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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2014	2014_168202_0011	T-009-14	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE - BRADFORD INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

BRADFORD VALLEY
2656 6th Line, Bradford, ON, L3Z-3H5

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

VALERIE JOHNSTON (202), ANN HENDERSON (559), LAURA BROWN-HUESKEN (503), VERON ASH (535)

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): April 22, 23, 25, 28, 29, 30, May 01, 02, 05, 06, 07, 08, 09, 12, 13, 2014.

During the course of the inspection, the following critical incident, complaint and follow up inspections were conducted: T-685-13, T-681-13, T-22-13, T-310-14, T-150-14.

During the course of the inspection, the inspector(s) spoke with executive director, director of dare (DOC), director of quality & resident services, associate director of care (ADOC), office manager, director of programs and admissions, recreation therapist, director of environmental services (DES), director of dietary services (DDS), food services supervisor, registered nursing staff (RN), registered dietitians, rai-coordinator, recreational therapy assistants, physiotherapist, occupational therapist, cooks, dietary aides, personal support workers, housekeeping staff, families, residents.

During the course of the inspection, the inspector(s) observed the provision of care to residents, food production, meal services, snack services, resident home areas, reviewed clinical records, menu, staff schedule, staff educational records, policies related to dietary, skin and wound care, housekeeping, reporting and complaints, medication, laundry, continence, infection prevention and control, abuse and neglect, cleaning of personal care equipment, falls prevention and management, reviewed Resident Council and Family Council meeting minutes for January-March 2014, reviewed the home's annual quality management reports.

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

An interview with the ADOC indicated that the home offers resident immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules. Residents are to provide the home with consent to the immunization upon admission and registered staff are directed to provide the immunization. A review of resident #4245, #010 and #4165's plan of care identified these residents as having consented to receive a tetanus immunization. Resident #4245, #010 and #4165 all consented on an identified dates between 2011 and 2012, however, the tetanus immunization remain outstanding. The ADOC confirmed that the above mentioned residents have not received the tetanus immunization as set out in each resident's plan of care. [s. 6. (7)]

2. Resident #005's plan of care identified the resident as a high nutritional risk. Resident #005's written plan of care directs staff to provide 125 ml of pudding at the afternoon nourishment pass. Resident #006's plan of care identified the resident as a high nutritional risk and the written plan of care directs staff to provide 125 ml of pudding at the afternoon nourishment pass. On April 30, 2014, at 3:45 p.m., the afternoon nourishment cart on an identified home area was observed to be in the servery area untouched. An interview with resident #005 indicated that he/she had not received his/her afternoon nourishment and that he/she seldom receives a nourishment in the afternoon. An interview with an identified PSW indicated that the afternoon nourishment pass is seldom provided to residents because there are only two staff members to care for all 32 residents. The PSW indicated that the nourishment pass is the responsibility of the day shift and should the day shift staff not have time before shift change at 3:00 p.m., the evening shift staff try to provide the residents with a nourishment, however, most days it does not happen. [s. 6. (7)]

3. Resident #006's written plan of care directs staff to provide oxygen. At 5:45 p.m., during the dinner meal service, resident #006 was wearing nasal prongs for oxygen therapy, however, the portable oxygen tank attached to his/her prongs was empty of oxygen. Resident #006 confirmed in an interview that he/she was not receiving oxygen through the nasal prongs and that this happens often. An interview with an identified registered staff member confirmed that resident #006's portable oxygen tank was empty. The registered staff member proceeded to leave the home area to retrieve a full portable oxygen tank because the remaining three portable oxygen tanks at the nursing station were empty. [s. 6. (7)]

4. Resident #4295's written plan of care directs staff to provide him/her with a bath on

Tuesday and Friday. Night shift staff are directed to clean the resident's wheelchair on bath days. On two separate occasions, April 22 and May 7, 2014, the inspector observed the resident sitting in the wheelchair and noted a strong odor of urinary incontinence. The PSW providing direct care to the resident confirmed that the odor was coming from the resident's wheelchair. A review of the night time PSW cleaning schedule binder revealed that the resident's wheelchair had not been cleaned on the corresponding bath days. An interview with the ADOC confirmed that the night PSW cleaning schedule for the resident on both bath days had not been signed by staff, and cleaning of the resident's wheelchair had not occurred. [s. 6. (7)]

5. Resident #4295's written plan of care directs staff to provide a green continence product. On March 12, 2014, the inspector observed the resident wearing a yellow continence product. An identified primary care PSW confirmed that he/she provided the resident with a yellow continence product, as he/she felt this was more appropriate for the resident. The PSW indicated that he/she usually provides the resident with a yellow continence product and not a green product as directed in the residents plan of care. [s. 6. (7)]

6. The licensee failed to ensure that staff and others who provide direct care to residents are kept aware of the contents of the plan of care and have convenient and immediate access to it.

On March 19, 2014, a social worker's report of resident #4166 identified him/her as having responsive behaviors. The report recommended "staff are sensitized to this resident's reactive behaviors and take a gentle approach in correcting him/her when needed." PSWs revealed that the visual/bedside kardex report used by them to care for this resident does not address the responsive behaviors or give interventions and they do not have access to the written plan of care. Registered staff confirmed the visual/bedside kardex report did not identify this resident as having responsive behaviors to the PSWs. [s. 6. (8)]

7. Resident #4093's written plan of care identified the resident as requiring a continence product. The plan of care indicated that the resident required a medium product, however, the visual/bedside kardex report indicated that a small product was to be provided. Interviews with direct care staff indicated that the resident uses a small product and not a medium product. An interview with a registered nurse confirmed that the written plan of care is not accessible to PSWs. The registered nurse also indicated that the kardex for the resident contradicted the written plan of care and did

not provide clear direction to staff. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the written plan of care sets out clear directions to staff and others who provide care and to provide the care as set out in the plan of care and to ensure that staff and others who provide direct care to residents are kept aware of the contents of the plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy, deep cleaning of common areas-housekeeping, #XII-F-10.70, revised April 2011, is complied with.

On April 28, 29, 30, and May 05 2014, during the course of this inspection the following was observed in resident lounge areas:
Cottage home area:
-activity room was unclean, table was sticky, chairs were soiled and stained.
-three resident lounge chairs were soiled with large brown stains.
Harvest Home Area:
-two resident lounge chairs were soiled with large brown stains in the resident's lounge

Garden Home Area:
-lounge area carpets were stained, resident lounge chairs were soiled with large dark brown stains.
Orchard Home Area:
-six out of nine lounge chairs outside nursing station were soiled with dark stains.
Simcoe Home Area:
-two soiled lounge chairs in resident lounge.
Tub rooms on all home areas:
Interviews with housekeeping staff and direct care staff confirmed the above findings. Staff indicated that resident lounge chairs and furniture are only spot cleaned occasionally. A housekeeping staff member indicated that the resident chairs located in the lounge area are not all owned by the home. The chairs that recline were donated to the home and are not spot cleaned. The chairs that the home owns are cleaned using a spot cleaning method. The home's policy states all common areas should be deep cleaned at least weekly and directs staff to thoroughly wipe down all furniture surfaces with disinfectant. Housekeeping staff confirmed that all furniture owned by the home is spot cleaned as required and deep cleaned monthly. An interview with the DES confirmed that all common areas in the home are deep cleaned monthly and not weekly as directed in the policy. [s. 8. (1) (b)]

2. The licensee failed to ensure that the home's policy, missing resident laundry, #XII-K-20.50, titled revised April 2011, is complied with.

Resident #010 and #4166 indicated in an interview that they have had several personal clothing items missing and never returned. Direct care staff interviews indicated that when a resident reports missing laundry or personal items, staff are to search the home area, and should the item not be found within 24 hours, staff are to fill in a missing laundry report and send the form to the laundry department. An interview with a laundry aide indicated that once the missing laundry form is received the laundry department searches for the missing items and a follow up is to be completed by the administration. A review of the missing laundry reports indicated that on an identified date, resident #010 reported that his/her shoes were missing and was reported to the laundry department on the same day. Resident #4166 reported that on three identified dates between 2012 and 2013, pieces of his/her clothing went missing, and three items that went for labeling had not been returned. The reports indicated that all the above items were still missing and that no follow up had been provided by administration. The home's missing resident laundry policy directs the director of support services to follow up on a monthly basis on all lost items that are not resolved.

The DES confirmed that there is no monthly follow up to residents/families in respect to reported missing laundry as directed in the home's policy. [s. 8. (1) (b)]

3. The licensee failed to ensure that the home's policy, disinfecting resident nail clippers, #VIII D-70.00, revised November 2012, is complied with.

Staff interviews indicated that the home provides basic nail care to residents, and residents receive nail care on bath days. Staff indicated that nail clippers are used to trim resident nails, however, the location and cleaning of nail clippers varied among staff interviews. Direct care staff indicated that nail clippers are often obtained from the registered staff or clean utility room. Staff indicated that nail clippers are to be soaked after use in disinfectant by the night staff by using a designated container in the clean utility room as directed by the home's policy. On April 30, and May 02, 2014, two clean utility rooms were observed, which revealed a small container assigned to disinfect nail clippers, however, there were no nail clippers found in the containers and the containers were found to be heavily soiled. An identified registered staff member confirmed the above information and that staff have not used the containers for disinfecting resident nail clippers for some time. The RN indicated that PSWs will often retrieve new nail clippers from him/her to attend to resident nails, however, does not know where the nail clippers go after issuing them. The RN confirmed that nail clippers are not always cleaned or disinfected after use or between residents as per the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following home's policies are complied with:
-deep cleaning of common areas-housekeeping, #XII-F-10.70, revised April 2011,
-missing resident laundry, #XII-K-20.50, revised April 2011,
-disinfecting resident nail clippers, #VIII D-70.00, revised November 2012, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle reviewed by Residents' Council.

An interview the president of the Residents' Council revealed the Residents' Council had not reviewed the menu cycle. The Residents' Council assistant confirmed that the menu cycle had not been reviewed by Residents' Council. [s. 71. (1) (f)]

2. The licensee failed to ensure that each resident is offered a minimum of, a snack in the afternoon and evening.

On April 30, and May 01, 2014 at 3:45 p.m., the afternoon nourishment cart on an identified home area was observed to be in the servery area untouched. An interview with resident #005 indicated that he/she had not received his/her afternoon nourishment and that he/she seldom receives a nourishment in the afternoon. An interview with an identified PSW indicated that the afternoon nourishment pass is seldom provided to residents because there are only two staff members to care for all 32 residents. The PSW indicated that the nourishment pass is the responsibility of the day shift and should the day shift staff not have time before shift change at 3:00 p.m., the evening shift staff try to provide the residents with a nourishment, however, most days it does not happen. [s. 71. (3) (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 each resident is offered a minimum of, a snack in the afternoon and evening, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

s. 72. (2) The food production system must, at a minimum, provide for, (e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provides for preparation of all menu items according to the planned menu.

The lunch meal preparation was observed on May 9, 2014. The cook was observed to add an unmeasured amount of water to the pureed wax beans and pureed coleslaw during their preparation. Review of the standardized recipes for these items did not include the addition of water. During the preparation of the broccoli soup the cook was observed to add an unmeasured amount of a water and flour mixture to the soup after all other ingredients had been combined and the soup did not thicken to the desired consistency. The cook then added an unmeasured amount of neutral cream powder base to the soup which caused clumping. The soup was then pureed for palatability. Review of the standardized recipes for the soup revealed that the flour was not added in the sequence directed by the recipe, the recipe did not call for neutral cream powder base and did not direct staff to puree the soup. The cook confirmed that the standardized recipes for the pureed wax beans, pureed coleslaw and broccoli soup had not been followed. The DDS confirmed that the cooks are directed to follow the standardized recipes and that the menu had not been prepared according to the planned menu as the recipes had not been followed. [s. 72. (2) (d)]

2. The licensee failed to ensure that the food production system provides for menu substitutions that are comparable to the planned menu.

The planned menu for lunch on May 8, 2014, included baked beans, carrot coins and a wheat roll. Interviews with the cooks confirmed that the beans and carrots were not available. Pancakes, sausage patties and orange slices were substituted. Interviews with the cooks revealed that menu substitutions are made based on the availability of items. Policy XI-F-70.00, menu changes–emergency, directs staff to make menu changes of similar nutritional and economic value and reflect the preferences of the residents. An interview with the DDS confirmed that the substituted meal was not of comparable nutritional value to the planned menu items. [s. 72. (2) (e)]

3. The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods which prevent adulteration, contamination and food borne illness.

The lunch meal preparation was observed on May 9, 2014. The cook was observed to prepare the pureed beef, pureed wax beans and pureed coleslaw without taking the temperature of these items. The home's policy XI-G-170.00, titled, food temperatures-production, November 2013, directs cooks to record the temperature of all cold foods a half hour prior to meal service and to record the temperature of all hot foods prior to placing the food in the hot holding cabinet. Review of the point of service food temperature form located in the kitchen found that no temperatures were recorded for the pureed beef, pureed coleslaw or pureed wax beans. The DDS confirmed that these items were not prepared according to policy and in a manner consistent with food safety guidelines for the prevention of food borne illness. [s. 72. (3) (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 food production system provides for preparation of all menu items according to the planned menu, menu substitutions that are comparable to the planned menu, and that foods and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #5: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the meal and snack times are reviewed by Residents' Council.

The licensee failed to ensure that the meal and snack times are reviewed by Residents' Council. The president of the Residents' Council revealed that the Residents' Council had not reviewed the home's meal and snack times and the Resident Council assistant confirmed in an interview that the meal and snack times had not been reviewed by Residents' Council. [s. 73. (1) 2.]

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

The first option for the lunch meal on May 8, 2014 was a sliced turkey sandwich served cold with tossed salad. During the meal service on the Garden House home area, the dietary aide serving lunch was observed to remove a stainless steel container containing the cooled pureed bread from the cooling table and to place it on the counter at room temperature. This pureed bread was later plated along with cold minced turkey. At the time of plating, the bread was reported to be 61 degrees Fahrenheit and the minced turkey was reported to be 43.6 degrees Fahrenheit. The point of service food temperature form directs staff to take corrective action when cold foods are not equal to or below 40 degrees Fahrenheit to achieve the acceptable temperature of no higher than 40 degrees Fahrenheit. The plate was then observed to be served to a resident without corrective action taken by the dietary aide. The DDS confirmed that these items were not served at a temperature that is safe for residents. [s. 73. (1) 6.]

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 meal and snack times are reviewed by Residents' Council and that the home has a dining and snack service that includes food and fluids being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.

Resident #016 was admitted to the home on an identified date in 2012. The resident's plan of care identified him/her as being tall and prefers sleeping with the head of the bed elevated. An interview with the resident indicated that shortly after his/her admission to the home, the resident complained to various staff that the bed was too short to accommodate him/her and was not sleeping comfortably. The resident indicated that there was a incident when the foot of the bed became dislodged requiring repair from environmental services to replace the foot board. Staff interviews and an interview with the DES confirmed that the home was aware of the resident's complaint from his/her admission, however, confirmed that there were no actions taken to assess or replace the resident's bed. An interview with the ADOC confirmed that he/she was unaware of the resident's complaint until May 6, 2014. On that same date, the resident's bed was changed from a 76 inch bed frame to a 80 inch bed frame. [s. 101. (1) 1.]

2. The licensee failed to ensure that a complaint that cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days of the receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided for as soon as possible in the circumstances.

The DOC confirmed in an interview that he/she had received a complaint from a family member on an identified date, concerned that there had been an increase in bruising found on resident #035 after routine blood work. The family requested an investigation of the laboratory staff. The DOC confirmed that the investigation had been started but that the family member had not been provided a response within 10 business days of the receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response. [s. 101. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

A review of resident #017's plan of care indicated documented approval to self-administer a number of identified medications. During an interview with the resident, however, the resident indicated that he/she also self-administers another medication which has not been approved for self-administration. The resident indicated that during the night registered staff are busy and not readily available to administer this medication when needed and prefers to keep the medication on hand in his/her room. The registered staff and ADOC were aware that the resident was approved to self-administer medications, however, they were not aware that the resident was also using an unapproved medication. The registered staff confirmed that one of the identified medications that resident #017 had been using, had not been prescribed for self administration. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that 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 is fully respected and promoted.

Resident #08 and #13's plan of care identified these residents as enjoying the occasional cigarette and sitting outside in the back patio, the home's designated smoking area. Interviews with resident #08 and #13, indicated that they were both concerned and upset by a letter received by the home indicating changes to their smoking schedule, to be effective March 31, 2014. The letter indicated that residents who smoke will only be permitted to smoke in the designated smoking area four times per day and only between 10:30-11:00 a.m., 1:30-2:00 p.m., 4:00-4:30 p.m., and 7:00-7:30 p.m., or be provided assistance with smoking cessation. The residents indicated that although there are designated smoking times, it has been challenging to find staff at the allotted times to receive their cigarettes and lighters, and by the time they have found the staff, the smoking time is over. Interviews with registered staff indicated that cigarettes and lighters have always been kept with the nurse for safety reasons and residents have been able to obtain their cigarettes and lighters at anytime. Registered staff indicated, however, that because residents were asking for their cigarettes too frequently and staff did not have time to provide the cigarettes, and lighters on an as needed basis, designated smoking times were put in place without resident consultation. [s. 3. (1) 1.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On April 28, 29, 30, and May 05 2014, during the course of this inspection the following was observed:
Cottage home area:
-activity room was unclean, table was sticky, chairs were soiled and stained.
-three resident lounge chairs were soiled with large brown stains.
-resident tub chair, white and brown stains underneath chair along entire length of curvature
Harvest Home Area:
-two resident lounge chairs were soiled with large brown stains in the resident's lounge
Garden Home Area:
-lounge area carpets were stained, resident lounge chairs were soiled with large dark brown stains.
Orchard Home Area:
-six out of nine lounge chairs outside nursing station were soiled with dark stains.
Simcoe Home Area:
-two soiled lounge chairs in resident lounge.
Tub rooms on all home areas:
-all seven resident tub chairs located in tub rooms were found to be soiled with white and brown scum beneath the underside of the chair

Interviews with housekeeping staff and direct care staff confirmed the above findings. Staff indicated that resident lounge chairs and furniture are only spot cleaned once in awhile. A housekeeping staff member indicated that the resident chairs found in the lounge area are not all owned by the home. The chairs that recline were donated to the home and are not spot cleaned. The chairs that the home owns are cleaned using a spot cleaning method. PSW's indicated that all tubs and tub chairs are to be cleaned after each resident's bath by soaking the tub and chair with disinfectant and scrubbing with a bath brush. PSW's indicated that the underside of the bath chair is often missed and at times there is no bath brush available. The ADOC confirmed that all tub chairs in the home appeared to have not been cleaned regularly as directed. Resident #4166 indicated in an interview that he/she dislikes having baths at the home because he/she has experienced multiple baths in which residual scum was noticed on the surface on the water in the bath tub. [s. 15. (2) (a)]

WN #10: 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 failed to ensure that the home is equipped with a resident-staff communication and response system that, is available in every area accessible by residents.

On May 06, 2014 at 2:30 p.m., resident #006, called out to the inspector from his/her room. The resident indicated to the inspector that he/she needed staff assistance, however, was unable to reach the call bell and call staff. The resident was sitting in his/her wheelchair by one side of the bed, while the call bell was located along the opposite of the bed, tucked between the bed and wall. The resident indicated that he/she rarely has access to the call bell because staff do not leave it beside him/her. An identified PSW confirmed that the resident did not have access to the call bell. The PSW also indicated that call bell pager phones are to be carried by staff in order to respond to all resident and staff calls. The PSW indicated, however, that there are only two call bell pager phones available on this home area and as a result, when there are three PSW's scheduled to work, one staff member will not be able to respond to residents or staff requiring assistance. The PSW confirmed that he/she did not have access to a call bell pager phone on this day, which would have alerted him/her to resident or staff requiring assistance. [s. 17. (1) (e)]

WN #11: 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:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care be based on, at a minimum, interdisciplinary assessment of the resident's communication abilities, including hearing and language.

On April 30, 2014, during the dinner meal service, resident #005 indicated to the inspector, that he/she is often without his/her bilateral hearing aids most mornings and has to wait in his/her room for staff to bring them due to the severity of his/her impairment. Resident #005 indicated that he/she was without his/her hearing aids all day, and only received them just before dinner. Direct care staff interviews confirmed that resident #005 did not receive his/her hearing aids until after 3:00 p.m. when the evening shift arrived. Staff indicated that there is often an issue with resident #005 receiving his/her hearing aids due to the uncertainty of where the hearing aids are stored and which staff member is responsible to insert them in resident #005's ears. An interview with a identified registered staff member confirmed that resident #005's plan of care did not include an interdisciplinary assessment of resident #005's hearing abilities and any such use of bilateral hearing aids. [s. 26. (3) 3.]

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).

Findings/Faits saillants :

1. The licensee failed to ensure that 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.

The plan of care for resident #0035 and #4093 identified these residents as incontinent and requiring assistance from staff for toileting and product changes. A review of the clinical records for these residents revealed that both residents had not received an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. The ADOC confirmed that the home does not use a clinically appropriate assessment instrument that is specifically designed for assessment of incontinent residents. [s. 51. (2) (a)]

2. The plan of care for resident #4136 and #4295 identified these residents as incontinent and requiring assistance from staff for toileting and product changes. A review of the clinical records for these residents revealed that both residents had not received an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. The ADOC confirmed that the home does not use a clinically appropriate assessment instrument that is specifically designed for assessment of incontinent residents. [s. 51. (2) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns.

A review of the Residents' Council meeting minutes for the past three months revealed that there were two concerns brought forward from the December meeting. Residents' Council minutes for January 28, 2014, also identified that the residents were anxious to see what new and different programs were to take place on each unit as a result of staff changes. Resident Council minutes for February 25, 2014, requested that grab bars be installed in the visitor washrooms. Resident Council minutes for March 25, 2014, revealed three concerns. A home area had a couch and carpet that had a smell, a different home area had chairs in the dining room with uneven feet and the third concern was continence product availability. The Residents' Council assistant, ADOC, DES and administrator confirmed the concerns were not responded to Resident Council in writing in 10 days as required. [s. 57. (2)]

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 did not seek the advice of the Family Council in developing and carrying out the satisfaction survey.

A third party organization was contracted to develop a resident satisfaction survey for 2013 with a direction for Family Council to agree to the survey. Members of the Family Council confirmed that the licensee did not meet with them to seek advice on the development or carrying out of the satisfaction survey. The Family Council did not provide input into the survey questions or the manner the survey would be carried out. [s. 85. (3)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee failed to comply with the Long-term care home service accountability agreement (LSAA) held between the Central Local Integration Network (LHIN) and Specialty Care in respect of Specialty Care, Bradford Valley.

Article 4.2 of the L-SAA states Specialty Care will only use the funding provided by the LHIN for the purposes or providing services in accordance with the terms of the agreement. The cooks in the home revealed in an interview that they have been providing home made soups from the kitchen to the home's tuck shop for sale. The DDS revealed that home made soup is provided to tuck shop approximately three times weekly and that it is made using ingredients purchased using the home's dietary budget. The office manager revealed that the dietary budget is not compensated for the soup that is provided. [s. 101. (3)]

WN #16: 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. (2) The licensee shall ensure,
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).

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 failed to ensure that the local Medical Officer of Health is invited to the Infection Prevention and Control team meetings.

An interview with the home's infection prevention and control lead, indicated that infection prevention and control meetings are held quarterly at the home and confirmed that the local Medical Officer of Health has never been invited to attend. [s. 229. (2) (c)]

2. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On April 22, 2014, during a meal observation, the inspector observed that the home's registered and non-registered staff were not cleaning their hands between assisting resident's with their meals. On April 28, 2014, the inspector noted that two of the three registered staff observed during medication passes on three separate home areas, did not clean their hands between medication administration passes after they made contact with a resident. An interview with the DOC confirmed that staff should use the hand sanitizer provided to clean their hands between contact residents and wash their hands with soap and water if visibly soiled. [s. 229. (4)]

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

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 55.	CO #001	2013_168202_0063	202

Issued on this 20th day of May, 2014

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