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
Oct 21, 2015	2015_377502_0017	T-1665-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE SCARBOROUGH
3830 LAWRENCE AVENUE EAST SCARBOROUGH ON M1G 1R6

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

JULIENNE NGONLOGA (502), JOANNE ZAHUR (589), SHIHANA RUMZI (604), TILDA HUI (512)

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): August 24, 25, 26, 28, 31, September 1, 2, 3, 4, 8, 9, 10 and 11, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), registered nurses (RNs) registered practical nurses (RPNs), personal support workers (PSWs), restorative care coordinator (RCC), restorative care aide, dietary manager (DM), registered dietitian (RD), dietary aides, cooks, Resident program Manager, physiotherapist (PT), physiotherapist aide (PTA), resident care relation coordinator, support service manager (SSM), maintenance staff, housekeeping staff, residents, substitute decision makers (SDMs) and family members of residents.

The inspectors also conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following intakes were conducted concurrently with the Resident Quality Inspection: T-1078-14, T-129-14, T-1286-14, T-1049-14, T-2130-14, and T-2218-15.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 90. (2)	CO #003	2015_360111_0001	604

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

1. The licensee had failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Review of progress notes for resident #018 revealed the resident had unwitnessed falls on identified dates. All three falls occurred while resident was performing selfcare, walking in the hallway or sitting on his/her walker seat.

Review of the resident's written plan of care revealed the following interventions for fall prevention:

answer call bell promptly, check hourly for safety during periods when risks for falls was increased
such as toileting, coordinate with appropriate staff to ensure a safe environment with floor surfaces
even, glare free lightning, bed in low position, and personal item within reach. The resident can
weight bear and can participate in the transfer by grabbing onto railings or grab bar, then pivot with
staff assistance. The level of assistance for transfers varies between supervised transfer by one staff
to extensive assistance from staff based on the resident capability to bear weight during transfer.

Review of the post fall assessment with a specified date, revealed a specified risk management intervention to increase the resident's ability to see in particular circumstances. The above mentioned information and interventions were not noted in the resident's written plan of care.

Interviews with identified staff revealed conflicting information as indicated on the written plan of care. Interview with an identified staff indicated the resident sometimes transfers by him/herself without calling
staff to assist. The staff also stated staff sometimes used chair or bed alarm for the resident
when he/she complaints of identified medical symptoms.

Interview with an identified staff revealed he/she was not aware of the above mentioned interventions. The identified nursing staff confirmed the above mentioned incident prevention strategies were not included in the resident's written plan of care to provide clear directions to direct care staff.

Interview with the DOC confirmed the above mentioned prevention strategies should be included in the written plan of care to provide clear directions to the staff. [s. 6. (1) (c)]

2. Review of a critical incident report and resident #023's progress notes revealed the resident had a witnessed fall on a specified date and time while receiving care. The resident sustained a specified injury as result of the incident, was transferred to the hospital for further treatment and was returned to the home on the same evening.

Interviews with the resident revealed he/she was diagnosed with a specified medical condition, experienced identified physical change after a specified surgery in the past and was having difficulty weight bearing. The resident also stated he/she had a specified pain at times and the pain was managed by identified drug.

Interview with the physiotherapist (PT) and review of PT assessments for identified dates indicated the resident was using an identified therapy device for support, and if the device was not applied, the resident would definitely sustained the specified injury.

The resident stated in the morning of the incident, he/she had told an identified staff prior to receiving care that he/she was experiencing pain more than normal. The resident confirmed he/she did not have the therapy device while being transferred. During the transfer from toilet to the wheelchair, the identified staff asked the resident to stand up from the toilet and hold on the grab bar, and attempted to transfer the resident onto the wheelchair. The resident stated he/she was having pain and was too weak to stand up. At this moment, the resident felt weak in his/her legs and started to fall down.

Interview with an identified staff indicated the resident did not fall onto the floor during the transfer. The staff stated he/she held onto the resident and assisted him/her to slide down onto the floor. The staff stated the resident's foot may have made contact with the wheelchair behind him/her. The staff then called for help and other staff came in to assist to put resident onto the wheelchair. The registered nursing staff did head toe and pain assessments and administered pain medication for the resident. The resident received a PT assessment post fall and was transferred to the hospital where he/she was diagnosed with a fracture.

Review of the resident's written plan of care did not reveal any indication of strategies developed to address the use of the therapy device during transfer and while weight bearing.

Interview with an identified nursing staff confirmed he/she was aware that the resident was to use the therapy devise while up in wheelchair and while walking. The staff stated that the above information should have been included in the written plan of care providing clear directions to direct care staff.

Interview with the DOC confirmed the above mentioned fall prevention strategy should be included in the written plan of care to provide clear direction to staff. [s. 6. (1) (c)]

3. The licensee had failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Interview with resident #009 revealed he/she would like to be dressed in his/her own day clothes.

On an identified date at 11:28 a.m., and at 3:45 p.m., the inspector observed resident #009 lying in bed wearing a night gown.

Interview with an identified staff indicated the resident was wearing a night gown because the resident had gained weight and clothing did not fit the resident. Interview with an identified staff indicated the resident had a lot of nice clothes and he/she likes to be dressed up and feel good. Furthermore both staff indicated resident #009 was altered bed mobility, because he/she would get exhausted, become tired and slide down as soon as he/she was transferred to his/her wheelchair, and they indicated the resident chair had been removed from his/her room and stored in the PT's room.

Interview with an identified staff confirmed he/she was not informed that resident #009 had no fitting clothes and was left wearing his/her night gown the whole day. In addition, the staff and DOC revealed the resident did not had altered bed mobility.

The record review and staff interviews confirmed PSWs and registered staff did not collaborate with each other in the assessment of the resident related to his/her bed mobility and dressing. [s. 6. (4) (a)]

4. 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 a critical incident report and resident #023's progress notes revealed the resident had a witnessed fall on a specified date and time while receiving care. The resident sustained a specified injury as result of the incident, was transferred to the hospital for further treatment and was returned to the home on the same evening. Review of the resident's current written plan of care revealed interventions were developed to reduce the risk of fall, including floor mattress beside the resident's bed and put resident's bed in a low position.

On identified dates at 1:30 p.m. and 2:15 p.m., respectively the inspector observed the resident resting in bed. The use of floor mattress beside the resident's bed and low bed positions were not noted at time of observations.

Interviews with identified staff confirmed the above mentioned interventions were not being used for the resident.

Interview with the DOC confirmed the above mentioned fall prevention interventions should be implemented for the resident. [s. 6. (7)]

5. The licensee had failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

On September 2, 2015, the inspector observed the resident sitting in his/her wheelchair while being interviewed. On September 9, 2015, the inspector observed the resident moving in the corridor using his/her wheelchair. Interviews with identified staff confirmed resident #020 had been wheelchair bound for over a year.

Record review of the resident's most recent plan of care indicated resident #020 required extensive assistance of one staff to walk in room and corridor. The plan of care directed staff to "Refer the resident to PT if changes in walking ability occurred".

Interview with Restorative Care Coordinator (RCC) confirmed resident #020 was discharged from the walking program in 2014, because his/her disease had progressed, he/she had an unsteady gait and balance. The staff confirmed he/she did not refer resident #020 to the PT. The PT confirmed he/she did not assess the resident when his/her walking ability had declined.

Interviews with the RCC and the DOC confirmed that the resident's plan of care had not been revised when the resident's walking ability declined. [s. 6. (10) (b)]

6. Review of Entrostomal Therapist (ET) wound assessment for resident #019 for a specified date, indicated "Increasing bed rest and offloading pressure to both wound sites, resident can be up for two meals/day in w/c then return to bed".

Review of the resident's plan of care did not include the recommendations made by the ET for resident #019.

Interviews with identified nursing staff members confirmed the printed plan of care did not include the ET's recommendations and was not updated. [s. 6. (10) (b)]

7. On identified dates, the inspector observed resident #019, lying in bed with a fitted sheet on the air mattress.

Record review of the resident current plan of care indicated "No putting bed sheets to air mattress".

Interview with an identified confirmed not being aware of the plan of care directing staff not to put a bed sheet on the air mattress.

Interview with the DOC and Skin and Wound lead revealed resident #019 received a new air mattress which allow for fitted sheet to be place on the air mattress and confirmed the current plan of care was not updated with current information related to the resident's new air mattress [s. 6. (10) (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 plan of care sets out clear directions to staff and others who provide direct care to the resident,
- 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,
- the care set out in the plan of care is provided to the resident as specified in the plan, and
- the resident was reassessed and the plan of care reviewed and revised 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 #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 has 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 is complied with.

Review of the home's "Monitored Medication" Policy 6-5 entitled "Individual Monitored Medication Record" revealed that staff are required to sign on the "Individual Monitored Medication Record" each time a dose is administered. Include the date, time, amount given, amount wasted, and the new quantity remaining.

On identified date and time, the inspector observed the medication cart on an identified home area and noted the "Monitored Medication Record for 7-day Card" sheets for narcotics was not signed off for the 8:00 a.m., medication pass for resident #030, #031, #032 and the narcotic count did not correlate with the narcotic card.

Interview with an identified nursing staff confirmed the medication was administered to the above identified residents but failed to sign off the Monitored Medication Record for 7-day Card sheet.

Interviews with an identified nursing staff and DOC confirmed the "Monitored Medication Record for 7-day Card" sheets for narcotics was not signed off for the 8:00 a.m., medication pass for resident #030, #031, #032 and the home's policy for signing off the Monitored Medication Record was not followed. [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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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 are kept closed and locked when they are not being supervised by staff.

On identified date and time, the inspector observed on an identified home area "Soiled Utility Room" door was left open and unsupervised with a yellow housekeeping cart parked outside the door. The soiled utility room was beside the TV lounge with 10 residents were present. The following items were stored in the Soiled Utility Room:
- ECOLAB chemical mixer, which consisted of five chemicals
- Bottles of Hygenipak instafoam and Debonaire - anti bacterial foaming skin cleanser
- A shelf with two razors in a glass vase and a floor sink

Interviews with identified nursing staff and housekeeper confirmed the soiled utility room's door was open and posed a hazard to residents due to chemical access. Both staff stated the above mentioned door should have been kept locked.

Interview with Support Services Manager (SSM) confirmed the Soiled Utility Door was to be kept locked at all times when not in use. [s. 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 to ensure that all doors leading to non-residential areas must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: 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 are stored in an area or a medication cart that is secure and locked, and 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.

On identified date, the inspector observed one light green tablet inside a paper cup sitting on top of a locked medication cart parked outside the nursing station on an identified home area with no registered nursing staff present.

Interview with an identified nursing staff confirmed the light green tablet left unattended was a prescribed medication belonging to resident #033. The medication was accessible to the public and posed a hazard to residents on the unit. Interviews with an identified nursing staff and the DOC confirmed narcotics are not to be left unattended and was to be kept locked at all times. [s. 129. (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 drugs are stored in an area or a medication cart that is secure and locked, and 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, to be implemented voluntarily.

WN #5: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the right of resident to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, is fully respected and promoted.

On August 28, 2015, the inspectors observed residents charts were on a chart rack parked outside the nursing station in the hallway on two identified home areas next to residents' rooms. The charts were accessible to the public.

Interviews with identified nursing staff and the Administrator confirmed the resident's health information was not protected, as the charts were accessible to the public and could be accessed by the resident coming out of the room.

The Administrator indicated he/she would work with the DOC in ensuring the residents private health information was kept private and safe from the public by the end of the month.

On August 31, 2015, at 2:28 p.m., the inspector observed a white treatment flip chart which consisted of resident #024 and #034's specified treatment administrative record sitting on top of treatment cart; that was parked in front of the Form/Storage room on an identified home area.

Interview with DOC confirmed the resident #024 and #034's specified treatment was visible to the public and the home was not protecting the residents' private health information. [s. 3. (1) 11.]

2. On August 25, 2015, the inspector observed a white specimen collection hat stored in a shared bathroom on the top of the toilet tank which contained a clear sealed plastic bag containing an orange top specimen bottle, a lab requisition completed with resident #001's name, health card number, date of birth and specimen required to be collected.

Interview with the DOC confirmed resident #001's personal health information had not been kept confidential. [s. 3. (1) 11. iv.]

3. On identified date and time, the inspector observed during shift change report on an identified home area staff discussed resident medical condition and PHI in common area where other residents, resident #119's visitor and hairdresser were present.

Interviews with identified nursing staff indicated the home's procedure to protect residents' PHI during shift change report was to close resident room's door located by the nursing station, move other resident way from the area, and ensure no family member was present. The above mentioned staff confirmed the staff did not follow the procedure in place to protect the resident's PHI. [s. 3. (1) 11. iv.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that a safe and secure environment is provided to the residents.

Observation on specified date and time, noted trail of foot prints with fluid marks in hallway for a length of 30 feet. Upon close examination, fluid marks appeared to have started from a corner in the open dining and activity area leading to and along the hallway, ending in front of the nursing station. A pool of fluid three feet by five feet in size was noted in the corner. There were about six nursing staff at the nursing station during shift change, two PSWs were noted stocking up a supply cart opposite the nursing station. There were two residents noted sitting in the dining/activity areas in wheelchair watching TV, two residents were noted sitting in lounge chairs with their walker. There were eight residents sitting around a table with a staff playing games.

After making observation for five minutes with no action from the staff, the inspector brought the fluid on the floor to the attention of the evening charge nurse, an identified nursing staff who indicated that it was the home's practice to call housekeeping to mop up the fluid on the floor. At that time, a PSW came up with a mop and bucket and proceeded to mop up the fluid. The identified nursing stated he/she will call housekeeping to sanitize the floor after. No warning signs were used near the pool of fluid and along the hallway. There were yellow warning signs noted sitting in the corner of the dining room. The identified nursing staff then put out a sign in the hallway.

Interview with the identified nursing staff confirmed yellow warning signs should have been used to warn residents and others of the potential safety risks. Interview with the DOC confirmed that it was the expectation of the home for staff to mop up the fluids on the floor immediately and call housekeeping to disinfect the floor if it had been urine. [s. 5.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents are protected from abuse by anyone.

Interview with resident #020 revealed he/she was afraid because staff yells at him/her. The resident also indicated an identified staff had yelled at him/her and told the resident "you are very slow"; "you are doing wrong".

On identified date during a specified morning care resident #020 stated he/she had asked the identified staff for a mouth wash and the staff refused to give it to him/her. The resident stated he/she reported the above mentioned incidents to an identified nursing staff. The resident revealed the words from staff hurt him/her and made him/her feel sad.

Interview with an identified staff confirmed resident #020 reported the above mentioned incidents. The staff also confirmed while in the hallway administrating medication, he/she regularly heard staff being impatient and yelling at resident #020, the resident never talks back to staff. The staff believed the resident felt sadness, panic, and nervousness when staff yelled at him/her. The staff indicated when he/she heard staff being impatient with the resident he/she continued with the medication administration and cautioned the staff involved later in the shift with reminding them about the resident's medical condition. The identified nursing also confirmed he/she never reported those incidents to the management of the home or the Director.

Interview with the DOC confirmed the above mentioned incidents could make the resident feel "insecure and less than a person and it was emotionally abusive". [s. 19. (1)]

WN #8: 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 had failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Interview with resident #020 revealed he/she was afraid because staff yells at him/her. The resident also indicated an identified staff had yelled at him/her and told the resident "you are very slow"; "you are doing wrong".

On identified date during a specified morning care resident #020 stated he/she had asked the identified staff for a mouth wash and the staff refused to give it to him/her. The resident stated he/she reported the above mentioned incidents to an identified nursing staff. The resident revealed the words from staff hurt him/her and made him/her feel sad.

Interview with an identified staff confirmed resident #020 reported the above mentioned incidents. The staff also confirmed while in the hallway administrating medication, he/she regularly heard staff being impatient and yelling at resident #020, the resident never talks back to staff. The staff believed the resident felt sadness, panic, and nervousness when staff yelled at him/her. The staff indicated when he/she heard staff being impatient with the resident he/she continued with the medication administration and cautioned the staff involved later in the shift with reminding them about the resident's medical condition. The identified nursing also confirmed he/she never reported those incidents to the management of the home or the Director.

Interview with the DOC confirmed staff never report those incidents and his/her responsibility when the above mentioned incidents occurred was to make sure the resident was safe, talked to the involved staff immediately and report that the incidents to management. [s. 24. (1)]

WN #9: 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 has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the Resident's Council minutes for identified date, indicated a concern related to an unidentified resident on a specified floor who was taking juice, milk, and other residents' food items from the resident's refrigerator located in the lounge for consumption.

Interview with the Resident's Council Assistant confirmed the above concern was raised, a concern form was given to the head of the department. The form with a response was given back to him/her, which he/she shared with the Council in the next meeting. He/she confirmed the Council had not received a written response from the home with in the allotted time frame. [s. 57. (2)]

WN #10: 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,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the menu cycle include alternate beverage choices at snacks.

Observation on September 8, 2015, at 3:30 p.m., and a review of the Spring/Summer snack menu week-1 revealed no alternate beverage for afternoon and evening snacks were included in the menu.

Interviews with the Dietary Manager (DM) and Registered Dietitian (RD) confirmed snack menu week-1 did not provide alternate beverage choices for afternoon and evening snacks. [s. 71. (1) (d)]

WN #11: 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,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**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,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

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

**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 had failed to ensure that the food production system must, at a minimum, provide for standardized recipes for all menus.

On a specified date, the inspector observed an identified dietary staff during preparation of the cultural menu which was to be served the next day at lunch and dinner. The cook was following a homemade recipe of Okra Curry and Eggplant Curry that yield 20 portions each.

Record review of the cultural menu recipe book revealed and interview with the identified dietary staff confirmed the recipes he/she had followed to prepare 40 portions of Okra Curry and Eggplant Curry were not standardized. The cook and the DM confirmed the required ingredients are simply doubled to prepare the 40 portions. [s. 72. (2) (c)]

2. The licensee had failed to ensure that all menu items are prepared according to the planned menu.

On September 9, 2015, during lunch service the inspector observed the mashed potatoes planned for the residents on pureed diet were not served. The residents received pureed fish, PEI vegetable and bread.

Review of the week-1, day-3 therapeutic Spring/Summer menu revealed whipped mashed potatoes were planned for residents on pureed texture diet.

Interviews with identified dietary staff and DM confirmed whipped mashed potato were not prepared and not available to the residents. [s. 72. (2) (d)]

3. The licensee had failed to ensure that the menu substitutions are documented on the production sheet.

On September 1, 2015, during breakfast service the inspector observed the residents eating bananas.

Review of the week-3 Spring/Summer menu day-2 revealed honeydew was planned for breakfast. Review of the production' sheet for the above identified date revealed there was no substitution documented.

Interviews with identified dietary staff confirmed honeydew was not available or offered to the residents.

Interview with the DM indicated honeydew had been substituted with bananas, and confirmed the substitution had not been documented on the production sheets. [s. 72. (2) (g)]

4. The licensee had failed to ensure that all foods are prepared, using methods which preserve taste, nutritive value, appearance and food quality.

Review of the standardized "Submarine Mini Sandwich" recipe revealed that the following ingredients are required to prepare 52 mini submarine sandwiches: 1 kilogram (kg) salami, 1kg Ham Black Forest, 1kg Cheese, 780 grams(g) lettuce, 2 1/8 kg fresh tomato, 52 hot dog buns, 239 g margarine, and 260 ml Italian dressing.

Observation on September 9, 2015, at the lunch service mini submarine sandwich served to the residents revealed and interviews with cook #150 confirmed that 1kg of Ham Black Forest was not used during the preparation of the above mention sandwich.

Interview with the DM confirmed not adding 1kg of Ham Black Forest in the sandwich did not provide the protein content.

Review of the standardized "Turkey Thigh Rosemary w/Gravy" recipe revealed the following ingredients are required to prepared 57 Rosemary Turkey with Gravy: 6 and 3/8kg turkey thigh boneless and skinless, 456 ml canola oil, 34 ml black pepper, 45 ml garlic powder, 34g dried rosemary, and 2 litres poultry gravy. The recommended method of cooking is roasting. Recipes for texture modified minced and pureed direct staff to use the above prepared turkey rosemary w/gravy, add chicken base broth and blended it to desired consistency.

Observation on September 8, 2015, dinner preparation revealed and interview with cook #139 confirmed he/she mixed sliced turkey roast, garlic powder, black pepper, dried rosemary and gravy, and prepared the mixture for two hours in the steamer. For texture modified minced and pureed, ground turkey was mixed with gravy and corn starch, blended to the desired texture and prepared for two hours in the steamer.

Interview with an identified dietary staff confirmed he/she did not follow the above mentioned standardized recipe.

Interview with the DM confirmed not preparing menu items as per standardized recipes alter the nutritive value, taste, appearance and food quality of the above mentioned items. [s. 72. (3) (a)]

5. The licensee had failed to ensure that all food was prepared using methods which prevent adulteration and contamination.

On September 8, 2015, at 1:30 p.m., the inspector observed an identified dietary staff cut vegetables on a soiled cutting board without sanitizing it.

Interview with the identified dietary staff confirmed he/she did not follow the procedure in place which required him/her to wash and sanitize the cutting board after cutting each food items and prior to using or change the cutting board.

On September 8, 2015, at 2:30 p.m., the inspector observed an identified dietary staff wear single use gloves to place half of the eggplant in the pot, removed the gloves placing them on top of the remaining eggplant without performing hand hygiene. He/she reused the above soiled gloves to handle the remaining eggplant.

Interview with the identified dietary staff confirmed placing the soiled gloves on food items, reusing soiled gloves and not performing hand hygiene expose food to cross-contamination.

Interview with the DM confirmed staff should use clean color coded cutting board for different food items and they are required to perform hand hygiene regularly. [s. 72. (3) (b)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that all staff who provides direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: (1) Mental health issues, including caring for persons with dementia, (2) Behaviour management and (3) How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

Review of an identified nursing staff's training record revealed and interviews with the identified nursing staff and the ADOC confirmed the identified staff was hired on April 30, 2015, had assumed his/her nursing responsibilities since May 14, 2015, and had not been trained on the above mentioned areas. [s. 76. (7)]

WN #13: 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 failed to ensure that staff participates in the implementation of the infection prevention and control program.

On a specified date, observations revealed the following in identified residents' rooms:
- unlabeled hairbrush with hair top of the toilet tank and blue hair pick comb on the sink
- unlabeled slipper bed pan located on top of the toilet tank,
- unlabeled white specimen collection hat wedged between the top of the toilet tank and the bathroom wall.
- unlabeled square wash basin wedged between the top of the toilet tank and the bathroom wall.

On a specified date, further observations with the DOC and ADOC revealed the bed pan and wash basin should have been labeled and not stored in the shared bathroom. In addition the DOC revealed the white specimen collection hats are single use items and are not to be stored in residents shared bathrooms. The DOC placed these items into the garbage.

Interview with DOC and ADOC confirmed staff had not participated in the implementation of the infection prevention and control program. [s. 229. (4)]

2. Observation made on specified date and time, in specified resident's room, noted an identified staff opening privacy curtain with a pair of vinyl gloves on his/her hands. When asked why he/she was wearing the pair of gloves, the identified staff stated he/she was changing the resident’s incontinence brief and was in the process of completing the task. The identified staff then proceeded to roll up the soiled brief and remove his/her gloves to dispose of them.

Interview with the identified staff stated he/she should have removed the soiled gloves on his/her hands before touching the privacy curtain. Interview with the DOC confirmed it was the home’s expectation the staff removed soiled gloves on his/her hands prior to touching any room furnishings. [s. 229. (4)]

Issued on this 23rd day of November, 2015

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

Original report signed by the inspector.