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
Nov 9, 2015	2015_288549_0029	O-002663-15	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 WEST END VILLA
2179 ELMIRA DRIVE OTTAWA ON K2C 3S1

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

RENA BOWEN (549), AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), LINDA HARKINS (126)

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): October 19, 20, 21, 22, 23, 26, 27, 28, 29 and 30, 2015

The following logs were also completed during the Resident Quality Inspection:O-002310-15, O-002397-15, O-002488-15, O-002536-15, O-002819-15, O-002900-15, O-002926-15 and O-002950-15.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, the Vice President of Residents Council, the Secretary of the Family Council, Personal Support Workers (PSW), Dietary Aides (DA), the Resident Assessment Instrument(RAI) Coordinator, a Coder, Food Service Workers (FSW), the Nutritional Manager (NM), the Registered Dietitian (RD), the Food Services Supervisor(FSS), the Behaviour Support Outreach Personal Support Worker (BSO), Housekeeping Aides, the Infection Prevention and Control Lead, the Wound Care Nurse, the Restorative Care Manager, the Physio Therapist (PT), Registered Practical Nurses (RPN), Registered Nurses (RN), the Staffing Clerk, the Nursing Clerk, the Support Services Manager (SSM), a Maintenance Worker, the Director of Care (DOC), the Assistant Director of Care (ADOC)and the Administrator (ADM).

In addition the Inspector(s) completed a tour of the home, reviewed resident health care records, family and resident council meeting minutes, several of the home's policies and procedures,observed medication administration, meal service, resident care and staff/resident interaction.

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
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

- **9 WN(s)**
- **5 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).

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

The most recent Minimum Data Set (MDS) Assessment completed for Resident #029 indicates that the resident requires assistance with activities of daily living including hygiene. In addition the resident rarely understands and rarely is understood due to the advancement of disease and confusion. PSW staff involved in the resident's care,

indicated that the resident requires strategies such as yes and no questions and simple instructions when speaking with the resident. Staff also confirmed the resident's inability to perform activities related to oral care and hygiene and that staff assistance is required. A PSW staff member familiar with the resident's care noted that when she is on shift she provides the resident with specific mouth care in the morning, she is not sure what other staff may provide.

A review of the resident's current written plan of care indicates that there is no item pertaining to the resident's communication deficiencies, despite the MDS assessment which indicated the item required care planning. In addition, while the written plan of care indicated the resident requires assistance with hygiene, the plan of care did not include any of the planned care to be provided to the resident as it relates to oral care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the written plan of care for Resident #049 sets out the planned care for the resident.

On a specific day in October, Inspector #573 observed Resident #049 in his/her room and a meal tray was placed next to the resident's bed with 75% of the meal untouched. PSW S#103 came to resident and asked if the resident was finished with the meal, the resident replied yes and the PSW S#103 took the remaining meal back to the kitchen.

The inspector spoke with PSW S#103 who indicated that Resident #049 could feed himself/herself and does not require any assistance from staff for feeding. PSW S#103 also indicated that she will monitor the resident in-between meals. Further PSW S#103 indicated to the inspector that it has been a specific length of time since Resident #049 started receiving meals by tray service in the resident room for a specific reason.

On October 29, 2015 during an interview Charge RN S#100 indicated to the inspector that Resident #049 does not require any assistance from staff for feeding. Further RN S#100 stated to the inspector that she was unaware that the resident is getting tray service for meals in his/her room for a specific reason.

Inspector #573 reviewed Resident #049's written plan of care which identifies that the resident requires assistance from staff for eating due dementia. The plan of care indicates staff are to ensure that the resident is in the dining room for all meals. It directs staff to set up the resident with the meals in the feeding table, to monitor and encourage the resident to be as independent as possible with eating. Further the plan of care directs

staff to assist the resident to complete meals.

On October 29, 2015 Inspector #573 reviewed Resident #049's written plan of care with the ADOC who confirmed that the written plan of care does not have any information regarding the resident receiving tray services in resident room for a specific reason and further concurred with Inspector #573 that the written plan of care for Resident #049 does not set out the planned care for the resident.(Log O-002397-15) [s. 6. (1) (a)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Resident #022.

Resident #022 was admitted to the home on a specific date in 2012. Resident # 022 was observed to have significant weight loss between January 2015 and October 2015. Resident # 022 is presently on a specific diet.

On a specific date in 2015, Resident #022 was assessed by a Speech Language Pathologist (SLP) for a swallowing assessment. As per the progress note documented by the SLP on a specific date in July 2015, Resident #022 was at a high risk of choking and aspiration and recommended that the resident be Nothing Per Os(NPO). At that time, the resident's daughter was aware of the risks but wished to continue feeding orally using safe swallowing strategies. Resident #022 is being fed on a daily basis, by the daughter, 3 meals a day that takes a specific period of time per meal, seven days a week. The daughter gives a specific syrup to Resident #022 after meals if required for throat irritation.

Resident # 022 care plan dated a specific date in July, 2015 and printed on a specific date in September 2015 was reviewed. The documentation in the plan of care under section Activity of Daily Living(ADL) indicates that for eating, Resident # 022 was to be fed by staff and his/her daughter and that fluids was to be given in a specific type of cup. In several interviews held between October 20 and 23, 2015 with the resident's daughter, RPN #119, the Registered Dietitian and several PSWs, they indicated that the only person allowed to feed and give medication to Resident # 022 is the daughter. Also, the daughter indicated she no longer uses the specific cup for Resident # 022.

The written plan of care does not provide clear direction to the staff and others related to the nutritional care needs and medication administration for Resident # 022. [s. 6. (1) (c)]

4. The licensee failed to ensure that the staff and others involved in the different aspects

of care of the resident collaborate with each other, 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.

Resident #50 was admitted to the home on a specific date in September 2015, with recent history of seizure activity. On admission the resident was ordered a specific anticonvulsant medication twice a day. Medication Administration Records indicate that from September 11 to September 14, 2015, the anticonvulsant medication was not available for administration. On a specific date in September 2015, the resident was sent out to hospital for assessment due to seizure activity. The resident's substitute decision maker (SDM) reported concerns with the administration of the anticonvulsant medication while at West End Villa.

A review of the health care record indicates that on a specific date in September 2015, RN #126 contacted pharmacy and the physician with concerns that the anticonvulsant medication had not been provided to the resident. RN #126 spoke with the on-call physician who informed the RN that missed administration of the medication today would be acceptable and to call the attending physician tomorrow. On a specific date in September 2015, RPN #127 spoke with the attending physician who ordered a different anticonvulsant, no change was made to the order for the original anticonvulsant medication. The order for the different anticonvulsant was processed late day on a specific date in September 2015, after pharmacy closing; therefore, the different anticonvulsant was sent to the home a day later.

The home's investigation related to the availability of the original anticonvulsant for Resident #50, indicated that on a specific date in September 2015, the resident's SDM was informed by the pharmacy provider of three medications that required payment from the SDM, including the original anticonvulsant. At no time did the pharmacy receive confirmation that payment was to be provided for the original anticonvulsant, therefore, the medication was not made available to the home for administration.

As demonstrated, staff and others did not collaborate with each other to ensure the implementation of the plan of care as it relates to the administration of medications is integrated. (Log O-002819-15) [s. 6. (4) (b)]

5. The licensee has failed to ensure that the resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or substituted decision-maker are given an opportunity to participate fully in the development and

implementation of the resident's plan of care.

On a specific date in September 2015, Resident #045 was ordered a liquid supplement by the home's Registered Dietitian. The SDM for Resident #045 reported to Inspector #148, that he/she was visiting the resident on a weekend in October and observed the resident receiving the liquid supplement. The SDM inquired as to what the supplement was and why the resident was receiving it. The SDM indicated that at no time prior to this was he/she informed of the new supplement.

An interview with the home's Registered Dietitian and discussions with Resident #045's SDM, demonstrated that the SDM was not given an opportunity to participate in the development and implementation of the resident's plan of care as it relates to the identified nutritional supplement. (Log O-002900-15) [s. 6. (5)]

6. The licensee has failed to ensure that the plan of care is revised when the care set out in the plan is no longer necessary.

Resident #031 is cognitively impaired and requires total assistance with activities of daily living. The home assessed the resident to be at a high risk for falls.

Inspector #549 reviewed Resident #031's current written plan of care, last updated on a specific date in June 2015. The written plan of care indicated that the resident wears a seat belt, when up in wheel chair and has a table top on while in wheel chair, bed in lowest position and mat on floor at bedtime related to poor balance, unaware of limitations due to dementia.

A review of Resident's #031's health care file indicated that the resident's physician discontinued the order for a table top while in wheel chair on a specific date in June 2015. The POA's consent for the table top was withdrawn on a specific date in June 2015 as per the documentation on the original consent.

Resident #031 was observed by Inspector #549 on October 19, 20, 21 and 26, 2015 to be in a wheelchair with a front closure seat belt on with no table top.

PSW #103 who regularly provides care to Resident #031 indicated to the inspector during an interview that the resident does not have a table top on while up in a wheel chair. PSW #103 indicated the resident does have a front closure seat belt which the resident can undo when up in a wheel chair.

RPN #101 confirmed with the inspector that Resident #031 no longer requires a table top and does not have a table top on when up in a wheelchair and there is no physician's order or POA consent for a table top.

RN#100 confirmed with Inspector #549 that the plan of care was not revised to reflect that the table top is no longer necessary for the care of Resident #031. [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 there is a written plan of care for each resident that sets out the planned care for the resident, that the planned care sets out clear direction to staff and others who provide direct care to the resident, that staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated, that the resident's SDM be given the opportunity to participate fully in the development and implementation of the resident's plan of care and that the plan of care be revised when the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure the home, furnishings, and equipment is kept clean and sanitary.

During the resident observation, Inspectors observed several unclean resident mobility equipment.

On October 20, 2015 Inspector #148 observed that Resident #002's wheelchair was unclean, with several drip marks running down the side of the wheel chair cushion and metal parts at the side of the wheelchair. There is also unidentified debris and stains on the frame of the wheel chair and padding of the leg rest behind the foot petals.

On October 20, 2015 Inspector #549 observed that Resident #025's wheelchair frame, seat and sides of seat was covered with dried debris. On October 21, 2015 Inspector #549 also observed that Resident #031's wheelchair is unclean with dried debris and white stains on the wheel chair frame and seat cushion.

On October 26, 2015 Inspector #573 observed that Resident #025 and Resident #031's wheelchair frames under the seat and side of the brakes had a heavy accumulation of dirt and debris. Resident #031's wheelchair was soiled with unidentified debris and stains on the wheelchair seat frame, cushion, wheel guards and wheels. Inspector #573 also observed that Resident #043 and Resident #044's wheelchair frames, cushions, lap belts and wheels were heavily soiled with dark brown color stains and debris resembling old dried food.

Inspector #573 spoke with the Infection Control Lead #118 who is in charge of monthly audits for the cleaning of resident mobility equipment who indicated that every resident's mobility equipment cleaning is done on a monthly basis by the night PSWs. Infection Control Lead #118 also indicated that resident wheelchairs and walkers are to be spot cleaned by the PSWs whenever they were observed to be unclean.

On October 26, 2015 Inspector #573 observed the identified three wheelchairs for Residents #031, #043 and #044 in the presence of the Infection Control Lead #118 who confirmed with the inspector that the unidentified stains and dried debris on the wheelchairs was very obvious that the wheel chairs are not kept clean and sanitary. [s. 15. (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 to ensure that resident mobility equipment is kept clean and sanitary, to be implemented voluntarily.

WN #3: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that Resident #048's plan of care included an interdisciplinary assessment of safety risks.

A review of a Critical Incident Report indicated that Resident #048 was picked up at the home by Para Transpo on a specific date in July 2015 to go to a physician's appointment at a specific clinic at a specific hospital. The resident left the home unescorted with Para Transpo. The Critical Incident Report also indicated that the Charge RN #128 called the clinic at the hospital to confirm Resident #048's appointment. The Charge RN #128 made arrangements with the clinic to have a porter meet the resident at the information desk and remain with the resident until Para Transpo returned to pick the resident up. The resident was received at the clinic; however, the appointment was cancelled as the resident was not cooperative. The porter did not stay with the resident and when Para Transpo arrive to pick the resident up to return the resident to the Long Term Care home, the driver refused to bring the resident back to the home because the resident was not accompanied. This meant that the resident was on his/her own wandering in the hospital. The home contacted the security at the hospital; the resident was with the security guard. The Long Term Care home sent a PSW in a taxi to bring the resident back. The resident arrived back at the home; he/she was assessed and found to have no injuries.

Resident #048 was admitted to a specific unit of the home on a specific date in May

2013. A review of the Minimum Data Set (MDS) Assessment dated a specific date in June 2015 indicated the following; the resident's cognitive skills for daily decision – making was moderately impaired- decisions poor, cues or supervision required. Wandering (moved with no rational purpose, seemingly oblivious to needs or safety), behaviour of this type occurred daily. Resists Care (resisted taking medications/ injections, ADL assistance, or eating), behaviour of this type occurred daily.

Inspector #549 reviewed Resident #048's plan of care dated a specific date in June 2015. The plan of care indicated the following; Locomotion on/off unit: resident now ambulates with walker. Monitor for falls.

During an interview with RPN#118 on October 30, 2015, it was indicated to Inspector #549 that all residents on this specific unit are to be signed out by a responsible party when leaving home.

A review of Resident #048's sign out sheet for a specific date in July 2015 indicated that the resident was not signed out by a responsible party when he/she left the home to attend an appointment at the clinic.

The Administrator indicated to Inspector #549 that the home's expectation is that all residents on this specific unit will be accompanied by a responsible party when leaving the home and this safety risk assessment should be included in the plan of care.

On October 30, 2015 during an interview with the Administrator and the ADOC it was confirmed with Inspector #549 that Resident #048's plan of care did not include the interdisciplinary assessment of the safety risk of Resident #048 leaving the home unattended by a responsible party (Log O-002536-15) [s. 26. (3) 19.]

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 Resident #048's plan of care includes an interdisciplinary assessment of safety risks related to leaving the home unescorted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any:
• within six weeks of the admission of the resident, and
• at least annually after that?
(b) the resident, their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and
(c) a record is kept of the date, the participants, and the results of the conferences?

Resident #048 was admitted to the home on a specific date in May 2013.

A review of the resident's health care file by Inspector #549 on October 28, 2015 indicated that an admission interdisciplinary care conference was held on a specific date in July 2013 with the resident's POA present.

Inspector #549 interviewed RN #100 who also reviewed Resident #048's health care file and was not able to locate documentation indicating that the resident or the POA was invited to participate in an annual interdisciplinary care conference or the record that included the participants and the results of the care conference.

RPN Nursing Clerk #122 was not able to locate documentation indicating that the resident or the POA was invited to participate in an annual interdisciplinary care conference or a record of the care conferences for the year 2014 or 2015.

On October 30, 2015 during an interview the Administrator confirmed that an annual interdisciplinary care conference for Resident #048 was not held and that the resident or the POA was not invited to participate in 2014 or 2015.(Log O-002536-15) [s. 27. (1)]

2. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

Resident #045 was admitted to the home in March 2015. Upon discussion with Inspector #148, the resident's substitute decision-maker (SDM) indicated that no care conference was held with the home within six weeks following the resident's admission. On a specific date in September 2015, after request by the resident's SDM, a meeting was held in September with the family and RPN. A review of the health care record and interviews with the home's ADOC and a nursing clerk confirmed that no care conference of the interdisciplinary team was completed for this resident and SDM within six weeks following admission.(Log O-002900-15) [s. 27. (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 to ensure that a care conference of the interdisciplinary team is held within six weeks of the admission of the resident, and at least annually after that. The resident , their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and a record is kept of the date, the participants, and the results of the conferences, to be implemented voluntarily.

WN #5: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Resident bathroom, shared by specific residents on the fifth floor, was observed by Inspector #148 on October 20, 21, 22 and 23, 2015, at various times of day to have a lingering odour of urine. During the observations the room appeared clean with no visible source of the odour.

On October 23, 2015, Inspector #148 spoke with two PSW staff members regarding the odours in this bathroom. It was reported that the odours are known to exist and that it is primarily related to the toileting needs of Resident #042 and the resident's refusal to wear incontinence products or to request/accept assistance from staff for toileting. The Housekeeping aide providing services to this floor was not aware of any odour issues in this bathroom and had not planned to clean any resident rooms on that specific wing, as that wing was completed yesterday.

Resident bathroom, shared by specific rooms on the fourth floor, was observed by Inspector #126 on October 21 and by Inspector #148 on October 22 and 23, 2015, at various times of day to have a lingering odour of urine. During the observation of October 23, 2015, the bathroom garbage was overflowing with paper towel and toilet paper that was visibly wet. When asked by Inspector #148, Resident #018 who also resides in this room, reported that the bathroom often smells of urine.

On October 23, 2015, Inspector #148 spoke to the regular day shift Housekeeping aide for this floor, who reported that the odours in this room are known to exist and are primarily related to the behaviours of Resident #017 associated with toileting; for this reason it is difficult to manage the odours in the bathroom. She further explained that resident rooms and bathrooms are scheduled to be cleaned every other day but that when she is on shift she will clean this bathroom everyday and usually check the room

prior to leaving for the day to help control cleanliness and odours.

On October 23, 2015, Inspector #148 and the home's Support Services Manager toured both identified bathrooms. The Support Services Manager has been with the home for six weeks and was not aware of any odour issues in the identified bathrooms. He indicated that an investigation would be done into the odours as per the home's policy related to odours, to identify the cause and source of the odours. If a deep clean or deodorizing products are required the Janitor in the home would apply.

The home's policy, as provided by the Support Services Manager, titled Dealing with Persistent odours (#HL-05-03-08) indicates that all staff will immediately report any unacceptable lingering odours to the Support Services Manager whereby a investigation will be conducted to identify and eliminate the source of the odour; if the odour is not eliminated, the investigation is to be repeated.

On October 23, 2015 Inspector #148 observed the bathroom of specific rooms on the fourth floor to be provided a deep clean and product application by the home's Janitor. Upon observation on October 26, 2015, Inspector #148 noted that the odour of urine remained.

As of October 22, 2015, the policy related to incidents of lingering offensive odours was not implemented for addressing the lingering odours in bathrooms on the fourth floor and fifth floor, whereby staff had not reported the lingering odour and an investigation had not been completed. As confirmed by observations of October 26, 2015, the lingering odours remain. [s. 87. (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 to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

In accordance with section 31 of the Act, a resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care. Such restraining may be included in the plan of care only if there is significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.

On October 22, 2015, Inspector #148 observed Resident #041 to be seated in a wheelchair being brought to the dining room by PSW Staff #103. Inspector observed that a lap belt was laying across the resident thighs but did not appear to be latched. On closer observation, in the presence of Staff #103, it was determined that the lap belt was in disrepair and that Staff #103 had intended to apply the lap belt but that it has been in disrepair since at least a specific date in October 2015, when she first reported it to registered nursing staff. Moments later the Restorative Care Manager was on the floor with a vendor who was in the dining room and replacing the lap belt. The Manager

indicated that she was made aware that the belt needed replacement on a specific date in October 2015; she was not aware of what purpose the belt served for the resident. Inspector #148 observed the resident, after the vendor had left the floor, the lap belt had been replaced and was applied. The resident could not understand instructions to release the belt. Upon speaking further with Staff #103 she indicated that she is not sure why the belt is applied, only that it is "there" and so she applies it. Inspector #148 reviewed the health care record and spoke to RN #100, it was determined that the lap belt was being used as a physical device to restrain the resident not in accordance with section 31 or 36 of the Act. The RN proceeded to release the belt and communicated to Staff #103 that it was not to be applied.

On the morning of October 26, 2015, Inspector #148 observed Resident #041 to be seated in a wheelchair in the hallway with the lap belt applied. Inspector #148 spoke with the PSW staff member who provided care that morning, she confirmed that she had applied the belt. She indicated that the belt is available for use and therefore applied the belt noting that the resident has had several falls out of bed. Inspector #148 spoke with RN #100 who was not sure why the belt was applied and suggested the Inspector speak with the PT. The PT arrived to discuss the belt with the Inspector. He reported that the belt should not be applied to this resident, as there is no indication for it to be applied. The PT released the belt and clipped the belt at the back of the wheelchair.

Resident #041 was observed on two separate occasions to be restrained by the use of a physical device, other than in accordance with section 31 or 36 of the Act. [s. 30. (1) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the weight monitoring system measures and records with respect to each resident the height upon admission and annually thereafter.

During health care record reviews conducted during Stage 1 activities, it was noted by the inspection team that resident heights were recorded near a resident's admission to the home but were not completed on an annual basis. A review of the forty randomly selected residents, demonstrated that twenty-four did not have a height measure within the last year, with five resident's last measured in 2002-2010 and eleven last measured in 2012-2013.

Inspector #148 spoke with two PSW staff members, an RPN and an RN, all of whom identified themselves as regular staff members in the home. Staff reported that resident height is measured on admission but not conducted annually thereafter. [s. 68. (2) (e) (ii)]

WN #8: 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 are offered and available at each meal and snack.

The lunch meal service was observed on the fifth floor on October 19, 2015. The planned puree menu was hamburger on a bun with red and green peppers or chicken asiago Caesar salad and roll. Inspector #148 asked the FSW serving the food items to identify the items available for those resident's on the puree texture modification. The FSW identified there to be puree beef, puree carrots and puree bread. Upon questioning the FSW indicated that there is no second choice of entrée or vegetable for resident's requiring puree texture. After observing the first of the meal service, the Inspector asked for clarification on the items available as a fourth item was being served on the puree plates. At this time the FSW indicated that a white puree food item in the hot cart was identified as potato and being placed on the puree plate with gravy. Choice of entrée or vegetable was not observed to be offered to residents on a puree texture modification.

The lunch meal service was observed on the fourth floor, October 20, 2015. The planned puree menu was egg salad on croissant with puree carrot salad or beef lasagna and Italian mixed vegetable. Inspector #148 asked the FSW serving the food items to identify the items available for those resident's on the puree texture modification. The FSW identified there to be puree beef and puree Italian vegetables. The FSW had difficulty in identifying the puree items and referred to the planned menu to assist. Upon questioning the FSW indicated that there is no second choice of entrée or vegetable. Choice of entrée or vegetable was not observed to be offered to residents on a puree texture modification.

The planned menu items were not offered and/or available at each meal on October 19 and 20, 2015, for resident's on a puree texture modification; impacting on the provision of choice of puree entrée and vegetable. [s. 71. (4)]

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 a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response that complies with paragraph 3, is provided within 10 business days of the receipt of the complaint.

On a specific date in September 2015, the substitute decision maker (SDM) for Resident #045 sent a written complaint to the home's Administrator, DOC and ADOC. The complaint described concerns with the care of Resident #045 including physiotherapy services and notification of health changes. In addition, the complaint included concerns with the operation of the home as it relates to the provision of a care conference. The home's Administrator responded on a specific date in September 2015, to indicate that the home's ADOC would initiate an investigation into the concerns and a response would be provided the following day on the initial investigation.

Inspector #148 spoke with the SDM for Resident #045 and the home's ADOC on October 28, 2015, both confirming that the response on a specific date in September 2015, was the only response provided to the SDM. As of October 28, 2015, a response had not been provided to the SDM indicating what the licensee had done to resolve the complaints or that the licensee believes the complaints to be unfounded and the reasons for the belief. (Log O-002900-15) [s. 101. (1) 1.]

Issued on this 10th day of November, 2015

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

Original report signed by the inspector.