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

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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 12, 2015	2015_191107_0006	H-002203-15	Resident Quality Inspection

Licensee/Titulaire de permis

DELCARE LTC INC.
4800 DUFFERIN STREET TORONTO ON M3H 5S9

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

CAWTHRA GARDENS LIMITED PARTNERSHIP
590 Lolita Gardens MISSISSAUGA ON L5A 4N8

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

MICHELLE WARRENER (107), CATHIE ROBITAILLE (536), DARIA TRZOS (561), KATHLEEN MILLAR (527)

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 24, 25, 26, 27, 30, 31, April 1, 2, 2015

Complaint inspections H-001930-15 and H-002167-15 were completed concurrently during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members of residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Business Manager, Environmental Service Manager (ESM), Nutrition & Hospitality Manager, Social Service Worker, Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, and Pharmacy Consultant.

The inspectors toured the home, observed care and meal service, reviewed clinical health records, relevant policies and procedures, meeting minutes, complaint logs, and laundry and maintenance processes

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.

- **13 WN(s)**
- **11 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. 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) Resident #001's bed system was assessed and tested by the home. After reviewing the resident's clinical record and interviewing the registered staff they confirmed they conducted the bed system assessment and testing of the resident and their bed system when the resident was admitted to the home and at the quarterly review. The registered staff confirmed they did not contact the Environmental Services Manager (ESM) to obtain the bed entrapment information for the resident's assessment and conducted their own test based on observation. The ESM was interviewed and confirmed they were not aware that nursing was conducting bed entrapment assessments and testing for residents. The DOC was interviewed and confirmed they did not involve or collaborate with the ESM when conducting resident bed system assessments and testing to ensure their assessments were integrated and were consistent with and complement each other. (527)

B)Residents #006 and #009 had bed rails applied as Personal Assistance Services Device(PASD). The residents had been assessed for bed rails using a Bed System Assessment by registered staff. The assessment for resident #006 indicated that the

resident's bed was not assessed for zones of entrapment as the resident had a therapeutic surface mattress. The bed system assessment for resident #009 indicated that the bed had passed entrapment testing for zones 1-7. The home had completed the assessments for bed entrapment for residents #006 and #009 by the Environmental Manager and only zones 1-5 were tested in the year 2014. The registered staff indicated that the nursing department was not aware of the testing done by the Environmental Manager. The Environmental Manager indicated that she was not aware that the nursing department was assessing the beds for zones of entrapment. The Bed System Assessments done by registered staff were not consistent with the assessments of zones of entrapment done by the Environmental Manager. The staff in the home involved in the care of residents did not collaborate with each other in the assessment of residents so that their assessments were consistent and complemented each other.(561) [s. 6. (4) (a)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Resident #006 used bed rails as a PASD since their admission to the home. The Bed System Assessment, indicated that the resident had two assist rails applied while in bed for bed mobility and positioning assistance. The written plan of care (previous month) indicated that the resident had two assist rails used as a PASD. The most current written plan of care indicated that the resident had a three quarter rail on one side of the bed and a quarter rail on the other side of bed used as PASD. The registered staff confirmed that the resident had a three quarter and a quarter rails applied on the bed since their admission to the home. The DOC confirmed that the resident had three quarter and a quarter bed rails applied while in bed and was assessed for such. The DOC indicated that the registered staff documented in error that the resident had two assist rails on the Bed System Assessment and in the written plan of care. [s. 6. (9) 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 with section 6(4)(a) 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, 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 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, (b) was complied with.

A) The home's complaint policy, "LTC-CA-WQ-100-05-09", revised November 2014, stated that "Verbal complaints resolved within 24 hours will not be logged on the home's complaint log rather they will be logged in the workbook on the tab titled "verbalComp.Resolved 24h". Verbal complaints that cannot be resolved within 24 hours after receipt will be fully investigated with the written investigation report and complaint communication log being completed and logged in the home's complaint log workbook.

B) A resident voiced concerns to the Administrator about services at the home. The

Administrator confirmed that the concerns had been discussed with the resident; however, the concerns had not been documented in the verbal complaints resolved within 24 hours or the complaint log.

C) The home's policy was not complied with as complaints not resolved within 24 hours were not documented on the complaint log and remained on the complaints resolved within 24 hours log.

i) A complaint was identified and the response was provided to the complainant two days later. The concern was not resolved with within 24 hrs. The information remained on the "concern log" and not placed on the "complaint log".

ii) A complaint was identified and signed as completed two days later. There was mo mention if a response was provided to the complainant.

iii) A complaint was identified with follow up action from the home up to 10 days after the initial concern was identified. The complaint was not identified as a complaint (remained on the concern log) and was not resolved within 24 hours.

iv) A complaint was identified with resolution three days later. This was identified as a concern on the verbal complaints resolved within 24 hours and not as a complaint but was not resolved within 24 hrs.

v) A complaint was identified with continued actions from the home five days after the initial date. The issue was not resolved within 24 hours and was identified on the verbal complaints resolved within 24 hour log and not on the complaint log.

vi) A complaint was identified with follow up three days later. The complaint was not resolved within 24 hours; however, it remained on the verbal complaint resolved within 24 hours log. [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 with ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: 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, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A tour of the home was completed on March 24, 2015 at 1000 hours and identified the following furnishings and equipment were not maintained in a safe condition and in a good state of repair:

A) The spa room on Beech Court and Aspen Grove units had shower faucets, which were observed leaking continuously from March 24 to April 1, 2015. The tile grout surrounding the leaking shower faucet in the Beech Court spa room was green in colour and tiles were missing under the shower.

B) The flooring in the spa and jacuzzi rooms in all resident units were splitting along the edges. In the Willow Way and Pine Ridge jacuzzi rooms the flooring was splitting approximately three feet in length on each side of the entrance and in some areas the glue was orange in colour.

C) At the entrance of the spa room on the Beech Court and Pine Ridge units the floor tiles were broken in two locations, which was creating a safety hazard.

D) The resident high-back arm chairs in all resident rooms and common areas observed had the wooden legs and arms chipped and the lacquer worn off, rendering them difficult to disinfect.

On March 30 and April 1, 2015 the Environmental Services Manager (ESM) was interviewed and toured the home with the LTC Inspector. The ESM confirmed that the repairs were not on the maintenance log for repairs until recently, and confirmed the equipment and furnishings need repair. [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 with ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #006 had bed rails applied while in bed. The resident was assessed for bed rail use when admitted to the home. The resident was then moved to another unit as per registered staff. Health records were reviewed and indicated that the resident was not assessed for bed rails use to minimize risk to the resident when they were moved to another bed on a different unit. The DOC confirmed that the resident should have been assessed for bed rails again when they were moved to another unit. [s. 15. (1) (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 with ensuring that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone.

A) A family member alleged through a complaint that an identified PSW forced a resident to do something the resident stated they were unable to do. The Administrator confirmed the home did not investigate the actions of the PSW.

B) A family member voiced concerns about a PSW's attitude and actions. Documentation did not include an investigation into the PSW's conduct. The Administrator confirmed the allegations were not investigated.

C) Resident #045 voiced concerns about a PSW to inspector #107 and alleged retaliation by the PSW. The Administrator confirmed that the resident had told the Administrator they did not like the identified PSW; however, no investigation had occurred into why the resident had concerns about the PSW. The PSW had been named by two other residents without investigation.

D) During this inspection, resident #045 voiced concerns to inspector #107 about a staff member and the resident stated they felt intimidated and was avoiding the staff member. The resident was able to recall the same information on two different dates when interviewed by the inspector. An investigation by the home into the allegations was not immediately initiated.

E) The home's abuse policy identified denying, ignoring requests for assistance, teasing, shouting, yelling, sarcasm, intimidation and retaliation as an examples of emotional abuse. The home's abuse policy identified demeaning, derogatory, yelling, inappropriate tone, humiliating, talk that might upset a resident, as examples of verbal abuse. [s. 23. (1) (a) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who were incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) Resident #001 had a significant change of condition and their incontinence had worsened. Registered staff did not conduct a bladder continence assessment and a bowel function assessment at that time. When the resident's quarterly assessment was conducted a bladder continence assessment was not completed. The home's "Assessment Guide", revised December 2014, identified that the resident should have had a bladder continence assessment conducted at the time the resident had a

significant change in condition, and at the time of the MDS quarterly assessment. In addition, the resident should have had a bowel function assessment at the time of the resident's significant change in condition and this was not done. When reviewing the resident's clinical record, there was no bladder continence assessment or bowel function assessment in the record. The registered staff confirmed that they were expected to complete the assessments when the resident had a significant change in condition and quarterly and this was not done. The ADOC confirmed that staff were expected to complete the bladder continence and bowel function assessments as they were outlined in the Assessment Guide.

B) Resident #044 had a significant change of condition and registered staff did not conduct a bladder continence assessment and a bowel function assessment at that time. The resident's bowel continence had worsened during the significant change in condition. When the resident's quarterly assessment was conducted the resident did not have a bladder continence assessment and bowel function assessment. The home's "Assessment Guide", revised December 2014, identified that the resident should have had a bladder continence assessment and a bowel function assessment conducted at the time the resident had a significant change in condition, and a bladder continence assessment at the time of the MDS quarterly assessment. When reviewing the resident's clinical record there was no bladder continence assessment and bowel function assessment conducted using a clinically appropriate tool since the resident was admitted to the home. The registered staff confirmed that they were expected to complete the assessments when the resident had a significant change in condition and quarterly. The ADOC confirmed that staff were expected to complete the bladder continence and bowel function assessments as they were outlined in the Assessment Guide. [s. 51. (2) (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 with ensuring that residents who are incontinent receive 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, to be implemented voluntarily.

WN #7: 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 was served using methods that preserved taste, appearance and food quality.

At the lunch meal service March 24, 2015, multiple PSW staff were observed mixing items together when assisting residents with eating, resulting in altered taste, appearance and quality of the meal.

A) Staff assisting resident #047 with eating were placing ravioli onto the fork and using a spoon to scoop spinach on top of the ravioli on the fork for each bite prior to feeding it to the resident. When asked if there was a reason for doing so, the staff member stated, "No particular reason". The resident was unable to voice their preferences and the resident's plan of care did not instruct staff to mix the resident's food items together.

B) Staff assisting residents #017 and #048 with eating were mixing their pureed food items together prior to feeding the foods to the residents. Resident #017 had their pureed bread mixed with their pureed ravioli. The resident was unable to voice their preference to the inspector. Staff stated the resident disliked the pureed bread so she was mixing it with the ravioli. The resident's plan of care did not instruct staff to mix the resident's foods together. Resident #048 had their pureed spinach and pureed ravioli mixed together on the spoon for each bite. The staff member did not provide a reason for doing this. The resident was not able to voice their preferences and the resident's plan of care did not instruct staff to mix the food items together.

C) Staff assisting resident #049 with eating were mixing regular texture bread (cut into pieces) with spinach or spinach and ravioli with each bite. The resident had not requested that staff do this and appeared to be having some behaviours while being assisted with eating. The resident's plan of care did not direct staff to mix the resident's foods together. [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 with ensuring that all food is served using methods that preserved taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

During the initial tour of the home on March 24, 2015, and during observations on March 27, March 30 and April 1, 2015, the LTC Inspector identified the following:

A) The piping under the sinks in the spa rooms on the Mulberry Lane, Aspen Grove, Willow Way, Birch Trail and Pine Ridge units were orange coloured, rusted and corroded.

B) The hot water pipe under the sink in Willow Way spa was loose.

C) The toilet seat lid on the toilet in Apsen Grove unit had deep groves and scratches on the lid.

D) In the resident's beauty salon the water pipes under the hair wash sinks were corroded.

The home's audits, which they conducted quarterly, related to showers and faucets were reviewed. The last audit was completed January 2015, but did not identify any issues of pipes being rusted, corroded, or that the plumbing and toilets required any repairs. The ESM was interviewed and toured the units with the LTC Inspector on March 30 and April 1, 2015 and confirmed that the water pipes were rusted and corroded, and the toilet and plumbing fixtures need to be fixed. [s. 90. (2) (d)]

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 with ensuring that procedures are developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Not all allegations documented in the home's complaint binder were investigated as required.

B) A response was not provided within 10 business days of receipt of complaints. Eight of 22 complaints reviewed between July 2014 and March 2015 did not have documentation of a response provided to the complainant.
Some examples:

i) Concerns were identified and signed as reviewed three days later. There was no documentation of follow up with the complainant.

ii) Concerns were identified; however, no follow up with the complainant was documented.

iii) Concerns were identified and the documentation stated there was no answer on the complainant's cell phone. No follow up with the complainant was documented. [s. 101. (1) 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 with ensuring that every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible and a response provided within 10 business days of receipt of the complaint, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (4) The licensee shall ensure that the changes identified in the quarterly evaluation are implemented. O. Reg. 79/10, s. 115 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that changes identified in the quarterly evaluation were implemented.

The MediSystem pharmacy report dated December 12, 2014, of the audit done by the pharmacy on July 24, 2014, identified that the fridge temperature logs were not documented in the home. The ADOC confirmed that the home did not monitor and did not record the temperatures of the fridges that store the medications in the home. The ADOC also confirmed that the report provided by the pharmacy was reviewed and after the July 24, 2014, the home had implemented thermometer monitoring for all fridges but missed the fact that they needed to record the temperatures at minimum once daily. [s. 115. (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 with ensuring that changes identified in the quarterly evaluation were implemented for the medication management system, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in a fridge that complied with manufacturer's instructions for the storage of the drugs.

The medication room on the main floor on Mulberry Lane had a fridge with medications, such as insulin, and the thermometer that monitored the temperature of the fridge read 8.7 degrees Celsius (C) on April 1, 2015, and 8.1 degrees C on April 2, 2015. The ADOC reported that the home did not record the temperatures of the fridge and there were no policies around the storage of the refrigerated medications. The MediSystem pharmacy policies on management of drugs was reviewed and a policy on Storage of Refrigerated Medications was found. The policy called Inventory Control - Storage of Refrigerated Medications, Index Number: 02-06-12, last reviewed: Jun 23, 2014 indicated that "refrigerators must be able to maintain a temperature of 2 to 8 Celsius, striving for an average temperature of 5 C. Temperatures should be recorded at a minimum once daily and records should be kept for at least 1 year". The ADOC confirmed on April 2, 2015, that there was a policy from the pharmacy on storage of refrigerated medications and that the home had not followed it. [s. 129. (1) (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 with ensuring that drugs are stored in a fridge that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #020 received individualized personal care, including hygiene care and grooming on a daily basis.

The MDS assessment identified that resident #020 required extensive assistance by staff for personal care, which included grooming on a daily basis. When the PSWs were interviewed on March 27, 2015, they stated they checked the resident daily when providing personal hygiene. The resident was observed on March 24, 26, and 27, 2015, and required personal grooming. The PSW for resident #020 confirmed the resident was not provided with individualized personal care and should have been. The RN confirmed that PSWs were expected to groom residents when providing personal care. The DOC and ADOC were interviewed on March 27, 2015, and also confirmed the PSWs were expected to groom residents daily while providing personal care. [s. 32.]

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 the planned menu items were available and offered at the afternoon snack pass March 24, 2015.

The planned menu for Week 1 Tuesday afternoon snack (March 24, 2015) identified cranberry citrus oat cookies for all diet textures. The observed snack for residents receiving a regular texture menu was a homemade cookie which the Nutrition & Hospitality Manager confirmed was the cranberry citrus oat cookies. A yellow pudding was available for residents receiving a pureed menu. Staff serving the snack cart confirmed that the only snack for the pureed menu was the yellow pudding (which some residents also received at the lunch meal that day). The planned menu for the pureed texture identified the same cranberry citrus oat cookie as for the regular textured menu. The Nutrition & Hospitality Manager confirmed that staff did not prepare the pureed cookies for the pureed texture menu and the cookies were not offered as per the planned menu. [s. 71. (4)]

Issued on this 27th day of May, 2015

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

Original report signed by the inspector.