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

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2014	2014_226192_0010	L-000284-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

FOREST HEIGHTS
60 WESTHEIGHTS DRIVE, KITCHENER, ON, N2N-2A8

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

DEBORA SAVILLE (192), MELANIE NORTHEY (563), RUTH HILDEBRAND (128), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 17, 18, 19, 20, 21, 25, 26, 27 and 31, 2014

Follow-up on Compliance Order #001 related to inspection 2013_303563_0011 which identified that the home had failed to comply with their policies related to Power Mobility Devices and Alcohol, was completed by inspector #563 during the course of this inspection.

During the course of the inspection, the inspector(s) spoke with The Executive Director, Director of Care, Assistant Directors of Care, Resident Services Coordinator, Regional Manager of Clinical Services Region 1, Program Manager, Food Services Manager, Environmental Manager, Dietary Aides, Personal Support Workers, Registered Nurses, Registered Practical Nurses, Housekeeping Aides, Cook, Registered Dietitian, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedure, observed recreational programing, staff interaction with residents and general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
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
Quality Improvement
Residents' Council
Safe and Secure Home
Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #557 was incontinent. The Minimum Data Set (MDS) assessment indicated a decline in the resident's continence during the specified time period.

There is no evidence of a Continence Assessment in the resident's medical record.

Interview with the Assistant Director of Care(ADOC)/ Resident Assessment Instrument (RAI) Coordinator in 2014 confirmed that no formal continence assessment had been completed for resident #557.

Interview with a Registered Practical Nurse (RPN) confirmed that she was not aware of a separate continence assessment that was done for resident #557 or any resident of the home, other than the voiding diary kept on Point of Care by the Personal Support Workers (PSWs).

Interview with another Assistant Director of Care (ADOC)/ Continence Team Lead confirmed that there had not been a Continence Assessment done for resident #557 and that the home did not have a Continence Assessment used to assess any resident of the home who is incontinent.

The Policy, #LTC-E-50, dated as reviewed on May 2013 titled "Continence Care" stated that a 3 day Continence Assessment is to be initiated on admission and/or if there is a change in level of continence. This Continence Assessment was not completed when resident #557 had a decline in continence identified in a 2014 MDS assessment.

The licensee failed to ensure that resident #557 and other residents of the home who are incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:
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 failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and are locked when they are not being supervised by staff.

During the initial home tour on March 17, 2014 it was identified that a dirty utility room on the second floor was unlocked. There were no staff near this area at the time of observation supervising this unlocked door.

The door was designed to lock when left to close on its own but this feature was not working. The Inspector closed the door, which then locked, to restrict unsupervised access to residents.

The Licensee failed to ensure that all doors leading to non-residential areas, the dirty utility room on the second floor, are equipped with locks to restrict unsupervised access to those areas by residents, and are locked when they are not being supervised by staff. [s. 9. (1) 2.]

2. During observations on March 25, 2014 at 1030 hours by Inspector #192 it was identified that the dirty utility room on the second floor was unlocked and not latched closed. It was noted at the time that there were chemicals in the room at resident height, at the edge of the hopper. There was a spray bottle of disinfectant labeled

"PCS Oxidizing Disinfectant" and two large bottles with a dispenser lid labeled "Virucide PCS Oxidizing Disinfectant". At the time the door was not being supervised by staff.

Inspector #192 spoke with the Housekeeping Aide who then wrote it in the Maintenance book in the nurses station. Inspector #192 ensured the door was then locked.

The unlocked room provided unsupervised access to residents and exposure to chemicals in the room.

B. During observations on March 26, 2014 at 1030 hours by Inspector #519 it was discovered that the dirty utility room and the clean utility room in the same hall on the second floor, were unlocked and not latched closed. Electrical cords were accessible in the clean utility room to the left side of the door at resident height, even if the resident would be in a wheelchair. A Personal Support Worker was approached and cautioned to make sure the doors are pulled closed after every entry to the rooms. The doors were pulled closed and locked by Inspector #519.

The unlocked door provided unsupervised access to residents and exposure to electrical wires in the room.

The Licensee failed to ensure that the dirty utility and the clean utility room on the second floor are equipped with locks to restrict unsupervised access to those areas by residents, and are locked when they are not being supervised by staff. [s. 9. (1) 2.]

3. During an interview with the Environmental Service Manager in 2014 it was confirmed that doors on both the dirty utility room and the clean utility room were repaired and were self locking when closed.

During observations March 31, 2014 at 1030 hours it was noted by Inspector #519 that the clean utility room was gaping open with electrical cords visible and at resident height just inside the open door. There were no staff present supervising the open door. The clean utility room door would not self close and lock when attempted by Inspector #519. The door was then pulled closed to ensure resident safety. Inspector #519 immediately contacted the Environmental Service Manager.

The Licensee failed to ensure that the clean utility room door on second floor was

equipped with locks to restrict unsupervised access to the clean utility room by residents, and were locked when not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident is offered a minimum of, three meals daily.

During first sitting lunch meal service, on March 20, 2014, it was observed that 10 of 50 Residents (20%), were not present in the dining room.

A Registered Nursing staff member confirmed that the ten residents were cognitively impaired.

A Dietary aide confirmed that only one meal tray was prepared at the lunch meal but the Dietary Aide was unsure who the tray was prepared for.

A Personal Support Worker was able to confirm, to Inspector #128, that the meal tray was delivered to resident #1000.

Inspector #128 queried two Registered Staff about residents who were not in the dining room and they indicated that they had been informed that all residents had been provided lunch.

Two dietary Aides confirmed that one tray was prepared for the residents not in the dining room. They confirmed that nine of ten residents (90%) were not offered a lunch meal by way of a tray.

Four Personal Support Workers queried in regard to residents being offered a lunch meal indicated that they had not taken any trays to residents.

One Personal Support Worker indicated that trays had been taken to two residents after Ministry of Health and Long Term Care (MOHLTC) intervention/questions.

Another Personal Support Worker stated that trays were taken to two additional Residents.

A Dietary Aide confirmed that a total of two trays were provided after MOHLTC intervention.

A registered nursing staff member indicated that the expectation is that a full meal tray is taken to all cognitively impaired residents not eating in the dining room and that they are offered choice by use of "show plates". It was also established that the expectation is that a requisition is filled out for every tray that is made.

Three Dietary Aides confirmed that there were two tray requisitions filled out. When Inspector #128, queried two Registered Nursing staff, at 1430 hours about action that would be taken in regard to residents who had missed lunch, they indicated that snack would be served soon.

At 1436 hours, Inspector #165 observed resident #1001 sitting in the second floor dining room. When questioned, the cognitively impaired resident indicated that they had not eaten and were waiting for lunch.

The Director of Care stated the expectation is that every resident is fed and that cognitively impaired residents who are not in the dining room are offered a meal via a tray, unless indicated otherwise in their plan of care.

On March 20, 2014, seven cognitively impaired residents were not in the second floor dining room for first sitting and they did not receive a meal via a tray. [s. 71. (3) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act includes, hand hygiene, modes of infection transmission, cleaning and disinfection practices and use of personal protective equipment.

A) In 2013, training in infection prevention and control was completed by 50 of 270 (19%) staff in the home.

The Assistant Director of Care responsible for Infection Prevention and Control confirmed that their was a gap in providing the education and training for all staff related to infection prevention and control.

B) The staff of the home demonstrated a lack of knowledge of the current system for communication of residents with Antibiotic Resistant Organisms which can be contagious within a vulnerable population such as the residents of a Long Term Care Home.

The Assistant Director of Care (ADOC) responsible for Infection Prevention and Control indicated that if a resident had an Antibiotic Resistant Organism (ARO) a sign would be posted and personal protective equipment (PPE) would be available.

Six of seven Personal Support Workers (PSW) interviewed on March 31, 2014, on all care areas of the home identified that they may have residents with ARO's but they were not sure. They believed that if a resident had an ARO the registered staff would notify them and a sign would be posted.

One PSW on the third floor was specifically asked what the specified sign would mean. The staff member indicated they did not know what it meant, indicating that maybe someone has a cough, nothing dangerous. The staff member then indicated that they did not have the identified area as part of their assignment but had other areas. One of these areas also had a sign that the PSW was not aware of. (192)

C) On March 31, 2014 a Housekeeping Aide was interviewed to determine who was responsible for the cleaning of hand sanitizer containers located in front of the elevator on the third floor. The staff member indicated she was not responsible and was unaware of the person who was responsible or what process would be used to clean the hand sanitizer dispensing system.(192)

D) On March 17, 2014 observation of the noon meal service by inspectors #128, #192 and #519 identified that in two of three home areas, staff of the home did not complete hand hygiene after handling dirty dishes or before serving food to residents. (192)

E) Record review of two of three residents included on the specified 2013 line listing identified that staff continued to bring residents #607 and #1201 to common areas where they would be in close proximity to other at risk residents, after they had documented signs and symptoms of respiratory infections. (192) [s. 219. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure a written record of the annual Infection Prevention and Control program evaluation was kept that included the following: the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented.

Record review and interview with the Assistant Director of Care (ADOC) responsible for Infection Control in the home confirmed that there is no written record of the annual Infection Prevention and Control program evaluation conducted when she assumed responsibility for the infection control program approximately one year ago. [s. 229. (2) (e)]

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

Infection control risks were observed, March 18 and 19, 2014, in shared resident rooms/washrooms, including unlabeled personal care items and improperly stored items:

A. An unlabeled urine collection hat on the back of the toilet in the shared washroom in a specified room;
An unlabeled white hair brush containing hair on the shared bathroom counter in a specified room;

B. Two unlabeled black hair brushes with hair in them sitting on the back of the toilet in a blue personal care caddy in the shared washroom of a specified room;

C. Two unlabeled urinals in a specified room - one was hanging on the night stand of resident #694 and the other which was full of urine was between the bed and night stand of the same resident;

D. Three unlabeled wash basins in the shared washroom of a specified room - one was hanging on the back of the toilet and two were on the floor. An unlabeled urinal and a unlabeled urinary drainage bag were also observed inside the wash basins on the floor.

E) Infection Control risks were also observed related to two Personal Support Workers (PSW) observed, during the first sitting of lunch meal service on March 17 and March 20, 2014. They were touching residents and wheelchairs; removing dirty cups, glasses, soup bowls from tables and then serving tea/coffee and provided assistance with eating to residents with no evidence of hand hygiene in-between touching clean and dirty items. [s. 229. (4)]

3. The Licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

During lunch dining observation on March 17, 2014 at 1200 hours, it was observed that four Personal Support Workers in the dining room did not wash their hands between delivering resident food trays and clearing dirty dishes between courses. It was observed that only one Dietary Aide washed their hands with hand sanitizer while delivering desserts to residents.

The Licensee failed to ensure that the staff serving lunch on March 17, 2014 at 1200 hours participated in the implementation of the infection prevention and control program. [s. 229. (4)]

4. The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interview with the Assistant Director of Care (ADOC) and policy review indicated that

staff are to record symptoms of infection in residents on the daily line listing and take immediate action as required.

Record review identified that respiratory symptoms were identified and documented in the progress notes for resident #607 on a specified date in 2013 but were not included on the line listing provided by the ADOC for that time period. The residents respiratory symptoms were not included on the line listing until 18 days after symptoms started.

Record review identified that respiratory symptoms were identified and documented in the progress notes for resident #1201 on specified dates in 2013. Resident #1201 was not included on the line listing provided by the ADOC until four days later.

Record review identified that respiratory symptoms were identified and documented in the progress notes for resident #1202 on a specified date in 2013. Resident #1202 was not included on the line listing provided by the ADOC until 10 days after symptoms of respiratory infection were identified.

Record review identified that on a specified date in 2013, resident #619 developed symptoms of a respiratory infection that were documented in the progress notes. The resident was not added to the line listing until six days later when an antibiotic was ordered by the physician.

Interview with the ADOC responsible for Infection Control confirmed that the line listing is completed predominately by the night shift after an antibiotic is ordered. Signs and symptoms of infection identified by all staff, on all shifts were recorded in the progress note, but had not been added to the line listing.

Staff failed to monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 229. (5) (a)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices, to be implemented voluntarily.

WN #6: 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. During observations on March 17, 2014 it was identified that there were several call bells not functioning.

During the interview with the Environmental Services Manager (ESM) March 25, 2014 at 1100 hours a request for the call bell audit forms were made. These were given to the Inspector on March 26, 2014 at 0900 hours. The call bell audit form was completed for only the month of January 2014 and dated January 29, 2014 for the four home areas (Gieger House, Gibbon House, Clarke House, and Hewson House). There were notations on the audit form relating to several rooms requiring call bell replacements. Included in these replacements was one of the non-functioning call bells found by the Inspectors.

The policy, #ES-75-05, dated as revised January 2, 2012, stated that the ESM or designate is required to inspect the nurse call system on a monthly basis.

During the interview with the Environmental Services Manager (ESM) on March 26, 2014 at 1415 hours it was confirmed that there were no records of monthly call bell audits available to review as audits were completed quarterly.

The Licensee failed to ensure that the call bell policy #ES E-75-05, put in place for monthly nurse call system audits; is complied with. [s. 8. (1)]

2. During observation of the medication room on a specified home area on March 27, 2014 at 1252 hours it was observed that the medication fridge, with resident medication inside, also had a 2 litre container of homogenized milk on the inside door, a package of cigarettes on the top of the inside door, a can of soda, a bottle of Ensure, a bottle of water, and a small styrofoam container of vanilla ice cream. The interior of this medication fridge also had remnants of a previously spilled brown sticky substance that was coating some of the resident`s medication packages.

The policy, number 4.8, dated as revised October 2010 titled Safe Storage of Medications, stated that medications, which require refrigeration, are stored in a refrigerator in the medication room or in a locked box in a refrigerator. The medication refrigerator should NOT contain vaccines, food, or specimens.

The Licensee failed to ensure that the Safe Storage of Medications policy was complied with when food was placed in the medication refrigerator.

During medication room observation on a specified home area on March 27, 2014 at 1252 hours and March 31, 2014 at 1045 hours it was noted that in the stock medication cupboard there was a blue bin with stock medication present as well as a resident's Nitroglycerine spray labeled with the resident name.

Upon interview with a Registered Practical Nurse (RPN) it was confirmed that the resident for whom the Nitroglycerine spray was ordered was no longer a resident of the home.

The policy, #5.8, date of revision October 2010, titled "Medication Disposal" stated that in most cases, Long Term Care Home medications designated for disposal are comprised of expired drugs, drugs with illegible labels, drugs in containers that do not meet the necessary marking requirements, drugs that were held or refused, discontinued drugs, drugs for a deceased resident, or drugs for a discharged resident

that were not sent with the resident.

The Licensee failed to ensure that the Medication Disposal policy was complied with when a discharged resident's medication remained in the medication room. [s. 8. (1)]

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the monthly weight records, on March 25, 2014, revealed 46 Residents did not have a weight recorded for the month of November 2013. Additionally, 21 residents did not have a weight recorded for the month of March 2014.

The Registered Dietitian stated that the expectation was that weights are done by the 7th day of each month and indicated that they aren't always done.

The Nutritional Assessment and Care policy, entitled Weight Management policy #LTC-G-60, revised date August 2012 states "Residents will be weighed and weight documented by the 7th day of each month".

The Director of Care acknowledged there were issues with weights being taken monthly and confirmed that the policy had not been complied with. She agreed that the 21 residents who had not been weighed by March 25, 2014 should have been weighed by the 7th day of the month, to comply with the policy. [s. 8. (1) (a),s. 8. (1) (b)]

4. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The Nutritional Assessment and Care policy, entitled Weight Management policy #LTC-G-60, revised date August 2012 states "Residents will be weighed and weight documented by the 7th day of each month".

During initial record review it was identified that five of fourteen residents reviewed had weights missing for one or more months during the period reviewed.

Resident #596, had no weight recorded for three of four months reviewed.

Resident #642, #698 and #755 had no weight recorded for one of four months

reviewed.

Resident #778 had no weight recorded for two of four months reviewed.

Interview with the Executive Director on March 17, 2014 confirmed that the home has not consistently completed and recorded monthly weights for all residents. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Resident bed systems in the home were evaluated March 26, 2013. Records revealed that 49 beds in the home failed the potential zones for entrapment.

Interviews with the Director of Care, Regional Manager of Clinical Services and the Executive Director confirmed that the home did not have bed system tracking in place to ensure that steps had been taken to ensure that failed bed systems had been corrected as of March 21, 2014.

On March 25, 2014, the Executive Director confirmed that the home had at least 12 bed systems in which steps were not taken to prevent resident entrapment until identified March 21, 2014, by the inspector. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control program included daily monitoring of infection in residents.

Policy review and interview with the Assistant Director of Care (ADOC) identified that registered staff are to maintain a daily line listing, documenting residents with signs and symptoms of infection and notifying the infection control nurse when changes in resident condition occur.

A review of the line listing for a specified month in 2013 for a specified home area identified that resident #607 had one symptom of infection on a specified date in 2013. The resident was entered on the line listing but this was not updated when the resident developed further symptoms. Documentation indicated that resident #607 continued to attend meals in the dining room in spite of the documented signs and symptoms of infection.

Resident #607 was again entered on the line listing on a specified date in 2013. The line listing indicated that at this time the resident had specified signs and symptoms. Record review indicated that the resident had additional signs and symptoms of infection. Record review also indicated that the resident continued to participate in recreational programs and have meals in the communal dining room.

Record review identified that resident #1201 developed respiratory symptoms on specified dates in 2013. The resident was not added to the home area line listing until six days later and did not include all symptoms the resident exhibited.

Record review identified that resident #1202 demonstrated symptoms of a respiratory infection on a specified date in 2013. The line listing does not include resident #1202 until ten days later when treatment was initiated. Documentation in the progress notes identified that resident #1202 continued to go to the dining room for meals in spite of demonstrating signs and symptoms of respiratory infection that may be contagious to others.

The home failed to maintain a daily monitoring system that reflected all residents with signs and symptoms of infection. [s. 86. (2) (a)]

2. Interview with the Assistant Director of Care (ADOC) and policy review indicated that staff are to record symptoms of infection in residents on the daily line listing and take immediate action as required. The ADOC indicated that the home follows the recommendations of the Region of Waterloo Public Health which indicated that where two or more residents meeting the case definition of two or more respiratory symptoms within 48 hours, droplet isolation should be initiated and Public Health consulted.

The licensee failed to identify an Outbreak when residents #607, #1201, and #1202 demonstrated two or more respiratory symptoms on specified dates in the same 48

hour period in 2013. [s. 86. (2) (a)]

3. The licensee failed to ensure that measures are in place to prevent the transmission of infections.

During observation on March 31, 2014 at 1100 hours it was observed that a signage indicated the presence of infection for specified residents.

The Assistant Director of Care (ADOC) responsible for Infection Prevention and Control indicated that if a resident had an Antibiotic Resistant Organism (ARO) a sign would be posted and personal protective equipment (PPE) would be available for staff use. The ADOC also indicated that this was communicated to staff via an memo and staff meetings.

Six of seven Personal Support Workers (PSW) interviewed on all care areas identified that they may have residents with ARO's but they were not sure. If a resident had an ARO the registered staff would notify them and a sign would be posted on the door.

When observed on March 31, 2014 at 1100 hours specified areas did not have PPE available for staff us and the communication used was ineffective in notifying staff of residents with ARO's which could be transmitted to other residents of the home if PPE is not used. [s. 86. (2) (b)]

4. The licensee failed to ensure that measures are in place to prevent the transmission of infections.

Policy review and interview with the Assistant Director of Care (ADOC) identified that registered staff are to maintain a daily line listing, documenting residents with signs and symptoms of infection and notifying the infection control nurse when changes in resident condition occur. Once a resident is identified with signs and symptoms of respiratory infection, registered staff is to implement practices to minimize the spread of infection including isolating residents with symptoms that may be contagious.

A review of the line listing for a specified month in 2013 for the specified home area identified that resident #607 had symptoms of infection. The resident was entered on the line listing but this was not updated when the resident developed further symptoms of infection. Documentation indicated that resident #607 continued to attend meals in the dining room in spite of the documented signs and symptoms of

infection.

Resident #607 was again entered on the line listing in 2013. The line listing indicated that at this time the resident had two signs and symptoms of infection. Record review indicated that the resident had multiple symptoms of infection and also indicated that the resident continued to participate in recreational programs and have meals in the communal dining room.

Record review identified that resident #1202 demonstrated symptoms of a respiratory infection in 2013. The line listing does not include resident #1202 until ten days later, at this time the resident is identified to have additional symptoms of infection. Documentation in the progress notes identified that resident #1202 continued to go to the dining room for meals in spite of demonstrating signs and symptoms of respiratory infection that may be contagious to others. [s. 86. (2) (b)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was not fully respected and promoted.

A) In 2014, resident #809 requested to speak with the Nurse Manager in regards to concerns related to transportation. Interview and a review of the resident's clinical health record revealed that the Nurse Manager's response to the resident was that they were were responsible for finding their own transportation.

B) In 2014, resident #809 and a table mate were upset with staff related to a seating plan change. A review of the resident's clinical health record revealed that the Registered Practical Nurse, told the residents if they were not happy they could leave the table. The resident reported that staff do not have a general respect or caring for residents. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #10: 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 failed to ensure that the home was a safe and secure environment for its residents.

In 2014, two residents were observed unattended in the hairdressing room.

The curling iron was turned on and hot to touch.

The Regional Manager Clinical Services was called to the hairdressing room and acknowledged the potential risk to residents. She indicated the expectation was that residents should not have been left alone and stayed with the residents until the hairdresser returned. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #11: 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. (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 of the long term care home failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A) On two specified dates in 2014 resident #694 was observed with a front facing seat belt applied.

The resident was capable of releasing the seat belt when requested however, was unable to apply the seat belt independently.

The resident reported that the seat belt was always applied when sitting in their wheel chair and that staff had to apply the seat belt.

The RAI Coordinator confirmed that the use of the seat belt was not set out in the planned care for the resident.

B) In 2014, resident #694 was observed laying in bed with two bed rails in the up position.

The Minimum Data Set (MDS) quarterly assessment completed in 2014, for physical functioning indicated that the resident used bed rails for mobility or transfers.

The resident reported that two bed rails were used when in bed for positioning and they did not inhibit the resident.

The RAI Coordinator confirmed that the use of bed rails was not set out in the planned care for the resident.[s. 6. (1) (a)]

2. The Licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

The Plan of Care for Resident #557 on Point Click Care (PCC), stated that this resident will be toileted each morning, before, and after meals, and before bed.

The Personal Support Worker (PSW) binder that has copied Plans of Care for each resident had a Plan of Care for Resident #557 that stated to toilet the resident after meals and ask resident if they need to go every two hours through the day. This Plan of Care was still present in the binder on March 25, 2014.

On interview with a Registered Nurse and a Personal Support Worker it was confirmed that Resident #557 is only toileted after meals; not before and after meals as the current Care Plan indicates. It was confirmed by interview by both staff members that this resident's brief was consistently wet when they were toileted.

The Licensee failed to ensure that Resident #557 had a plan of care that set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. Resident #642 required assistance with their oral care. The plan of care directed staff to rinse mouth with water after each meal and as needed. The Kardex accessible to staff providing care does not provide direction related to the provision of oral care for resident #642.

Interview with resident #642 identified that oral care is not provided by staff of the home.

Interview with a Personal Support Worker (PSW) identified that the resident gargled with the assistance of staff prior to going to bed. A second PSW interviewed stated that resident #642 had their own teeth and was able to do oral care independently.

Review of documentation completed on specified dates identified that the resident had their own teeth, had dentures, does oral care independently, and that oral care was not applicable.

The plan of care and kardex do not provide clear direction related to the oral care required by resident #642. [s. 6. (1) (c)]

4. Resident #694 reported and the plan of care identified that the resident had dentures and some natural teeth however; the plan of care did not provide clear direction for staff that set out the oral care required by the resident or the cleaning of dentures. [s. 6. (1) (c)]

5. The licensee failed to ensure that the plan of care for resident #619 sets out clear directions to staff and others who provide direct care to the resident related to the provision of oral hygiene and the brushing of teeth.

The plan of care for resident #619 indicated that the resident had their own teeth and

that staff were to brush their teeth.

Interview with the resident and substitute decision maker (SDM) indicated that their teeth are not always brushed.

Interview with the Personal Support Worker responsible for care indicated that staff on the evening shift brush the residents teeth using a toothbrush and toothpaste.

Interview with the Personal Support Worker responsible for resident #619's care indicated oral care had been completed by using a sponge and mouthwash. The resident indicated that their teeth had not been cleaned.

The plan of care for resident #619 failed to provide clear direction related to oral care and brushing the residents teeth. [s. 6. (1) (c)]

6. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any any other time when the resident's care needs change.

A) The Minimum Data Set (MDS) assessment indicated that resident #694 was usually continent of bowel and occasionally incontinent of bladder.

The MDS annual assessment indicated that the resident's continence function had changed.

The resident's plan of care indicated the resident was usually continent of both bladder and bowel.

The Resident Assessment Instrument (RAI) Coordinator confirmed that the resident's continence function had changed from in 2013, and that the resident's plan of care was not revised to reflect the change in the resident's care needs. [s. 6. (10) (b)]

7. Resident #732 sustained a change in condition in 2014.

The plan of care for resident #732 indicated that the resident can ambulate in their wheelchair for short distances, used a urinal, was able to wash their face and assist during bathing, and used a sensory device.

Interview with the registered staff, Personal Support Worker and Substitute Decision maker confirm that the resident is dependent for all care. The resident is incontinent of bowel and bladder and uses an incontinence product, is able to move their body in the chair but is no longer able to mobilize in the wheelchair.

Interview with the registered staff confirmed that interventions currently on the plan of care, such as the ability to ask to use the bathroom and mobility in the wheelchair had not been updated in the plan of care with the residents current change in condition.

Interview with the same staff member also identified that the Point of Care Kardex and tasks available to front line staff identified the resident to require turning every two hours related to altered skin integrity which the staff member identified to be healed.

In 2014, the plan of care for resident #732 was updated to include the use of bed rails as a restraint. The plan of care was not updated to include the required hourly monitoring of the resident who is restrained. When the plan of care was reviewed on specified dates in 2014 monitoring the resident while restrained was not included in the plan of care.

Interview with the registered staff confirmed that the plan of care had not been updated to include monitoring of the restrained resident and that the Kardex and Point of Care was not updated.

The Personal Support Worker interviewed identified that information available to front line staff through the Kardex available on Point of Care is often not updated when changes in resident care are identified. [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 ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, provides clear direction to staff and others who provide direct care to the resident and ensuring that residents are reassessed and their plan of care reviewed and revised at least every six months and at any any other time when the resident's care needs change, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings
Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care.

In 2014 the mattress in Resident #750's room was observed to be in poor condition with peeling of the vinyl and sagging where the resident's torso would lay. The mattress smelled of urine.

The mattress was measured by inspectors #165 and #519 and it was determined that the center of the mattress measured 8 cm. This is 2.1 cm less than what is required under the Legislation.

The Licensee failed to ensure that Resident #750 has a firm, comfortable mattress that is least 10.16 centimetres thick. [s. 12. (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 ensuring that the resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

clean and sanitary.

A) Observations in the second floor dining room on March 17, 2014 revealed that equipment including the drinking glasses used by residents were not kept clean and sanitary. Observation identified 12 of 38 (32%) glasses on one tray were cloudy and stained. A Dietary Aide indicated that the glasses come out of the dishwasher in that condition.

The fan to the exterior of the second floor dining room, near the exterior door, was observed to have a build up of dust on it.

The trolley/cart containing the garbage and dirty bus pans had a buildup of debris in the cracks on the top shelf of the cart.

The Food Service Manager stated the expectation was that glasses and equipment were to be clean. She indicated that the home has difficulty keeping glasses de-stained and free from lime build up because of the hard water. She stated that the glasses should have been pulled from circulation and that there are glasses in stock to replace them. [s. 15. (2) (a)]

2. The Licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

During the Initial Home Tour on March 17, 2014 at 1100 hours it was observed that on the Second Floor (Geiger House) there were dirty glasses perched on the handrails in the hallway, on Hewson House there was a dirty bathroom door with scuffs, on the South West Wing the hallway walls were dirty, on the North West Wing the floors were scuffed, the walls were scuffed, the lower wall trim was dirty, and the floors were dirty with spills.

On Gibbon House the South West Wing had dirty floors and the doors to the TV room were scuffed and dirty.

On March 17, 2014 during initial tour areas of observation included a specified room where there was a dirty wheelchair, and a soiled privacy screen, a specified room where there was a strong urine odour in the room, and a specified room where there was a lingering offensive odour in bathroom. The tub room on the third floor had dirty floors and smelled of urine, there was a marked floor around the third floor elevator,

there was dirt on the floor and a build up of dirt around the desk, and the doors to the dining room are marked with spills.

The Licensee has failed to ensure that the home, furnishings and equipment on Geiger House, Hewson House, Gibbon House and common areas are kept clean and sanitary. [s. 15. (2) (a)]

3. During observation of the Geiger House medication room on March 27, 2014 at 1212 hours it was noted that the counters were cluttered and untidy, there were loose ceiling tiles and a dirty sink.

During observation of the Hewson House medication room on March 27, 2014 at 1252 hours it was noted the medication fridge had a brown sticky substance spilled inside, the counters were dirty, and the sink was dirty.

The Licensee failed to ensure the medication rooms on Geiger House and Hewson House are kept clean and sanitary. [s. 15. (2) (a)]

4. The Licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

A) Maintenance concerns including one of the walls being damaged and requiring painting were observed in the second floor dining room, March 17, 2014. The dining room doors were observed to be scraped and had paint chipped off of them.

One of the trolleys/carts used to serve tea/coffee had rust on the pegs between the shelves, staining on the top and one of the shelves was cracked. A Personal Support Worker confirmed these observations.

The Food Services Manager indicated that the stained, rusty damaged cart should have been removed from circulation and replaced.(128)

Observations made during the initial tour of the Home on March 17, 2014 at 1100 hours on second floor North East Wing of Gieger House included: the lower walls in the hallway near the nurses station were scratched, the paint was chipped off of the walls in the hallway.

Observation on Hewson House area near the Nurses Station identified scuffs on the

lower walls, and the hallway handrails was worn. On the South West Wing of Hewson House there was paint chipping off the door, the hallway walls were dirty with paint chipping.

On the North West Wing of Hewson House there was paint chipping off along the hallway walls.

During initial tour observations March 17, 2014 at 1100 hours, on Clarke House on the third floor, the walls by the elevator, the drywall was observed to be damaged. On the North East Wing of Clarke House there was paint chipping along all of the hallways, the utility room door had paint chipping off, and the wood under the handrail was observed to be damaged.

During initial tour observations March 17, 2014 at 1100 hours, on Gibbon House on the third floor, the south west wing had dirty floors and a heat register at the end of the hall that was scuffed.
On the North West Wing of Gibbon House under the "NW" sign there was a large hole in the drywall , the walls were scuffed, and in specified rooms the doors and the trim were scuffed.

During observations on the initial tour of the home in the a resident room there was noticeable wall damage, in a specified room the privacy screen was observed to be coming off the track, and the floor was damaged with a crack down the middle, in a specified room there was wall damage observed, in a specified room the wall in the bathroom has had a drywall repair with no paint applied on the primer, and the door frame to the bathroom has paint chipped off.

During observation in the initial home tour the common areas on third floor such as the tub room were toured. There was construction being done in the corner of the room, the lighting was poor, there was an exposed drain, and there was yellow tape draped over the exposed walls as well as an open ceiling.

The Licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home, furnishing and equipment are kept clean and sanitary and the home, furnishing and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was can be easily seen, accessed and used by residents, staff and visitors at all times.

The bed side call bells/resident-staff communication and response system in specified rooms were observed to be not functioning and had no sound.

The two call bells that were not functioning on March 18, 2014 were noted to be repaired March 19, 2014 and accessible to the residents.

The call bell that was not functioning on March 19, 2014 was noted to be repaired on March 20, 2014 and accessible to the resident. [s. 17. (1) (a)]

2. During room observations on March 17, 2014 it was found that the call bell for resident #797 and for resident #758 were not functional.

This was communicated to the Environmental Services Manager. Call bells were noted to be functional on March 18, 2014.

The Licensee failed to ensure that for resident #797 and Resident #758 the resident-staff communication and response system could be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

3. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

Observation on March 17 and 18, 2014 and interview with the Executive Director March 18, 2014 confirm that the main floor communal resident areas including the dining room, and lounges off the lobby do not have access to the resident-staff communication and response system. (192)

An additional three areas were observed, on March 18, 2014, to not have a resident-staff communication and response system accessible to residents.

A. A Registered Practical Nurse confirmed that there is no call bell in the 2nd floor dining room.

B. The hairdressing room and chapel were noted to have no call bells.

C. The Executive Director acknowledged awareness that there was no call bell in these areas and indicated that the home has put a call bell system update in the capital budget this year and areas that don't have a call bell will be having one installed. She stated that there are phones in each of these areas to mitigate the risk in the interim. [s. 17. (1) (e)]

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 home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions.

A) In 2014, resident #694 was observed in their wheel chair with a front facing seat belt applied. The resident was capable of releasing the seat belt independently on request.

The resident reported that it was in place to prevent falling from the chair and the Resident Assessment Instrument (RAI) Coordinator reported that the seat belt was applied as a resident preference.

The seat belt was applied loosely approximately 4-5 inches from the resident's pelvic crest to the seat belt.

The Registered Nurse (RN) confirmed that the seat belt was applied too loose and should be snug on the resident. The RN was unable to tighten the seat belt any further.

Therapy was contacted by the RN to make adjustments in order for staff to tighten and apply the seat belt in accordance with any manufacturer's instructions. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written description of the nutrition and hydration program that includes its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes.

A. There was no evidence to demonstrate that the home had written policies, procedures and protocols to ensure that each Resident was offered a minimum of, three meals daily.

Six Residents from Geiger House eat their meals in the main dining room.

A Dietary Aide acknowledged, March 20, 2014 that if a Resident does not come to the main dining room for a meal, it is assumed that they have eaten on the floor.

A Registered Nursing staff member indicated the same day that the six Residents that leave the floor for meals have to be able to get themselves to the main dining room and back.

A Personal Support Worker indicated on March 25, 2014 that they only chart on the Residents who are in the dining room and do not notify the floor if a Resident is absent. They indicated that if a resident is not in the main dining room it is assumed that they have eaten on the floor or they have gone out.

During first sitting lunch meal service, on March 20, 2014, on 2nd floor, it was observed that 10 of 50 Residents (20%), from Geiger House were not present in the dining room.

Registered Nursing staff confirmed that the ten Residents were cognitively impaired.

Two dietary Aides confirmed that one tray was prepared for the Residents not in the dining room.

They confirmed that nine of ten Residents (90%) were not offered a lunch meal by way of a tray. MOHLTC intervention was provided. Seven residents did not receive a tray.

The Director of Care confirmed that the home does not have a written policy,

procedure and protocol to ensure that each resident is provided three meals per day.

B. There was no documented evidence to support that there was a written description of the nutrition and hydration program that included its goals and objectives.

On March 26, 2014 at 1049 hours, the Food Service Manager and Registered Dietitian stated that the home had changed its policies and procedures recently but they were not aware of goals and objectives of the nutrition and hydration program [s. 30. (1) 1.]

2. The Licensee failed to ensure that there is a written description of the program of housekeeping; laundry and maintenance services that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

The home's policies and procedures on laundry, housekeeping, and maintenance were obtained on March 25, 2014 and noted to be last reviewed and updated January 2, 2012.

During an interview with the Environmental Services Manager on March 26, 2014 at 1415 hours, it was confirmed that the accommodation services do not have written goals and objectives. [s. 30. (1) 3.]

3. The Licensee failed to ensure that the housekeeping, laundry services and maintenance services for the home are evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's policies and procedures on laundry, housekeeping, and maintenance were obtained on March 25, 2014 and noted to be last reviewed and updated February 2, 2012. During an interview with the Environmental Services Manager on March 26, 2014 at 1415 hours, a request was made for the documentation that would show the program evaluation was completed for housekeeping, laundry, and maintenance annually. It was confirmed during the interview that program evaluations for these areas have not been done. [s. 30. (1) 3.]

4. The licensee Failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the

resident's responses to interventions are documented.

Resident #1200 was identified on the line listing to have developed signs and symptoms of a respiratory infection in 2013.

Record review for resident #1200 identified that there was no documentation of a change in the residents condition prior to the specified date when the physician ordered an antibiotic and diagnosed a lower respiratory tract infection.

Interview with the Assistant Director of Care (DOC) confirmed that signs and symptoms of infection that resident #1200 may have been experiencing were not documented in 2013. [s. 30. (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 there is a written description of the nutrition and hydration program that includes its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes for all organized programs required under section 8-16 of the Act and each of the interdisciplinary programs required under section 48 of the regulation, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #642 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening and or cleaning of dentures.

Resident #642 who is unable to complete oral care independently.

The plan of care for resident #642 indicated that they require assistance with rinsing their mouth after each meal and as needed.

Interview with the resident who is cognitively intact, indicated that the resident requires the assistance of staff to complete oral hygiene and that they do not receive the required assistance.

Interview with a Personal Support Workers responsible for resident #642's care indicated that the resident had their own teeth and was able to complete oral care independently. That the resident didn't require much assistance, would be set up and would be able to complete their own care including oral care.

Review of the Point of Care (POC) documentation for a specified date indicated that the resident completed self care for their teeth and mouth care. Documentation completed on a specified date indicated that the resident completed self care of their teeth, dentures and mouth care.

Resident #642 did not receive oral care, including mouth care in the morning and evening. [s. 34. (1) (a)]

2. A) Resident #694 reported that they had dentures and some natural teeth.

Point of Care records for resident #694 revealed that during a two week period in 2014, the resident did not receive oral care for their natural teeth on five occasions and only received oral care for their natural teeth once daily on five occasions.

The resident reported that their dentures were soaked overnight however; oral care was not provided in the morning and evening. [s. 34. (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 ensuring that residents receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening and or cleaning of dentures, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The licensee holds a separate Food Committee meeting monthly on the first Friday of the month, Residents' Council meetings are held the third Friday of each month.

The Resident Council minutes from January 2013 and prior include a standing agenda item: "Review and Approval of Food Council Meeting Minutes.

Record review identified that concerns related to food provided in the home are raised during the Food Committee Meeting.

The Food Committee minutes do not include the written response to concerns raised by residents attending the Food Committee meetings. Concerns raised are documented within the minutes of the meeting some indicating the immediate response, others offering a future response.

Interview with the Food Services Manager confirmed that no written response was provided to residents raising concerns during Food Committee meetings held as an extension of Residents' Council Meetings and reporting back to the Residents' Council. [s. 57. (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 providing a respond in writing within 10 days of receiving Residents' Council/Food Committee advice related to concerns or recommendations, to be implemented voluntarily.

WN #19: 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 the nutrition care and hydration programs included the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration, in consultation with a dietitian who was a member of the staff.

Nutrition care and dietary services and hydration policies and procedures were reviewed on March 25, 2014.

The Registered Dietitian confirmed that she did not have input into the following policies after she was hired in August 2012:

Nutritional Assessment and Care # LTC-G-10, revised date August 2012;
Food and Fluid Monitoring, #LTC-G-30, revised date August 2012;
Weight Management, #LTC-G-60, revised date August 2012; and
DRAFT In Room (Room Service) Dining, revised date Sept 2013.

The Registered Dietitian stated that she had never seen the DRAFT In Room (Room Service) Dining policy. [s. 68. (2) (a)]

2. The licensee failed to ensure that each resident's height was recorded upon admission and annually thereafter as part of the weight monitoring system.

Record reviews, on March 20, 2014 revealed that heights for six of twelve residents (50%) had not been taken annually:

Resident #612 - last height recorded was 2010;
Resident #640 - last height recorded was 2010;
Resident #732 - last height recorded was 2012;
Resident #750 - last height recorded was 2012;
Resident #669 - last height recorded was 2011;
Resident #736 - last height recorded was 2012.

The Registered Dietitian indicated that heights are taken on admission but not annually thereafter. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration programs include the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration, in consultation with a dietitian who was a member of the staff; that there is a weight monitoring system to measure and record each resident's height upon admission and annually thereafter, to be implemented voluntarily.

WN #20: 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, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The food production system must, at a minimum, provide for standardized recipes and production sheets for all menus.

A) A review of the home's production system revealed that there was no standardized recipes for the homemade chili prepared for the lunch meal March 26, 2014. This was confirmed by the Food Service Manager.

B) A review of the home's production sheets revealed that menu items required for individualized menus including vegetarian menus were not included on the daily production sheets for cooks. This was confirmed by the Food Service Manager. [s. 72. (2) (c)]

2. The food production system must, at a minimum, provide for preparation of all menu items according to planned menu.

A) All menu items for the individualized menus on third floor second sitting, including vegetarian menus were not prepared and available for the lunch meal March 26, 2014. This was confirmed by the dietary aide. [s. 72. (2) (d)]

3. The food production system must, at a minimum, provide for, communication to residents and staff of any menu substitutions.

A) On March 17, 2014, the home did not have sufficient quantities of carrot cake to serve for the lunch meal. The Food Service Manger reported that the shortage of cake resulted from staff using the carrot cake for assorted desserts on March 15, 2014.

The menu substitution for the carrot cake was not indicated on the production sheet for staff and menus were not updated to reflect the changes for residents. [s. 72. (2) (f)]

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 food production system at a minimum; provides for standardized recipes and production sheets for all menus, provides for preparation of all menu items according to planned menu and provides for, communication to residents and staff of any menu substitutions, to be implemented voluntarily.

WN #21: 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 failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in abuse recognition and prevention, behaviour management, how to minimize the restraining of residents and where restraining is necessary how to do so in accordance with this Act and regulations, palliative care, falls prevention and management, skin and wound care, continence care and bowel management and pain management, at times or at intervals provided for in the regulations.

A) In 2013, training in abuse recognition and prevention was completed by 60 of the 184 (33%)direct care staff in the home .

B) In 2013, training in behaviour management was completed by 49 of the 184 (27%) direct care staff in the home.

C) In 2013, training in how to minimize the restraining of residents and where restraining is necessary how to do so in accordance with this Act and regulations was completed by 26 of the 184 (14%) direct care staff in the home.

D) In 2013, training in palliative care was completed by 44 of the 184 (24%) direct care staff in the home.

E) In 2013, training in falls prevention and management was completed by 17 of the 184 (9) direct care staff in the home.

F) In 2013, training in skin and wound care was completed by 17 of the 184 (9%) direct care staff in the home.

G) In 2013, training in continence care and bowel management was completed by 37 of the 184 (20%) direct care staff in the home.

H) In 2013, training in pain management was completed by 21 of the 184 (11%) direct care staff in the home.

The Staff Educator confirmed that all direct care staff had not received training as identified in 2013.

Regulation s.221 identifies that all staff providing direct care to residents must receive annual training in all areas required under subsection 76(7) of the Act. [s. 76. (7)]

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 staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in abuse recognition and prevention, behaviour management, how to minimize the restraining of residents and where restraining is necessary how to do so in accordance with this Act and regulations, palliative care, falls prevention and management, skin and wound care, continence care and bowel management and pain management, at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 77. Orientation for volunteers
Every licensee of a long-term care home shall develop an orientation for volunteers that includes information on,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) the duty under section 24 to make mandatory reports;
(e) fire safety and universal infection control practices;
(f) any other areas provided for in the regulations; and
(g) the protections afforded by section 26. 2007, c. 8, s. 77.

Findings/Faits saillants :

1. The licensee of the long term care home failed to develop an orientation for volunteers that included information on the long term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

A) The Staff Educator confirmed that the orientation of volunteers was completed by the Program Manager.

The Program Manager confirmed that elder abuse was discussed with volunteers however; the home's policy to promote zero tolerance of abuse and neglect of residents including the duty under section 24 to make mandatory reports and whistle blowing protection was not included in the orientation of volunteers. [s. 77.]

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 the development of an orientation for volunteers that includes information on; the Resident's Bill of Rights; the home's mission statement; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports and fire safety and universal infection control practices, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

In 2014, two residents were observed unattended in the hairdressing room.

Hazardous chemicals including R2A neutralizer, Clippercide disinfectant, Kool Lube clipper cleaner, and an unlabeled blue coloured substance, were observed in lower unlocked cupboards. An unlabeled yellow substance in a water bottle was also observed on the open shelf next to the hairdressing station.

The Regional Manager Clinical Services, confirmed observation of the hazardous and unlabeled chemicals and indicated that the expectation was that chemicals were labeled properly and kept inaccessible to residents at all times. [s. 91.]

2. During observation on the second floor, it was observed that the Utility Room door was open and easily accessible to anyone passing by.

On entering the room, chemicals including a large dispenser of PCS Oxidizing disinfectant and Disinfectant General Virucide were observed and accessible. A spray bottle of PCS 1000 Oxidizing Disinfectant was sitting on the counter and would have been accessible to anyone entering the room.

The room was observed for a period greater than five minutes and only after it was brought to the attention of a staff member was the door pulled securely closed.

Staff confirmed that the door is to be closed and locked at all times.

During the period of observation residents were present in the corridor.

The licensee failed to ensure that all hazardous substances at the home were labeled properly and kept inaccessible to residents at all times. [s. 91.]

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 hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident received assistance, if required, to use personal aids.

A) Resident #850 was observed without wearing glasses.

When asked if the resident wore glasses the PSW was unsure and went to the resident's night stand. The PSW retrieved the glasses and stated, I do not know if the resident wears them.

The PSW reported that the resident would be able to indicate if she wanted to wear her glasses.

The resident was asked if they would like to wear the glasses however; the resident was not able to respond to the PSW with a clear yes or no response.

The glasses were placed on the resident and no attempts were made to remove the glasses. [s. 37. (2)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

A) The plan of care did not include an individualized bedtime and rest routine for resident #809. The resident reported that staff arrive to assist them to bed around 2100 hours however; would prefer to be in bed one to two hours earlier.

The resident reported if staff would give a 10 minute notice the resident could be ready for care when they arrived and would be assisted to bed earlier as desired. [s. 41.]

2. The licensee failed to ensure that resident #687's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

During stage one interview with resident #687 it was identified by inspector #165 that the resident would prefer to go to bed before 2030 hours.

Review of the Plan of Care, Kardex and Point of Care documentation do not identify a plan that identifies the residents desired bedtime or rest routines.

Interview confirmed that resident #687 would prefer to be assisted to bed before 2030 hours daily. The resident indicated they are put to bed when staff have time. [s. 41.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

The Home provides meals in two sittings on the second and third floors with the meal period extending for greater than two hours for each meal.

A review of the minutes of Residents' Council and the Food Committee meetings was conducted and failed to find documentation of discussion of meal and snack times.

Interview with the Food Services Manager and Program Manager confirm that residents of the home have not been provided opportunity to provide input into the meal and snack times. [s. 73. (1) 2.]

2. The licensee failed to ensure that the home had a dining and snack service that included sufficient time for every resident to eat at his or her own pace.

Resident #837 was observed, at the lunch meal.

On a specified date in 2014, a Personal Support Worker told the resident that they needed to take the dessert with them to eat as they needed to re-set the tables for the next sitting.

On a specified date in 2014, another Personal Support Worker told the resident that they needed to finish their coffee as they had to clear the dining room for the next sitting.

The resident indicated that they didn't want to hurry.

A clinical record review revealed that the resident is at moderate nutritional risk.

The Director of Care acknowledged that residents should be allowed to eat at their own pace and if it was a consistent issue for that resident it should be in the resident's plan of care with interventions in place. [s. 73. (1) 7.]

3. The licensee failed to ensure that the home has a dining and snack service that included providing residents with any eating aids, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Resident #1003 was observed at the lunch meal.

The Resident received no assistance and/or encouragement for 28 minutes and left the dining room without consuming any fluids.

Two Personal Support Workers were not aware of the Residents last name and reported that the resident was a new admission.

The resident was admitted in 2014.

A record review revealed that the the initial care plan for the resident stated that assistance with meals was required.

An Assistant Director of Care confirmed that the expectation is that residents receive the assistance that they need as per their assessed needs. [s. 73. (1) 9.]

4. Resident #1002 was observed at the lunch meal and noted to consume two bites of minced vegetable and a half slice of bread. The Resident chewed up the half slice of bread then spit it out on the plate and started to eat the chewed up bread.

The resident's nose was observed to be dripping and they wiped their nose on their shirt fully exposing their left breast while doing this. Staff did not come to aid the resident.

A record review revealed that the resident is at high nutritional risk related to a risk of choking, low fluid intake and weight loss.

The care plan indicated that the resident required verbal cueing to continue eating/pick up food/utensils and was often tired during mealtimes and needed encouragement to continue eating.

The Resident received no assistance and/or encouragement for 32 minutes on a specified date in 2014.

An Assistant Director of Care confirmed that the expectation is that Residents receive the assistance that they need as per their assessed needs. [s. 73. (1) 9.]

WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

Interview confirmed that the Family Council was not provided opportunity to participate in the development and carrying out of the satisfaction survey. [s. 85. (3)]

2. Interview with the Administrator and Regional Director Clinical Services confirmed that the satisfaction survey is created corporately and that input from Residents' Council and Family Council of the home were not sought in regard to the development and carrying out of the survey. [s. 85. (3)]

WN #28: 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 failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

The policy, #ES C-25-15, dated as revised January 2, 2012, stated that Nova will have a method for identifying lingering urine odours.

Under Procedure it stated that when a concern of lingering urine odour is identified the Urine Audit Form must be completed by the ESM. This will include the conclusion and suggested action to eliminate the odours.

A copy of the completed Urine Odour Audit will be given to the Administrator/Executive Director and Director of Care.

A solution to the odour concern will be implemented with corrective action taken, completed date and responsible party recorded on the audit form.

The completed Urine Odour Audit/Form will be kept on file in the environmental office.

During an interview with the Environmental Services Manager on March 26, 2014 at 1415 hours it was confirmed, when a request was made to see an example of a completed Urine Odour Audit Form, that this form is not used and has not been filled out at the home.

The Licensee failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The Licensee failed to ensure that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective, that any changes identified in the audit are implemented, and that a written record is kept of everything provided for in clauses (a) and (b).

On March 27, 2014 at 1515 hours the Director of Care (DOC) reported that an annual audit of the Licensee`s drug destruction and disposal system at the home had not been completed by the home.

The DOC verbalized that she believed that this was the responsibility of the Pharmacy.

The DOC confirmed that proof of the home`s annual audit for the drug destruction and disposal system could not be provided. [s. 136. (5)]

2. The Licensee failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

During the observation of the Hewson House medication room on March 27, 2014 at 1255 hours two medication disposal bins with grey bases and blue flip secure tops were sitting on the floor by the medication room door.

Interview with a Registered Practical Nurse (RPN) and a Registered Nurse (RN) confirmed that these two bins are used to dispose of medications that have been discontinued, or from residents that have been discharged or have passed away. These staff also confirmed that they are not included in the destruction and disposal process that is completed with the narcotics and controlled drugs.

During an interview with the Director of Care on March 27, 2014 at 1445 hours it was confirmed that the only medications that are altered or denatured are the narcotics and controlled medications; not the contents of the two gray disposal bins containing the remaining medications for destruction.

The Licensee failed to ensure that when all drugs are destroyed such as; discharge medications, and discontinued medication; the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable. [s. 136. (6)]

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least annually, the program was evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) The Staff Educator confirmed that the training and orientation program was not evaluated and updated in 2013. [s. 216. (2)]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's quality improvement and utilization review system required under section 84 of the Act includes a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

Interview and the Long Term Care Home Licensee Confirmation Checklist for Quality Improvement completed on March 17, 2014 identified that the home does not have a quality improvement and utilization review system that includes a written description of the system including goals, objectives, policies, procedures, protocols and a process to identify initiatives for review. [s. 228. 1.]

2. The licensee failed to maintain a record setting out the improvements made to the quality of the accommodation, care, services, programs and goods provided residents.

Interview and the Long Term Care Home Licensee Confirmation Checklist for Quality Improvement completed on March 17, 2014 identified that the home does not maintain a record of the improvements made to the quality of the accommodation, care, services, programs and goods provided residents. [s. 228. 4. i.]

3. The licensee failed to maintain a record of the improvements made to the quality of accommodations, care, services, programs and goods provided to the residents that included the names of the persons who participated in evaluations, and the dates improvements were implemented.

Interview and the Long Term Care Home Licensee Confirmation Checklist for Quality Improvement completed on March 17, 2014 identified that the home did not maintain a record of the improvements made to the quality of accommodations, care, services, programs and goods provided to the residents that included the names of the persons who participated in evaluations, and the dates improvements were implemented. [s. 228. 4. ii.]

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

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 8. (1)	CO #001	2013_303563_0011	563

Issued on this 14th day of May, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), MELANIE NORTHEY (563), RUTH HILDEBRAND (128), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_226192_0010
Log No. / Registre no:	L-000284-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 8, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	FOREST HEIGHTS 60 WESTHEIGHTS DRIVE, KITCHENER, ON, N2N-2A8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Ois

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall conduct a continence assessment on resident #557 and all other incontinent residents using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Grounds / Motifs :

1. 1. The Licensee failed to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #557 was incontinent. The Minimum Data Set (MDS) assessment indicated a decline in the resident's continence during the specified time period.

There is no evidence of a Continence Assessment in the resident's medical record.

Interview with the Assistant Director of Care(ADOC)/ Resident Assessment Instrument (RAI) Coordinator in 2014 confirmed that no formal continence assessment had been completed for resident #557.

Interview with a Registered Practical Nurse (RPN) confirmed that she was not aware of a separate continence assessment that was done for resident #557 or any resident of the home, other than the voiding diary kept on Point of Care by the Personal Support Workers (PSWs).

Interview with another Assistant Director of Care (ADOC)/ Continence Team Lead confirmed that there had not been a Continence Assessment done for resident #557 and that the home did not have a Continence Assessment used to assess any resident of the home who is incontinent.

The Policy, #LTC-E-50, dated as reviewed on May 2013 titled "Continence Care" stated that a 3 day Continence Assessment is to be initiated on admission and/or if there is a change in level of continence. This Continence Assessment was not completed when resident #557 had a decline in continence identified in a 2014 MDS assessment.

The licensee failed to ensure that resident #557 and other residents of the home

who are incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)] (519)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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.

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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and are locked when they are not being supervised by staff.

The plan is to include, but is not limited to:
1. Routine checks and preventative maintenance of doors leading to non-residential areas,
2. Training of staff related to actions to take when a door leading to a non-residential area is not functioning, and
3. Evaluation of the plan.

The plan will be submitted electronically to Long Term Home Inspector Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, London Service Area Office, 130 Dufferine Avenue, 4th Floor, London Ontario, N6A 5R2 at debora.saville@ontario.ca by end of day May 30, 2014.

Grounds / Motifs :

1. The Licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and are locked when they are not being supervised by staff.

During the initial home tour on March 17, 2014 it was identified that a dirty utility room on the second floor was unlocked. There were no staff near this area at the time of observation supervising this unlocked door.

The door was designed to lock when left to close on its own but this feature was not working. The Inspector closed the door, which then locked, to restrict unsupervised access to residents.

The Licensee failed to ensure that all doors leading to non-residential areas, the dirty utility room on the second floor, are equipped with locks to restrict unsupervised access to those areas by residents, and are locked when they are not being supervised by staff. [s. 9. (1) 2.]
(519)

2. During observations on March 25, 2014 at 1030 hours by Inspector #192 it was identified that the dirty utility room on the second floor was unlocked and not

latched closed. It was noted at the time that there were chemicals in the room at resident height, at the edge of the hopper. There was a spray bottle of disinfectant labeled "PCS Oxidizing Disinfectant" and two large bottles with a dispenser lid labeled "Virucide PCS Oxidizing Disinfectant". At the time the door was not being supervised by staff.

Inspector #192 spoke with the Housekeeping Aide who then wrote it in the Maintenance book in the nurses station. Inspector #192 ensured the door was then locked.

The unlocked room provided unsupervised access to residents and exposure to chemicals in the room.

B. During observations on March 26, 2014 at 1030 hours by Inspector #519 it was discovered that the dirty utility room and the clean utility room in the same hall on the second floor, were unlocked and not latched closed. Electrical cords were accessible in the clean utility room to the left side of the door at resident height, even if the resident would be in a wheelchair. A Personal Support Worker was approached and cautioned to make sure the doors are pulled closed after every entry to the rooms. The doors were pulled closed and locked by Inspector #519.

The unlocked door provided unsupervised access to residents and exposure to electrical wires in the room.

The Licensee failed to ensure that the dirty utility and the clean utility room on the second floor are equipped with locks to restrict unsupervised access to those areas by residents, and are locked when they are not being supervised by staff. [s. 9. (1) 2.] (519)

3. During an interview with the Environmental Service Manager in 2014 it was confirmed that doors on both the dirty utility room and the clean utility room were repaired and were self locking when closed.

During observations March 31, 2014 at 1030 hours it was noted by Inspector #519 that the clean utility room was gaping open with electrical cords visible and at resident height just inside the open door. There were no staff present supervising the open door. The clean utility room door would not self close and lock when attempted by Inspector #519. The door was then pulled closed to

ensure resident safety.
Inspector #519 immediately contacted the Environmental Service Manager.

The Licensee failed to ensure that the clean utility room door on second floor was equipped with locks to restrict unsupervised access to the clean utility room by residents, and were locked when not being supervised by staff. [s. 9. (1) 2.] (519)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that each resident of the home is offered a minimum of three meals daily.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident is offered a minimum of, three meals daily.

During first sitting lunch meal service, on March 20, 2014, it was observed that 10 of 50 Residents (20%), were not present in the dining room.

A Registered Nursing staff member confirmed that the ten residents were cognitively impaired.

A Dietary aide confirmed that only one meal tray was prepared at the lunch meal but the Dietary Aide was unsure who the tray was prepared for.

A Personal Support Worker was able to confirm, to Inspector #128, that the meal tray was delivered to resident #1000.

Inspector #128 queried two Registered Staff about residents who were not in the dining room and they indicated that they had been informed that all residents had been provided lunch.

Two dietary Aides confirmed that one tray was prepared for the residents not in

the dining room. They confirmed that nine of ten residents (90%) were not offered a lunch meal by way of a tray.

Four Personal Support Workers queried in regard to residents being offered a lunch meal indicated that they had not taken any trays to residents.

One Personal Support Worker indicated that trays had been taken to two residents after Ministry of Health and Long Term Care (MOHLTC) intervention/questions.

Another Personal Support Worker stated that trays were taken to two additional Residents.

A Dietary Aide confirmed that a total of two trays were provided after MOHLTC intervention.

A registered nursing staff member indicated that the expectation is that a full meal tray is taken to all cognitively impaired residents not eating in the dining room and that they are offered choice by use of "show plates". It was also established that the expectation is that a requisition is filled out for every tray that is made.

Three Dietary Aides confirmed that there were two tray requisitions filled out. When Inspector #128, queried two Registered Nursing staff, at 1430 hours about action that would be taken in regard to residents who had missed lunch, they indicated that snack would be served soon.

At 1436 hours, Inspector #165 observed resident #1001 sitting in the second floor dining room. When questioned, the cognitively impaired resident indicated that they had not eaten and were waiting for lunch.

The Director of Care stated the expectation is that every resident is fed and that cognitively impaired residents who are not in the dining room are offered a meal via a tray, unless indicated otherwise in their plan of care.

On March 20, 2014, seven cognitively impaired residents were not in the second floor dining room for first sitting and they did not receive a meal via a tray. [s. 71. (3) (a)] (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practices; and
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff of the home receive training and retraining in infection prevention and control including hand hygiene, modes of infection transmission, cleaning and disinfection practices and the use of personal protective equipment.

The plan will be submitted electronically to Long Term Home Inspector Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, London Service Area Office, 130 Dufferine Avenue, 4th Floor, London Ontario, N6A 5R2 at debora.saville@ontario.ca by end of day May 30, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act includes, hand hygiene, modes of infection transmission, cleaning and disinfection practices and use of personal protective equipment.

A) In 2013, training in infection prevention and control was completed by 50 of 270 (19%) staff in the home.

The Assistant Director of Care responsible for Infection Prevention and Control

confirmed that their was a gap in providing the education and training for all staff related to infection prevention and control.

B) The staff of the home demonstrated a lack of knowledge of the current system for communication of residents with Antibiotic Resistant Organisms which can be contagious within a vulnerable population such as the residents of a Long Term Care Home.

The Assistant Director of Care (ADOC) responsible for Infection Prevention and Control indicated that if a resident had an Antibiotic Resistant Organism (ARO) a sign would be posted and personal protective equipment (PPE) would be available.

Six of seven Personal Support Workers (PSW) interviewed on March 31, 2014, on all care areas of the home identified that they may have residents with ARO's but they were not sure. They believed that if a resident had an ARO the registered staff would notify them and a sign would be posted.

One PSW on the third floor was specifically asked what the specified sign would mean. The staff member indicated they did not know what it meant, indicating that maybe someone has a cough, nothing dangerous. The staff member then indicated that they did not have the identified area as part of their assignment but had other areas. One of these areas also had a sign that the PSW was not aware of. (192)

C) On March 31, 2014 a Housekeeping Aide was interviewed to determine who was responsible for the cleaning of hand sanitizer containers located in front of the elevator on the third floor. The staff member indicated she was not responsible and was unaware of the person who was responsible or what process would be used to clean the hand sanitizer dispensing system.(192)

D) On March 17, 2014 observation of the noon meal service by inspectors #128, #192 and #519 identified that in two of three home areas, staff of the home did not complete hand hygiene after handling dirty dishes or before serving food to residents.(192)

E) Record review of two of three residents included on the specified 2013 line listing identified that staff continued to bring residents #607 and #1201 to common areas where they would be in close proximity to other at risk residents,

after they had documented signs and symptoms of respiratory infections. (192) (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff of the home participate in the implementation of the infection prevention and control program.

The plan will be submitted electronically to Long Term Home Inspector Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, London Service Area Office, 130 Dufferine Avenue, 4th Floor, London Ontario, N6A 5R2 at debora.saville@ontario.ca by end of day May 30, 2014.

Grounds / Motifs :

1. The Licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

During lunch dining observation on March 17, 2014 at 1200 hours, it was observed that four Personal Support Workers in the dining room did not wash their hands between delivering resident food trays and clearing dirty dishes between courses. It was observed that only one Dietary Aide washed their hands with hand sanitizer while delivering desserts to residents.

The Licensee failed to ensure that the staff serving lunch on March 17, 2014 at 1200 hours participated in the implementation of the infection prevention and control program. [s. 229. (4)] (519)

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

Infection control risks were observed, March 18 and 19, 2014, in shared resident

rooms/washrooms, including unlabeled personal care items and improperly stored items:

A. An unlabeled urine collection hat on the back of the toilet in the shared washroom in a specified room;
An unlabeled white hair brush containing hair on the shared bathroom counter in a specified room;

B. Two unlabeled black hair brushes with hair in them sitting on the back of the toilet in a blue personal care caddy in the shared washroom of a specified room;

C. Two unlabeled urinals in a specified room - one was hanging on the night stand of resident #694 and the other which was full of urine was between the bed and night stand of the same resident;

D. Three unlabeled wash basins in the shared washroom of a specified room - one was hanging on the back of the toilet and two were on the floor. An unlabeled urinal and a unlabeled urinary drainage bag were also observed inside the wash basins on the floor.

E) Infection Control risks were also observed related to two Personal Support Workers (PSW) observed, during the first sitting of lunch meal service on March 17 and March 20, 2014. They were touching residents and wheelchairs; removing dirty cups, glasses, soup bowls from tables and then serving tea/coffee and provided assistance with eating to residents with no evidence of hand hygiene in-between touching clean and dirty items. [s. 229. (4)] (128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that policy put in place by the home related to:
i) Medication Storage,
ii) Nurse Call System Audits,
iii) Weight Management and
iv) Medication Disposal are complied with.

Grounds / Motifs :

1. Previously issued: July 24, 2012 (VPC), October 25, 2013 (VPC), November 20, 2013 (VPC), December 3, 2013 (VPC), December 4, 2013 (VPC), and December 16, 2013 (VPC, CO)

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The Nutritional Assessment and Care policy, entitled Weight Management policy #LTC-G-60, revised date August 2012 states "Residents will be weighed and weight documented by the 7th day of each month".

A review of the monthly weight records, on March 25, 2014, revealed 46 Residents did not have a weight recorded for the month of November 2013. Additionally, 21 residents did not have a weight recorded for the month of March 2014.

The Registered Dietitian stated that the expectation was that weights are done by the 7th day of each month and indicated that they aren't always done.

The Director of Care acknowledged there were issues with weights being taken monthly and confirmed that the policy had not been complied with. She agreed that the 21 residents who had not been weighed by March 25, 2014 should have been weighed by the 7th day of the month, to comply with the policy. (128)

2. The policy, number 4.8, dated as revised October 2010 titled Safe Storage of Medications, stated that medications, which require refrigeration, are stored in a refrigerator in the medication room or in a locked box in a refrigerator. The medication refrigerator should NOT contain vaccines, food, or specimens.

During observation of the medication room on a specified home area on March 27, 2014 at 1252 hours it was observed that the medication fridge, with resident medication inside, also had a 2 litre container of homogenized milk on the inside door, a package of cigarettes on the top of the inside door, a can of soda, a bottle of Ensure, a bottle of water, and a small styrofoam container of vanilla ice cream. The interior of this medication fridge also had remnants of a previously spilled brown sticky substance that was coating some of the resident`s medication packages.

The Licensee failed to ensure that the Safe Storage of Medications policy was complied with when food was placed in the medication refrigerator. (519)

3. The policy, #ES-75-05, dated as revised January 2, 2012, stated that the ESM or designate is required to inspect the nurse call system on a monthly basis.

During observations on March 17, 2014 it was identified that there were several call bells not functioning. During the interview with the Environmental Services Manager (ESM) March 25, 2014 at 1100 hours a request for the call bell audit forms were made. These were given to the Inspector on March 26, 2014 at 0900 hours. The call bell audit form was completed for only the month of January 2014 and dated January 29, 2014 for the four home areas (Gieger House, Gibbon House, Clarke House, and Hewson House). There were notations on the audit form relating to several rooms requiring call bell replacements. Included in these replacements was one of the non-functioning call bells found by the

Inspectors.

During the interview with the Environmental Services Manager (ESM) on March 26, 2014 at 1415 hours it was confirmed that there were no records of monthly call bell audits available to review as audits were completed quarterly.

The Licensee failed to ensure that the call bell policy #ES E-75-05, put in place for monthly nurse call system audits; is complied with. [s. 8. (1)] (519)

4. The policy, #5.8, date of revision October 2010, titled "Medication Disposal" stated that in most cases, Long Term Care Home (LTCH) medications designated for disposal are comprised of expired drugs, drugs with illegible labels, drugs in containers that do not meet the necessary marking requirements, drugs that were held or refused, discontinued drugs, drugs for a deceased resident, or drugs for a discharged resident that were not sent with the resident.

During medication room observation on Hewson House March 27, 2014 at 1252 hours and March 31, 2014 at 1045 hours it was noted that in the stock medication cupboard there was a blue bin with stock medication present as well as a resident's Nitroglycerine spray labeled with the resident name.

Interview with a Registered Practical Nurse (RPN) on March 31, 2014 at 1045 hours confirmed that the resident whose name was on the Nitroglycerine spray bottle was no longer a resident of the home.

The Licensee failed to ensure 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. (519)

5. The Nutritional Assessment and Care policy, entitled Weight Management policy #LTC-G-60, revised date August 2012 states "Residents will be weighed and weight documented by the 7th day of each month".

During initial record review it was identified that five of fourteen residents reviewed had weights missing for one or more months during the period reviewed.

Resident #596, had no weight recorded for three of four months reviewed.

Resident #642, #698 and #755 had no weight recorded for one of four months reviewed.

Resident #778 had no weight recorded for two of four months reviewed.

Interview with the Executive Director on March 17, 2014 confirmed that the home has not consistently completed and recorded monthly weights for all residents. [s. 8. (1) (b)] (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that where bed rails are used steps are taken to prevent resident entrapment. Ensuring that all beds systems that failed testing for entrapment are addressed and the safety of residents in those beds is assessed and action taken.

The plan will be submitted electronically to Long Term Home Inspector Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, London Service Area Office, 130 Dufferine Avenue, 4th Floor, London Ontario, N6A 5R2 at debora.saville@ontario.ca by end of day May 30, 2014.

Grounds / Motifs :

1. The licensee of the long term care home failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Resident bed systems in the home were evaluated March 26, 2013. Records revealed that 49 beds in the home failed the potential zones for entrapment.

Interviews with the Director of Care, Regional Manager of Clinical Services and the Executive Director confirmed that the home did not have bed system tracking in place to ensure that steps had been taken to ensure that failed bed systems had been corrected as of March 21, 2014.

On March 25, 2014, the Executive Director confirmed that the home had at least 12 bed systems in which steps were not taken to prevent resident entrapment until identified March 21, 2014, by the inspector. [s. 15. (1) (b)] (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 008

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Order / Ordre :

The licensee shall maintain a daily monitoring system to detect the presence of infection in residents and take measures to prevent the transmission of infections.

Grounds / Motifs :

1. he licensee failed to ensure that the Infection Prevention and Control program included daily monitoring of infection in residents.

Policy review and interview with the Assistant Director of Care (ADOC) identified that registered staff are to maintain a daily line listing, documenting residents with signs and symptoms of infection and notifying the infection control nurse when changes in resident condition occur.

A review of the line listing for a specified month in 2013 for a specified home area identified that resident #607 had one symptom of infection on a specified date in 2013. The resident was entered on the line listing but this was not updated when the resident developed further symptoms.

Documentation indicated that resident #607 continued to attend meals in the dining room in spite of the documented signs and symptoms of infection.

Resident #607 was again entered on the line listing on a specified date in 2013. The line listing indicated that at this time the resident had specified signs and symptoms. Record review indicated that the resident had additional signs and

symptoms of infection.

Record review also indicated that the resident continued to participate in recreational programs and have meals in the communal dining room.

Record review identified that resident #1201 developed respiratory symptoms on specified dates in 2013. The resident was not added to the home area line listing until six days later and did not include all symptoms the resident exhibited.

Record review identified that resident #1202 demonstrated symptoms of a respiratory infection on a specified date in 2013. The line listing does not include resident #1202 until ten days later when treatment was initiated.

Documentation in the progress notes identified that resident #1202 continued to go to the dining room for meals in spite of demonstrating signs and symptoms of respiratory infection that may be contagious to others.

Interview with the Assistant Director of Care (ADOC) and policy review indicated that staff are to record symptoms of infection in residents on the daily line listing and take immediate action as required.

The ADOC indicated that the home follows the recommendations of the Region of Waterloo Public Health which indicated that where two or more residents meeting the case definition of two or more respiratory symptoms within 48 hours, droplet isolation should be initiated and Public Health consulted.

The licensee failed to identify an Outbreak when residents #607, #1201, and #1202 demonstrated two or more respiratory symptoms on specified dates in the same 48 hour period in 2013. [s. 86. (2) (a)]

The home failed to maintain a daily monitoring system that reflected all residents with signs and symptoms of infection and failed to take measures to prevent the transmission of infection. [s. 86. (2) (a)]

(192)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

Service Area Office /
Bureau régional de services : London Service Area Office