1. [O.Reg. 79/10, s. 72(1)]
The licensee did not ensure there was an organized food production system in the home.
a) Production sheets were not consistent with the recipe for the chicken sandwich at the lunch meal May 22, 2012. The recipe stated to use breaded chicken patties for the minced and pureed texture, however, the production sheets identified baked chicken instead of the breaded patties.
b) Direction was not provided to staff preparing and portioning the minced bologna sandwich (states 1 whole). Direction related to the portion size of the sandwich filling was not included in the recipe. Direction was also not provided to staff on the recipe for the egg wrap sandwich and Western omelets.
c) Discrepancies were noted between portion sizes listed on the recipes and portions identified on the therapeutic extension menus. One example: Perogies (recipe stated 5 Perogies and therapeutic extension menu stated 3 Perogies).
2. [O.Reg. 79/10, s. 72(3)(a)] Previously issued September 7, 2010 as a CO and May 24, 2011 as a CO.
Not all food was prepared and served using methods that preserved taste, nutritive value, appearance and food quality at the lunch and dinner meals.
a) Menu items were cooked too far in advance of meal service resulting in reduced nutritive value and food quality. Staff preparing the dinner meal May 22, 2012 started cooking the minced and pureed cauliflower and the potatoes at 1230 hours for the dinner meal at 1715 hours. The items were placed in hot holding from 1330 until after the dinner meal (over 4 hours). The minced beef stew was placed into hot holding at 1447 for the supper meal May 22, 2012. The Food Service Manager confirmed that the foods were cooked too far in advance of meal service. The Home's policy B.4 related to food production stated that the Nutrition Manager ensured that hot foods were produced so that the time from the completion of preparation to the time of the beginning of service did not exceed one hour. Recipes stated foods should not be hot held for longer than four hours. Food Committee meeting minutes in April 2012 reflect residents had concerns about overcooked food.
b) Items served for the texture modified menus did not preserve the same level of quality as items for the regular menu. Peameal bacon, prepared for the texture modified menu for the breakfast meal May 23, 2012 was cooked a day in advance (afternoon of May 22, 2012). The item was cooked, cooled and then would be reheated for the breakfast meal the next day, resulting in reduced quality for the pureed texture meal.
c) Cooking water was added to the cauliflower while it was being pureed for the dinner meal May 22, 2012, resulting in a runny texture requiring the addition of thickener. The recipe did not contain thickener. The taste, nutritive value, and quality of the cauliflower were not preserved.
d) At the lunch meal May 22, 2012 pureed texture menu items were mixed together without the consent of a resident being assisted with eating. Staff was observed mixing pureed quiche, mashed potatoes and mixed vegetables while feeding the resident. Staff interview confirmed that the resident had not requested their food be mixed together.
e) Some meals were not planned to preserve appearance and food quality. A side dish was not planned with the lunch meal Week 1 Friday. The hot dog and cheese was planned with a condiment sized portion of tomato and onions (60ml) and not a full side dish.
f) Desserts were stored and served on carts that had been sitting at room temperature for over 1 hour which did not preserve the taste and quality of the chocolate mousse with topping at the lunch meal May 2, 2012.
Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12.
3. [O.Reg. 79/10, s. 72(7)(c)]
The licensee did not ensure that there was a cleaning schedule for the servery areas. The Food Services Manager confirmed that a cleaning schedule was not currently in place for the servery areas.
4. [O.Reg. 79/10, s. 72(7)(a)]
The licensee did not ensure that there were policies and procedures for the safe operation and cleaning of equipment related to the food production system. Staff confirmed that these policies were not in place for the dietary department.
5. [O.Reg. 79/10, s. 72(2)(d)] Previously issued September 7, 2010 as a WN.
Not all menu items were prepared according to the planned menu.
a) Not all ingredients were available for preparation of menu items according to the planned menu at the dinner meal May 22, 2012. The tossed salad recipe stated fresh mushrooms, radishes, green onions and shredded carrots, and the beef stew recipe stated fresh carrots were required, however, the items were not available. The Food Service Manager confirmed that the items were not ordered and were not included as part of the home's food order guide.
b) Items provided to residents at the afternoon snack pass May 14, 2012, did not follow the planned snack menu. The planned menu identified oatmeal cookies for the regular texture menu and fig newtons for the minced textured menu. Residents were served chocolate chip cookies for the regular and minced textures. No rationale was provided for the

items being different than those on the planned menu.
Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(2)(b)] Previously issued September 7, 2010 as a VPC.
Not all residents who required assistance with eating were served a meal when someone was available to provide the assistance.
At the lunch meal May 2, 2012, an identified resident waited for 10 minutes for assistance with eating while their meal was sitting on the table. The resident required full staff assistance for eating.
2. [O.Reg. 79/10, s. 73(1)9] Previously issued January 7, 2010 under the Long Term Care Homes Manual as un-met criterion B3.32; Previously issued as s. 73(1)9 May 24, 2011 as a CO.
Not all residents were provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
a) Two identified residents who required assistance with eating were not provided with the required assistance during lunch meals May 2 and May 17, 2012. The residents did not eat well without the assistance. (165)
b) Assistive devices (nosey cups, 2 handled mugs, mugs with lids) were not available on the snack cart and the devices were not provided to the residents who required them at all snack passes observed:
The morning snack pass May 25, 2012 on two floors:
i) An identified resident required an assistive device, however, this was not provided to the resident. Staff stated the resident spilled beverages on themselves and staff had to stay with the resident while they drank without using the assistive device. The resident would be more independent with the required assistive device.
ii) An identified resident required an assistive device for beverages, however, this was not provided to the resident. Staff had to provide assistance to the resident, however, the resident would be independent with use of the assistive device.
iii) Staff interview confirmed that assistive devices were not consistently provided on the snack carts.
iv) Assistive devices were not available on another snack cart and staff stated that there were no residents who required assistive devices for beverages. Diet lists identified that two residents required assistive devices on that floor; these were not available.

At the afternoon snack pass May 14, 2012:
i) Two identified residents required assistive devices, however, these were not provided to the residents as indicated in their plans of care.
ii) Assistive devices were not placed on the snack cart and available for residents.

At the breakfast meal May 18, 2012:
i) Two identified residents did not receive assistive devices as per their plan of care.

3. [O.Reg. 79/10, s. 73(1)2]
The licensee did not ensure the dining and snack service included a review of the meal and snack times by the Residents' Council. This was confirmed by the President of the Residents' Council and the Administrator.
4. [O.Reg. 79/10, s. 73(1)10]
The licensee did not ensure that the dining service included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.
At the observed lunch meal May 2, 2012, an identified resident was seated in a specialized chair which was reclined. The resident had to sit upright with no back support.

Additional Required Actions:

CO # - 008 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 8(1)(b)] Previously issued September 7, 2010 as a VPC.
The licensee of the home did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.
a) The home did not comply with the policy related to monitoring residents' weights and heights which stated that if a resident had a loss or gain of 2.0kg over a month, a reweigh would be done immediately or within 48 hours by the health care staff. The old weight would be struck out and the new weight recorded in point click care. An identified resident had a 3.3kg weight loss over one month, 2.2kg weight loss over another month, 5.3kg weight loss over the consecutive month, 3.2kg weight loss over another month and 2.2kg weight loss over another month, however, there was no reweigh immediately or within 48 hours of the original weight taken by the health care staff and recorded in point click care. (PLEASE NOTE: This evidence of non-compliance was found during inspection #2012_066107_009/H-000094-12)
b) An identified resident had a weight loss of 3.5kg over a month, 3.5kg weight increase over another month, 2.9kg weight increase over one month, and a 3.2kg weight loss over one month, however, there was no reweigh immediately or within 48 hours of the original weight taken by the health care staff and recorded in point click care.
2. [O.Reg. 79/10, s. 8(1)(b)]
The licensee's policy and procedure related to meal service (C.1) was not complied with as it was not consistent with the Home's practice around meal times. The Home's policy stated that meals were served at 0800, 1200, 1700, however, meal times were set at different times than the stated policy. Actual meal times were 0830 hours for breakfast, 1215 hours for the second floor lunch, 1230 all other floors for lunch, and 1715 for the supper meal on all floors.
3. [O.Reg. 79/10, s. 8(1)(b)]
The licensee's policy and procedure related to monitoring of food temperatures (D.2) was not complied with by staff serving foods to residents.
The policy stated that a "Food Temperatures Recording Chart" was to be completed for hot menu items and for prepared cold foods. The policy stated that hot foods must be held at a minimum temperature of 60 degrees Celsius (C) (140 degrees Fahrenheit (F)) and perishable cold foods must be held in the refrigerator or on a bed of ice to maintain a temperature of 4 degrees C (40 degrees F) or lower.
Food was not always served at a temperature that was within these parameters, according to Food Temperature Recording charts.
a) Numerous interviewed residents identified that foods were not hot enough at meals. Food temperatures were not always recorded on temperature monitoring records. Food temperatures were not monitored for safety and palatability at the dinner meals May 15 and 16, 2012 on a specified floor and at the lunch meal May 15, 2012 on a specified floor.
b) Review of food temperature monitoring records reflected cold food temperatures that were too warm and in the danger zone. Some examples:
The records reflected on May 1, 2012 the cold salad plate was served at 61 degrees Fahrenheit (F). The reference on the monitoring records stated to serve below 40 degrees F. May 2, 2012 the cold salad plate was served at 59 degrees F and the minced and pureed vegetables were also served above 50 degrees F. Corrective action was not documented as required by the home's policy.
4. [O.Reg. 79/10, s. 8(1)(a)] Previously issued May 24, 2011 as a VPC.
The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.
a) The homes policies "Skin Care" dated effective September 2010 and "Skin and Wound Management" dated effective January 2011 related to the skin and wound care program did not include required components of the skin and wound care program, specifically: O.Reg. 79/10, s.50(2)(b)(iv): a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
5. [O.Reg. 79/10, s. 8(1)(b)]
The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.
The home's policy "Medical Pharmacies Policy and Procedure section 5 Handling of Medication policy 5-1 Expiry and Dating of medications, page 1 of 1 indicated that staff were to examine the expiry date of all medications on a regular basis, remove any expired medications from stock and order replacements as necessary. The policy also indicated that designated medications, including treatment creams, must be dated when opened and removed from stock when expired and treat expired prescription medications as surplus medications. On May 22, 2012, the Assistant Director of Care verified that a number of treatment creams prescribed for an identified number of residents, had not been dated when opened and were not removed from stock when found to be expired.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is in compliance with and is implemented in accordance with all applicable requirements under the Act; and is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

s. 71. (2) The licensee shall ensure that each menu,
(a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

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).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(2)(a)]
The Home's Fall/Winter menus did not provide for adequate fibre based on the current Dietary Reference Intake (DRI) of 30 grams for males aged 70+, as per Health Canada. The nutrient analysis of the second choice menu items reflect the DRI for fibre was not met for Week 2 of the Regular texture menu, and all three weeks of the menu cycle for the Modified Diabetic, Gluten Free, and the Modified Reducing diets. The nutrient analysis of the first choice menu items reflected that the DRI for fibre was not met for week three of the Modified Diabetic menu cycle and for all three weeks of the Modified Reducing diet. Staff interviewed identified high rates of constipation and use of laxatives within the home.
Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12.
2. [O.Reg. 79/10, s. 71(2)(b)]
The Home's menu did not provide for a variety of foods each day, from all food groups in keeping with Canada's Food Guide.
Canada's Food Guide requires three servings of meat or meat alternatives per day for male adults 51+ years of age. The home's planned menu did not contain three servings of meat or meat alternatives for some menu days. A protein choice was not offered at the lunch meals, resulting in a reduced number of meat and alternative servings for the day. Some examples: Thursday week 1 the alternative lunch meal choice does not contain a serving of meat or alternatives (3 Perogies); Tuesday Week 3 lunch choice did not contain a protein choice (bacon and tomato sandwiches with 1 slice of bacon - staff preparing meals confirmed they use side bacon, not peameal bacon).
Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12.
3. [O.Reg. 79/10, s. 71(4)] Previously issued September 7, 2010 as a WN; May 24, 2011 as a VPC.
Not all residents were offered the planned menu items at meals and snacks:
a) At the lunch meal May 2 and the breakfast meal May 18, 2012, residents requiring thickened fluids were not offered thickened milk at the lunch meal and were not offered thickened milk at the breakfast meal until identified by the inspector. Thickened milk was not included on the beverage cart that was being taken around the dining room.
b) Not all residents were offered the planned portion size of menu items at the lunch meals May 2 and May 22, 2012, and the afternoon snack pass May 14, 2012.
c) An identified resident was not offered the planned side dish at the lunch meal May 2, 2012. Staff confirmed that the side dish was forgotten.
d) Nectar thickened fluids were not available on the afternoon snack cart May 25, 2012, only honey thickened fluids were available on the cart. Four residents on the floor required nectar consistency thickened fluids.
Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12.
4. [O.Reg. 79/10, s. 71(3)(c)]
Not all residents were offered an afternoon snack at the observed snack pass May 14, 2012. Eight residents were not offered an afternoon snack with their beverage.
5. [O.Reg. 71(1)(e)]
The Fall/Winter menu cycle was not approved by a Registered Dietitian who was a member of the staff of the home. Staff interviews confirmed that the menu cycle was not approved by the home's Registered Dietitian due to concerns with the menu. The menu was implemented at the home without approval and had been in place for six months.
Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12.
6. [O.Reg. 71(1)(d)]
The menu cycle did not include alternate beverage choices at both meals and snacks. The planned menu cycle included only milk at meals and only one type of juice at the afternoon and evening snacks. An alternative beverage was not available (only thickened cranberry juice was available) for residents requiring thickened fluids at the afternoon snack pass on May 14, 2012.
Please note: this evidence of non-compliance is also related to complaint #H-000900-12/H-000615-12 report 2012_066107_009 / H-000094-12.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with sections 71(1)(d)(e), 71(2)(a)(b), 71(3)(c), and 71(4), to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 129(1)(a)(ii)]
The licensee did not ensure that drugs were stored in a medication cart that was secure and locked. On May 18, 2012, on the 3rd floor at 0910 hours, a medication cart was left unattended and unlocked in the hallway outside the dining room. A resident was in-front of the medication cart when the inspector observed the cart. Staff did not attempt to lock the cart until identified by the inspector. The ADOC confirmed that leaving the cart unattended and unlocked was not an acceptable practice at the home.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that drugs are stored in an area or a medication cart that the area or medication cart is secure and locked, to be implemented voluntarily.

WN #10: 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 subsections:

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).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 51(2)(b)]
Not all residents who were incontinent had their bowel and bladder continence plan implemented.
a) An identified resident had a plan of care that directed staff to check the resident a minimum of every two hours for incontinence. The resident was observed over a 2.25 hour period and they were not toileted during that time. The resident was re-positioned during this time, however, they were not toileted and their incontinence brief was not checked for over two hours.
PLEASE NOTE: this evidence of non-compliance was found during inspection #H-002426-11, report #2012_066107_0009/H-000094-12
b) An identified resident, who was incontinent, had an individualized plan of care to promote and manage bowel and bladder continence, however, the plan was not implemented the morning of May 17, 2012. The resident's most current plan of care stated to check a minimum of every two hours for incontinence, wash, rinse and dry soiled area, and change clothing as needed after incontinence episodes. The resident was observed over a 2.5 hours period without staff checking the resident's incontinent product. Family that was also present with the resident confirmed the resident was not toileted and did not have her incontinent brief checked.
2. [O.Reg. 79/10, s. 51(2)(a)]
The licensee did not ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.
a) An identified resident who was sometimes incontinent, did not receive a complete assessment that included identification of potential to restore function, patterns and specific interventions. Three bowel and bladder assessments were incomplete and contained conflicting information related to continence (the assessments stated the resident was both continent and incontinent).
b) An identified resident who was occasionally incontinent, did not receive a complete assessment that included identification of potential to restore function, patterns and specific interventions. Two bowel and bladder assessments were incomplete and contained conflicting information related to continence (the assessments stated the resident was both continent and incontinent).

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the requirements of 51(2)(a) and 51(2)(b) are met, to be implemented voluntarily.

WN #11: 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 subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)4] Previously issued January 7, 2010 under the Nursing Home Act s. 2(2); Previously issued as s. 3(1)4 on February 1, 2011 as a WN.
The licensee failed to ensure that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
On May 24, 2012 at 1158 hours an identified resident requested that the Personal Support Worker providing their care provide them with a razor, as they would like to shave the hair from their chin. The resident was observed to have several long hairs on their chin and had indicated that they were bothering them. The Personal Support Worker providing care stated "No - it's not that bad" and left the resident without shaving the resident's chin as requested. The plan of care indicated that the resident was dependent for all hygiene and was unable to complete the care requested independently.
2. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)11.ii] Previously issued January 7, 2010 under the Nursing Homes Act, section 2 (6)(iv).
The licensee did not fully respect and promote residents' rights to give or refuse consent to any treatment, care or service for which consent was required by law. The Power of Attorney (POA) for an identified resident reported they did not consent to all medications ordered for the resident. On two days in 2012 the physician ordered three different medications; the record showed the home did not contact the POA for consent.
(PLEASE NOTE: This evidence of non-compliance was found during Inspection # 2012_105130_0011)
3. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1] Previously issued September 12, 2011 as a VPC.
The licensee did not ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity, was fully respected and promoted. The plan of care for an identified resident indicated the resident required staff to assist with cutting up meats into bite size pieces. The resident reported that during the noon meal they requested assistance with cutting up their meal; an identified staff member stated no, you can do it yourself. The resident also reported the same identified staff member was rough when providing care. The DOC verified that assistance was not provided when requested and that the identified staff member had been rough with the resident.
(PLEASE NOTE: This evidence of non-compliance was found during Inspection # 2012_105130_0010)
4. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1]
The licensee had not fully respected and promoted residents' rights to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.
a) An identified resident stated the staff do not knock on their room door before entering and would prefer they knocked before entering.
b) An identified resident stated the staff do not knock on the room door before entering their room and they do not feel their privacy is respected.
c)Staff of the home did not always treat an identified resident with respect in a way that fully recognized their privacy by knocking prior to entering the resident's room. The resident indicated that several staff did not knock prior to entering their room. During an interview with the inspector May 3, 2012, a staff member entered the resident's room without knocking despite the door being fully closed. (165)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the 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, and
3(1)11.ii Every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent, to be implemented voluntarily.

WN #12: 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. [O.Reg. 79/10, s. 41]
The licensee did not ensure that each resident of the home had their desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.
a) An identified resident was interviewed and stated their bedtime was established with some resistance by staff. They stated staff like to get everyone in bed due to how their breaks are assigned and stated that if staff had had their way, they would go to bed very early. The staff usually put them to bed between 1900 and 1930 hours. They prefer to go to bed at 2100 hours. The staff confirmed they put them to bed around 1930 hours. Staff were aware the resident preferred to go to bed later.
An identified resident stated there were two start up times for getting up in the morning, 0600 hours and 0700 hours. The 0600 staff member comes on duty and starts getting residents out of bed without resident choice. The resident stated they did not have a choice when they got up in the morning as it was based on decisions made by staff. The resident stated they did not want to get up at either of the times offered to them by staff. Staff were unable to confirm what time the resident preferred to get up in the morning.
b)An identified resident stated they had no choice when they went to bed and when they got up. They stated staff told them, "look at all the people we must get up, so you must get up now". The resident expressed wanting to sleep in sometimes as they were still tired and the staff did not allow them to do so. Nursing staff confirmed they cannot always allow residents to sleep in as they miss their breakfast. Nursing staff also stated they put residents to bed when they have two staff available and must accommodate staff breaks. The resident required the assistance of staff to get up and go to bed.
c) The licensee did not ensure that an identified resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep. The resident was interviewed and stated they did not have any choice when they went to bed as the staff liked to choose the time based on the needs of other residents. The resident also stated the staff got them up when they could as when they were short staffed, they had to wait. Nursing staff confirmed they could not always get residents up when they wanted and put them to bed when they wanted. It was based on the number of staff they had and the needs of the other residents. Nursing staff confirmed residents had to wait sometimes to go to bed and to get up.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest, and sleep, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s.29 (1)(b)] Previously issued May 24, 2011 as a VPC.
The licensee did not ensure that the policy for minimizing restraint use was complied with.
The home's Least Restraint Policy page 4 of 6 stated "the home approved the following as restraints/PASD's: tabletops on wheelchairs and geri chairs; seatbelts; posture pals; bed rails; tilt chairs." The policy also stated that "Registered staff were to ensure that the following was documented on the resident's chart and plan of care:
- Alternatives that were considered and why these alternatives were ineffective.
- The physician's order with the following criteria: the device to be used and any instructions relating to the use of the device.
- Consent from the resident or POA if the resident is incapable.
- The person who applied the device and the time.
- Assessments and reassessments and monitoring, including the residents response.
- Times for when the device is to be released and repositioning of the resident.
- The removal or discontinuation of the device including times and care of the resident after removing the device.
- The resident's care plan will reflect the use of all restraining devices and care required."

a) According to the Director of Care, staff were required to complete "restraint observation" records whenever residents had 2 full bed rails raised when in bed, unless the bed rails were used for positioning aids and/or they were raised at the request of the resident. According to registered staff interviewed, "restraint observation" records were not completed for any residents with 2 full bed rails raised, regardless of the reason they were being used. This was confirmed by the restraint documentation reviewed. The registered staff were not consistently reviewing and signing the "restraint observation" records on two identified units. The restraint records for seven identified residents were reviewed and found to be incomplete. This was verified by registered staff, who stated registered staff were required to review and complete the record every 8 hours, but were not consistently doing it.
b)There was no Physician's order for a tilt chair restraint for an identified resident, despite observation of the resident in a tilt chair and a restraint observation record in place for tilt chair.
c) There were no physician's orders or restraint observation monitoring records in place for full bed rail restraints for two identified residents, despite staff confirming that bed rails for these residents were used to prevent the residents from climbing out of bed.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that there is a written policy to minimize the restraining of residents and the policy is complied with, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 107(3)4]
The licensee did not ensure the Director was informed no later than one business day after the occurrence of an incident for which a resident was injured and taken to hospital. Staff interviewed and the critical incident reviewed confirmed the incident was not reported to the ministry until 13 days later.
(PLEASE NOTE: This evidence of non-compliance was found during Inspection # 2012_105130_0010)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the Director is informed no later than one business day after the occurrence of an injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 126]
The licensee did not ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. On May 22, 2012 an ampule of medication was observed on a shelf in the second floor medication room. The Pharmacist and the Director of Care verified the medication should have been stored in a sealed container, stored with cotton batten and labeled for the resident for whom it had been prescribed.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.