also stated that he/she had an identified altercation with the same staff member. The DOC initiated investigation and filed a report to the MOH a day after receiving the complaint. The investigation did not demonstrate conclusive evidence for abuse of the resident against the staff member.

Interview with the DOC confirmed the incident involving the resident and the identified staff member was reported to the home on the identified date as mentioned above, and the critical incident report was submitted to the MOH two days later. The DOC confirmed that the home did not report to the Director immediately by using the after hour phone number when the suspected abuse was brought to their attention. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when/if a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids are prepared and served using methods which preserve taste, nutritive value, appearance and food quality.

1) Record review indicated that the preparation guide for thickened fluids directs staff to add two scoops of five millilitres (ml) each of Resource Thicken Up to thicken 125ml regular fluid to a honey thickened consistency. Review of resident #025's diet requirements were noted to be regular pureed with fluid in honey thickened consistency.

Observation made during the inspection period, noted the resident was served thickened fluid in nectar consistency.

The inspector brought that to staff's attention and an identified PSW indicated that the recipe was not followed and less Resource Thicken Up was added to the fluid. The PSW confirmed that the resident was not served honey thickened consistency and adjusted the resident's drink to a honey consistency.

2) Review of the Meat and Cheese Salad Plate's recipe indicated that the ingredients needed includes one leaf lettuce, ¾ ounces (oz) sliced turkey, ¾ oz sliced beef, ½ oz yellow cheese, ½ oz Swiss cheese, and a #8 scoop of beet and onion salad.

Observation made during the inspection period, at the lunch meal service on an identified floor revealed that the meat and cheese salad plate contained no beef.

Interview with an identified dietary staff confirmed that the meat and cheese plate was not prepared according to the recipe, and was served without any beef in it.

3) Review of the hamburger and bun pureed recipe directs staff to prepare and puree the hamburger and the hamburger bun separately, and to serve pureed hamburger bun on a #15 scoop and pureed hamburger on a #10 scoop.

Observation made during the inspection period in the kitchen revealed that the hamburger and hamburger bun were mixed and pureed together. The mixture was served with a #10 scoop.

Interview with an identified dietary staff indicated that she/he had pureed the hamburger and hamburger bun together, and she/he confirmed that by not following the recipe, the nutrient values per serving, food quality, and appearance of this dish were altered. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids are prepared and served using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #9: 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).

Findings/Faits saillants :

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

Observation made during the inspection period at an identified time and on an identified floor, noted pieces of soiled iodosorb dressing on the table in the den which is a common area for residents.

Interview with an identified registered nursing staff revealed that he/she had changed a resident's dressing in the room and forgot to dispose of the soiled dressing on the table. Interview with the DOC confirmed that the home’s expectation is that wound care is to be provided in a private area and leaving soiled dressing in a public area violated the home's infection prevention and control principles. [s. 229. (4)]

2. Observation made during the inspection period at an identified time and on an identified floor noted an identified PSW closing a shower room door with a pair of gloves on his/her hands. The inspector asked the PSW the reason for the vinyl gloves on his/her hands. The PSW stated that he/she was in the middle of making bed for the resident in a room and came out to get clean sheets for the bed. The PSW stated that he/she did not remove the gloves and performed hand hygiene before he/she left the resident’s room.

Interview with the ADOC, lead for the infection prevention and control program, confirmed that it is the home’s expectation that the PSW removed used gloves and performed hand hygiene after providing care. [s. 229. (4)]

3. Observation conducted during the inspection period at an identified time, noted an identified PSW walked out of an identified room in middle of providing care to the resident to speak to the inspector. The inspector asked to book a suitable time to interview the PSW. The PSW stated that he/she was free to speak at that time. The PSW came out of the resident’s room and proceeded to remove his/her gloves and was going to follow the inspector to a meeting room without performing hand hygiene. The inspector asked the PSW the home's expectation for staff in regards to performing hand hygiene after removing the gloves on his/her hands. The PSW then turned around to the care cart at the door and used the hand sanitizer on his/her hands.

Interview with the ADOC, lead for the infection prevention and control program, confirmed that the PSW should have performed hand hygiene after removing used gloves. [s. 229. (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 participate in the implementation of the infection prevention and control program, and that the home's hand-hygiene program included access to point-of-care hygiene agents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations throughout the inspection revealed that resident #006's nails were long and needed cutting.

Interview with the resident indicated that his/her nails are long and staffs have not cut them. Interviews with an identified PSW and a registered nursing staff revealed that the resident's nails are to be cut on bath days and as needed. Interview with the DOC confirmed that the home's expectation is residents' nails are to be trimmed on bath days and as needed, and that resident #006's fingernails should be cut. [s. 35. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident exhibiting altered skin integrity, including pressure ulcers is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review revealed that resident #007 had an altered skin integrity on his/her body and a weekly skin assessment was conducted on an identified date. The next assessment was not completed until 15 days later.

Interview with an identified registered nursing staff confirmed that the assessments were not conducted weekly during the above mention period. Interview with the DOC confirmed that the home's expectation is skin assessments for altered skin integrities are to be conducted weekly. [s. 50. (2) (b) (iv)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the 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.

Record review of the Minimum Data Set (MDS) assessment conducted for resident #005 on an identified date indicated that the resident was continent of bowel and bladder. The MDS assessment conducted three months later indicated that the resident's condition has worsened and the resident was incontinent of bowel and bladder.

Interview with an identified registered nursing staff indicated that during the above mentioned two quarters, the resident's condition has changed from continent to frequently incontinent of bowel and incontinent of bladder. The registered nursing staff also confirmed that the resident was not assessed when the resident's condition changed.

Interview with the DOC indicated that the home completes a seven day voiding diary, change the program sheet, document in the progress notes and update care plan with any change in residents' continence status. The DOC confirmed that the resident was not assessed and the seven day voiding diary was not completed when the resident's condition changed. [s. 51. (2) (a)]

2. Record review of resident #012 revealed that the resident was described as usually continent and uses incontinent briefs for both bladder and bowel functions in the MDS assessments conducted on two identified dates. The resident's bladder function was identified as incontinent in the MDS assessment conducted at the next quarter, indicating a deterioration of the bladder continence level. The resident's bowel function remained unchanged at this assessment. However, the resident's bowel function was described as incontinent in the MDS assessment conducted three months later, indicating a deterioration of the bowel continence level. There was no evidence of any bladder or bowel continence assessment conducted using a clinically appropriate tool between the three above mentioned quarters, during which the resident's bladder and bowel continence status has changed.

Interview with the ADOC, lead for the continence program, confirmed that there was no evidence of any bladder and bowel continence assessment using a clinically appropriate tool during the above mentioned periods for the resident. [s. 51. (2) (a)]

3. The licensee has failed to ensure that there is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

Interview with an identified PSW revealed that resident #009 fits the criteria for wearing pull-up incontinent brief as he/she toilet him/herself. The PSW indicated that the pull-up briefs were not provided to the staff for the resident's use. Interview with a registered nursing staff revealed that the resident meets the criteria for pull-up brief, but was told it is the family's responsibility to provide these for residents.

Interview with the ADOC confirmed that he/she was told that it is the family's responsibility to provide pull-up incontinent briefs for the resident. However, the ADOC stated that measures will be put in place to change this practice, and the pull-up incontinent briefs will be provided to the resident by the home. [s. 51. (2) (f)]

4. The licensee has failed to ensure that residents are provided with a range of continence care products that promote continued independence wherever possible.

Record review indicated that resident #005 is incontinent of bladder and requires a large size brief.

Observation made during the inspection period, revealed that resident #005 wears his/her continence brief in an identified way and toilet him/herself with no or limited assistance.

Interview with an identified PSW indicated that the resident is toileting him/herself. The resident only require assistance when the resident is not able to wipe him/herself clean after voiding, and the pull-up brief will be more appropriate for the resident's use. Interview with an identified registered staff indicated that the resident is provided with brief because pull-ups are not available in the home.

Interview with the ADOC confirmed that pull-up incontinent briefs were not available for the resident, and the resident is not provided with continence care products that promote continued independence. However, the ADOC stated that measures will be put in place to provide pull-up incontinent briefs for the residents in the home. [s. 51. (2) (h) (iv)]

WN #13: 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 are offered and available at each meal.

Observation made during the inspection period that bread and cottage cheese were on the menu for the lunch meal service, however pureed bread and cottage cheese were observed not served to residents.

Review of the production sheets revealed that pureed bread and cottage cheese were not prepared in the kitchen for lunch meal service.

Interview with an identified dietary staff indicated that pureed bread and cottage cheese were not available for the lunch meal service. Interview with an identified cook confirmed that he/she did not prepare the pureed bread for lunch meal service on the day of observation. [s. 71. (4)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

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

Interview with the Residents' Council assistant revealed that the home uses a standardized survey developed by the corporate head office, and residents were not consulted in developing and carrying out the home's satisfaction survey in 2014.

Interview with the executive director confirmed that the home uses a standardized satisfaction survey and Residents' Council was not consulted in the development or carrying out of the satisfaction survey since at least 5 years ago. [s. 85. (3)]

2. The licensee has failed to ensure to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the representative of the family council indicated that the home has not consulted the Family Council when the questions of the satisfaction survey were being developed. The representative indicated that he/she had sat on the Council for more than four years and then took on the current role since nine months ago and was not aware that Family Council was ever consulted to this regards.

Interview with the executive director confirm the above. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has failed to provide specific goods that the licensee is required to provide to the residents using funding that the licensee receives from the Minister under section 90 of the Act.

Staff interview indicated that pull-up briefs will be offered to an incontinent resident if the resident is able to participate more in toileting program and his/her family is in agreement to pay for the pull-up.

Record review revealed and staff interviews confirmed that resident #005 is incontinent since an identified date and the resident met the above condition for the use of pull-up, but not provided with pull-up for an identified reason.

After the inspectors' enquiry about the availability of pull-up for the resident who requires them, the DOC indicated that the home was not providing pull-up, but will start providing them to residents. [s. 245. 1.]

Issued on this 15th day of September, 2015

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

Original report signed by the inspector.