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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 27, 2015	2015_380593_0008	S-000793-15	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 VAN DAELE
39 Van Daele Street Sault Ste Marie ON P6B 4V3

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

GILLIAN CHAMBERLIN (593), BEVERLEY GELLERT (597), JENNIFER LAURICELLA (542), LISA MOORE (613)

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 13 - 17, 20 - 23, 2015

Two complaints were also inspected during the RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Dietitian (RD), Support Services Manager, Food Services Manager (FSM), Registered Nursing Staff, Personal Support Workers (PSW), Dietary Aides, residents and family members.

The Inspectors observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, staff training records and home policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

12 WN(s)
8 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #048's comfort device is included in the resident's plan of care.

Inspector #593 observed on numerous occasions, resident #048 seated with the comfort device in place.

A review of the resident's health care record found no mention of the comfort device, it was not included in the written care plan, the physician's orders, the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). The resident's current care plan documented the resident's primary mode of locomotion however there was no inclusion of the comfort device.

During an interview with Inspector #593 on April 23, 2015, #S-103 stated that resident #048 has the device in place for comfort and this also takes pressure off their bottom. #S-103 further added that the comfort device is applied whenever the resident is not in bed and when the resident is not eating. At this time, #S-103 was observed to apply the comfort device to the resident's chair as the resident had just finished eating breakfast.

During an interview with Inspector #593 April 23, 2015, #S-104 advised that the comfort device was not a restraint; it was in place for comfort measures and confirmed that this was not included in the resident's plan of care. #S-104 further added that this should be included in the resident's plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff

and others who provide direct care to resident #002.

On April 21, 2015, Inspector #542 completed a health record review for resident #002. The most current care plan indicated that the resident was to be put back to bed at certain times for rest periods and documented additional instructions for rest before and after meals. Throughout this inspection, Inspector # 542 observed the resident sitting in a chair until after lunch. The resident was not placed back to bed as indicated by their plan of care. Inspector #542 spoke with #S-113 and #S-114 who stated that resident #002 goes back to bed at a certain time in the afternoon routinely for rest periods. [s. 6. (1) (c)]

3. Over the course of the inspection, Inspector #542 observed resident #002 to be seated with a device applied at various times throughout the days. A health record review was completed which concluded that the most current care plan accessible to the direct care staff did not indicate any information regarding the use of a device for this resident. On a date in April, 2015, #S-115 added a new focus statement titled "Restraint" to the resident's care plan, however they did not identify any interventions related to the use of the device for the resident. Inspector interviewed #S-116 who stated that they apply the device for the resident whenever and it just depends as to how the device is used. #S-117 stated that the device is used whenever the resident has been sitting up too long and they complete checks every couple of hours. [s. 6. (1) (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 ensuring that the plan of care for resident #002 sets out clear directions to staff and others who provide direct care to the resident, specifically but not limited to care related to sleep and rest routines and use of PASD's, and that the plan of care for resident #048 includes all aspects of their planned care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with food and fluids that are safe.

Inspector #593 observed during the lunch service on April 20, 2015, in the second floor dining room, and resident #048 with two cups of cranberry juice, the fluids were observed to be an incorrect consistency. The resident was observed to consume one and a half cups of the fluid, before the inspector intervened and questioned #S-112 as to whether the resident was supposed to receive a different consistency of fluids. #S-112 advised that they were not sure and proceeded to remove the remainder of the fluid. #S-112 asked another PSW where the resident's fluids were, located these and gave the resident two beverages of the correct consistency.

During an interview with Inspector #593 April 21, 2015, #S-112 advised that they had not given resident #048 the incorrect fluids and was unsure who did give the incorrect fluids to the resident. #S-112 further stated that there is a binder located in the dining room with the residents' dietary requirements as well as dietary sheets attached to the beverage cart where they were advised to check for resident dietary requirements. #S-112 added that they had looked at the dietary records but had not memorized the details which is why they did not realize that resident #048 had been given the wrong fluid consistency.

A review of the dietary sheets located on the beverage cart in the level two dining room April 20, 2015, found that the resident was required to have a specific consistency of fluids.

A review of the resident's current care plan, found that the resident was at moderate nutritional risk and required a specific consistency of fluids.

During an interview with Inspector #593 on April 22, 2015, the home's Registered Dietitian advised that the provision of the incorrect fluid consistency was not acceptable and before staff give any resident a fluid, they are supposed to check the diet sheets attached to the beverage cart. [s. 11. (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 ensuring that all residents in the home receive fluids that are safe and appropriate for their requirements and as per their written plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care for resident #002 includes an order by the physician or the registered nurse in the extended class.

On April 20, 2015, Inspector #542 observed resident #002 seated with a restraining device applied. A health record review was completed. The most current care plan accessible to the direct care staff did not indicate any information regarding the use of such a device for this resident. #S-115 confirmed that there was no documentation pertaining to the use of this device. #S-115 also stated that they would update the care plan and obtain consent for this device. Inspector spoke with #S-123 at 1020h on April 21, 2015, who confirmed that there was not an order for this restraint and that the care plan was not completed with regards to the use of the restraint specifically pertaining to the interventions. #S-123 also stated that they would obtain a physician's order for the use of the restraint and complete the care plan. [s. 31. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the use of all restraining devices within the home, are done so by order from the physician or a registered nurse in the extended class, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD has been consented to by a substitute decision-maker (SDM) of the resident.

Inspector #593 observed on numerous occasions, resident #041 in bed with an assistive device.

A review of resident #041's health care record found a physician's order for the assistive device, the date of this order was earlier during the previous year. A recent progress note entry documented that consent was required for the use of the assistive device and that consent was obtained at this time from the resident's SDM. However, consent was not obtained until more than 12 months from when the order was first received from the physician for the use of the assistive device.

During an interview with Inspector #593 April 23, 2015, #S-104 advised that they recently obtained consent from the SDM for the use of the assistive device for resident #041. #S-104 had realized that the consent was missing for the use of the assistive device which is why it was obtained recently. #S-104 confirmed that there was no earlier consent received from the SDM for the use of this assistive device.

A review of the home's policy #RESI-10-01-06- Personal Assistance Service Devices, documented that informed consent for the use of the PASD must be obtained from the resident or the POA/SDM. The policy procedure also documented that consent may be obtained by telephone but should be signed by the party giving consent at the earliest opportunity. [s. 33. (4) 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 ensuring that the use of PASDs for all residents are included in the resident's plan of care and that use of a PASD has been consented to by the resident or the SDM of the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to respond to resident #046's behaviours.

During an interview with inspector #593 April 20, 2015, resident #046 advised that many of their belongings have gone missing. They added that some of their items have had their name written on them. Resident #046 further stated that they report the missing items to the staff including the Administrator and the Support Services Manager and they advise that they will look into the matter but then they do not hear anything after this.

During an interview with Inspector #593 on April 22, 2015, #S-105 reported that resident #046 does complain about their belongings being stolen. They added that they actually take things from other residents. #S-105 advised that usually they will humour the resident and say that they are looking for the missing item and will also sometimes bring in items from home that the resident likes. #S-105 reported that at Christmas, the resident gave #S-105 a gift, three days later the resident reported it stolen and so #S-105 gave it back to the resident. #S-105 feels that resident #046 is a little manipulative and to manage their behaviours, the staff will placate them to keep the peace as the resident can become angry if challenged. #S-105 added that they have not had a formal psychiatric retraining assessment nor have they referred the resident to BSO regarding these behaviours.

During an interview with Inspector #593 on April 22, 2015, #S-106 advised that resident #046 often complains that their belongings are missing, however #S-106 reports that the resident will take items that belong to the home or to staff members and then write their name on the items. #S-106 adds that the resident has been like this since admission. To manage these behaviours, staff will often tell the resident that they are looking for the items and many times they end up giving them the item that they have taken in the first place. If it is an item that the home needs back, #S-106 advised that they will explain to the resident that the item does not belong to them and they understand. #S-106 believes that the resident is cognitively aware of what they are doing.

During an interview with Inspector #593 April 22, 2015, the home's Support Services Manager #S-107 reported that they were involved with one of the resident's complaints about a missing item. #S-107 advised that the resident reported a missing item. #S-107 followed up with their housekeeping staff who worked the day the item had allegedly gone missing. One of the housekeepers advised that they were telling the resident about this particular item available at the dollar store; the housekeeper advised the resident that they would pick them up one if they liked. It was concluded that after the housekeeper told the resident about the item, resident #046 reported that they actually owned this item and that it was taken from them.

A review of the resident's progress notes found an entry relating to similar behaviours:

"Resident #046 has been exhibiting behaviours over the past month in regards to some of their personal items and things that they believes to be their personal items that belong to the home. Resident #046 has stated that they are upset with the entire activity department and accused activity staff of stealing their items. The resident then went on to say that Van Daele staff members and other residents have taken other items from their room. Van Daele items have been found in the residents room and have been removed. Various staff have had to search for and remove items from the residents room as well because the resident has hidden them from staff and other residents. Resident #046 said that they were upset with the home and their family because neither one can account for some of their items. Resident #046 says that they have not seen these items since moving into their present room from another floor and wants them returned".

A review of the resident's current plan of care found no documentation relating to managing these behaviours exhibited by the resident.

During an interview with Inspector #593 April 23, 2015, the home's DOC #S-108 advised

that they think that the resident really does believe that their belongings are going missing. In regards to managing the resident's behaviours, #S-108 advised that they follow the home's procedure in regards to missing items. #S-108 will advise the resident that they are looking into the complaint and will often give them something to replace what they believe is missing. #S-108 further stated that there should be something in the resident's plan of care to manage these behaviours however at this time; they did confirm that there was not.

A review of the home's policy # 03-01-02 Care Planning found that a comprehensive care plan includes consideration and assessment of the following areas: Mood and behaviour / responsive behaviours and that ongoing, registered staff and other members of the interdisciplinary team are responsible for updating the resident's plan of care to ensure it remains current and reflective of the care needs of the resident at any given point in time. [s. 53. (4) (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 ensuring that strategies are developed and implemented to respond to resident #046's behaviours, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle includes alternative choices of desserts at lunch.

During the lunch meal service April 13, 2015, in one of the home's dining rooms, Inspector #593 observed multiple dessert options being offered to some residents. It was observed that there was rainbow sherbet, peaches and jello being offered to residents on regular textured diets, minced textured diets and pureed textured diets. For residents requiring thickened fluids; they were only being offered one choice which was pureed peaches. There was no second option available for these residents.

During an interview with Inspector #593 April 13, 2015, #S-100 confirmed that there was only one dessert option available for residents who received thickened fluids.

During the lunch meal service April 20, 2015, in one of the home's dining rooms, Inspector #593 observed multiple dessert options being offered to some residents. It was observed that there was pears, ice-cream sandwiches and jello being offered to residents on regular textured diets, minced textured diets and pureed textured diets. For residents requiring thickened fluids; they were only being offered one choice which was lemon pudding. There was no second option available for these residents.

During an interview with Inspector #593 April 20, 2015, #S-101 confirmed that there was only one dessert option for residents on thickened fluids and further stated that often there is only one dessert choice available for residents requiring thickened fluids.

A review of the homes Policy # DIET-04-01-02 Diet Types, Textures and Fluid Consistencies, found that when jello, ice-cream or sorbet is on the menu, alternate desserts must be planned and provided to residents with thickened fluid orders.

During an interview with Inspector #593 April 23, 2015, the home's Food Service Manager #S-102 was advised of the two observed occasions when residents with thickened fluid orders were offered only one choice of dessert. The FSM reported that this is how they plan the menu and asked "should there be a second option?" They further added that this is something that they can fix up. [s. 71. (1) (c)]

2. The home has failed to ensure that each resident is offered a between meal beverage in the morning and the afternoon, and a snack in the afternoon.

On April 20, 2015, Inspector #542 observed during the AM nourishment pass on a

particular floor of the home between 09:55h and 11:10h, a PSW entered the dining room where numerous residents were seated; one resident was provided a thickened fluid. No other residents in the dining room were observed to be provided with a beverage during this time.

On April 21, 2015, Inspector #593 observed during the AM nourishment pass on a particular floor of the home between 09:55h and 11:00h, approximately 25 residents in the dining room during this time. It was also observed that no resident had a beverage when the Inspector entered the dining room at 09:55. An activity commenced in the dining room at 10:30 however, the nourishment cart did not enter the dining room during this time and therefore residents in the dining room were not provided with an AM beverage.

On April 17, 2015, Inspector #593 observed the PM nourishment cart on a particular unit of the home. The nourishment cart was observed to pass by resident #048's room at 15:18h, the PSW did not enter the resident's room and offer a snack or beverage. At this time, it was observed that the resident was lying in bed awake. There was no drink or snack observed in the resident's room by the inspector after the nourishment pass had been completed in this area.

A review of the posted meal times in the home, found that the AM nourishment pass is to commence at 10:00h and the PM nourishment pass is to commence at 15:00h. This was confirmed by the home's Food Service Manager.

During an interview with Inspector #593 on April 22, 2015, the home's Food Service Manager #S-102 stated that the nourishment cart should be taken through activities and the PSWs are supposed to take the nourishment cart through all resident areas.

During an interview with Inspector #593 on April 22, 2015, the home's Registered Dietitian #S-109 advised that it is the expectation of the home that the nourishment cart does service the residents involved in activities and that this is a problem, if the nourishment cart is not going into activity areas. [s. 71. (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 ensuring that all residents are offered two dessert choices at both lunch and dinner; that dessert alternatives are provided for residents receiving texture modified diets and thickened fluids; ensuring that two options are available for these residents; ensuring that all residents are offered a between meal beverage in the morning and afternoon and a snack in the afternoon; ensuring that residents involved in activities during this time are also offered and provided a beverage, to be implemented voluntarily.

WN #7: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

Inspector #593 observed on April 16, 2015, in the dining room, #S-110 feeding a beverage to resident #048. It was observed that the resident was seated with an assistive device and #S-110 was standing next to the resident while spooning the fluid into their mouth.

Observations by Inspector #593 on April 20, 2015, during the PM nourishment found #S-111 feeding resident #048 a fluid in the dining room. It was observed that the resident was seated with an assistive device, #S-111 was standing next to the resident while spooning the fluid into their mouth.

During an interview with Inspector #593, #S-111 advised that the education they have received about safe feeding and positioning was provided in their PSW education and that most of it is common sense including making sure that the resident is not lying down and ensuring that they are not left alone.

During an interview with Inspector #593 on April 23, 2015, #S-103 advised that the resident's assistive device is for comfort when the resident is not in bed or eating. They further stated that if the residents have just eaten, they do not use this particular assistive device straight away.

During an interview with Inspector #593 on April 22, 2015, the home's Registered Dietitian #S-109 was advised about the two observed incidents where two PSWs were standing next to a seated resident while providing feeding assistance. #S-109 stated that this was not acceptable and further added that the PSWs should definitely know about safe feeding and positioning of residents and that they watch a video on this during orientation to the home.

A review of the resident's care plan dated March 18, 2015, found that the resident is at moderate nutritional risk related to a condition and requires texture modified foods and fluids.

A review of the home's policy # RESI-05-02-11 Assisting the Resident to Eat, found that staff are to ensure that the resident's position is conducive to swallowing and they are to sit down beside the resident when feeding. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all residents requiring feeding assistance are done so safely, and in accordance with best practice, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's condition is reassessed and the effectiveness of the restraining is evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Resident #002 was observed with a specific restraint on numerous occasions during the inspection. Inspector #542 reviewed resident #002's health care record and was unable to locate any documentation to support the above. Inspector spoke with #S-118 and #S-119 who both stated that the documentation of the assessments are to be completed on the TAR by the registered staff. Both staff members reviewed the TARs for this month and confirmed that the reassessments were not being completed. Shortly after the inspector discussed this with the registered staff, the resident's care plan was updated to

include the use of the restraint. [s. 110. (2) 6.]

2. The licensee has failed to ensure that resident #025's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2)

The care plan for resident #025, indicates that a physical restraint is used. The interventions listed in the care plan include hourly safety checks and repositioning every two hours and as required.

A physician's order, for the restraint was located on the Health Care Record for resident #025. A consent for this restraint was signed by the SDM.

Resident #025 was observed with the restraint in place on numerous dates during the inspection.

#S-120 was interviewed regarding registered staff responsibility regarding resident restraints. #S-120 reported that RPNs are required to document in the treatment administration record (TAR) every 8 hours to indicate that they have assessed the restraints' effectiveness. When asked by the inspector to demonstrate where to find this documentation for resident #025, #S-120 was unable to find it listed as a task on the TAR. #S-120 reported that this task should be listed on the TAR for resident #025.

Copies of the TAR for resident #025 were obtained by Inspector #597 and it was confirmed that this task was not included on the TAR. [s. 110. (2) 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 ensuring that all residents restrained by a physical device, are reassessed and the effectiveness of the restraining is evaluated by a physician or a registered nurse in the extended class or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances, to be implemented voluntarily.

WN #9: 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:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #002 is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming.

Inspector # 542 reviewed resident #002's plan of care which indicated the resident's current dental status. The care plan did not identify any interventions associated to the type and level of assistance required for the resident's dental and oral hygiene. This inspector spoke with #S-113 who stated that the resident's family complete the resident's care and that the staff at the home brush the resident's teeth in the am. [s. 26. (3) 7.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #025 is bathed by a method of their choice. r. 33. (1).

During Stage one, a family interview was conducted with the SDM of resident #025 by Inspector #542. The SDM reported that they would like the resident to have a bath but there isn't a bathtub available to the residents on the floor where they are located in the home.

Inspector #597 interviewed #S-103 on April 23, 2015, at 1100 hrs regarding bathing practices on this floor of the home. #S-103 reported that most residents are showered due to the fact that it takes less time than filling the tub and providing a bath. They reported that they can't remember the last time that the tub on this floor was used.

The inspector asked #S-103 if residents on this floor are ever taken to another floor to have a bath in the new tub and they reported that "that would never happen".

Inspector #597 interviewed #S-121 on April 21, 2015 at 1130 hrs regarding the bathing preference for resident #025. They reported that staff provide resident #025 a shower twice per week. #S-121 reported that the tub on this floor is very old and small and most residents are not comfortable in the tub. They also reported that they don't know if resident #025 was ever tried in the tub.

The Director of Care (DOC) #S-108 was interviewed on April 22, 2015, by Inspector #597 regarding bathing preferences. #S-108 stated that a new tub has been installed on another floor and they have purchased a new tub for the other floor but have not received approval to install it.

The #S-108 stated that residents and families are provided a tour on admission and advised of the location of the newer bath tub. If residents on the other floor wish to have a bath, staff will take them to the other floor for their bath where the new tub is located. [s. 33. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented in accordance with manufacturer's specifications for cleaning and disinfection of resident supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Over the course of the inspection, Inspector #542 observed resident wheel chairs to be soiled with an unknown substance. On April 17, 2015, Inspector #542 found resident #005's wheel chair cushion to be soiled with a sticky substance all over the cover and the wheel chair was also soiled. On April 22, 2015, Inspector #542, observed resident #005's wheel chair still soiled and the seat belt to their wheel chair also noted to have dried debris.

Inspector spoke with the DOC #S-108 who stated that the home does have procedures in place to ensure that the wheel chairs are not left soiled and that the night shift is responsible for this. Inspector #542 noted that on the schedule, resident #005 was to have their wheel chair cleaned on a particular day each week.

Inspector #542 observed resident #007 and resident #008's to be soiled with unknown dried substances during this inspection. [s. 87. (2) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1) (b).

Inspector #597 interviewed #S-122 on April 21, 2015, regarding acquisition of medication in the home. #S-122 reported that some medications are not provided by the pharmacy service or the Government of Ontario, but provided by families.

There were four medications ordered for resident #025.

#S-122 confirmed that these medications were provided by the family of resident #025 and showed the inspector where they were located in the medication cart.

There was one medication ordered for resident #028.

#S-122 confirmed that this medication was provided by the family of resident #028 and showed the inspector where it was located in the medication cart. [s. 122. (1)]

Issued on this 29th day of June, 2015

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

Original report signed by the inspector.