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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2018	2018_514566_0003	008010-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

Isabel and Arthur Meighen Manor
155 Millwood Road TORONTO ON M4S 1J6

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

ARIEL JONES (566), JULIEANN HING (649), NATALIE MOLIN (652), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 23, 24, 25, 26, 27, 30, May 1, 2, 3, 4, 11, 24, 25, 28, 29, 31, June 1, 4, 5, 6, 7, 8, and 11, 2018.

The following Critical Incident System (CIS) inspections were conducted concurrently with the RQI: Log #017057-16 / CIS #C603-000014-16 & #C603-000015-16, Log #028173-16 / CIS #C603-000026-16, Log #028174-16 / CIS #C603-000027-16, Log #028175-16 / CIS #C603-000028-16, and Log #023632-16 / CIS #C603-000021-16 (related to duty to protect); Log #017884-16 / CIS #C603-000013-16 (related to falls);

Log #018187-17 / CIS #C603-000017-17, and Log #029782-17 / CIS #C603-000028-17 (related to injuries of unknown cause); Log #020091-16 / CIS #C603-000019-16, and Log #028172-16 / CIS #C603-000025-16 (related to improper treatment); and Log #026108-16 / CIS #C603-000023-16 (related to medication).

The following complaint inspections were conducted concurrently with the RQI: Log #011025-16 (related to nutrition and hydration program, and continence care and bowel management); Log #013801-16 (related to transferring and positioning, continence care and bowel management, dining and snack service, bathing, and infection prevention & control); Log #017887-16 (related to falls, and plan of care); Log #017448-17 (related to duty to protect, and falls).

The following follow up inspection was conducted concurrently with the RQI: Log #002641-18 (related to plan of care).

This inspection was also conducted concurrently with complaint Log #005176-18 and critical incident Log #007878-18 / CIS #C603-00006-18 (related to abuse, reporting, and plan of care) completed under Inspection Report 2018_370649_0008. A written notification (WN) and voluntary plan of correction (VPC) related to O. Reg. 79/10 s. 8(1)b was identified in this inspection and has been issued in that report (#2018_370649_0008), dated July 18, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Employee Relations, Food Service Manager (FSM), Facilities & Environmental Service Manager, Registered Dietitian (RD), Physiotherapist (PT), Food Service Supervisor (FSS), registered nursing staff (RN/RPN), personal support workers (PSW), dietary aides, housekeeping aides, unit clerk, scheduling clerk, Residents' Council president and Family Council representative, residents, substitute decision-makers (SDMs), family members, private caregivers, and complainants.

During the course of the inspection, the inspector(s): conducted a tour of the home, observed the delivery of resident care and services, observed staff-to-resident interactions and resident-to-resident interactions, observed meal and snack services, observed infection control practices, observed the administration of medications and reviewed the licensee's medication incidents, reviewed residents' health care records, staff training records, minutes of the Residents' Council, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Snack Observation

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_486653_0001	652

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that the following rights of residents were fully respected and promoted: 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.

The Ministry of Health and Long-term Care (MOHLTC) received a complaint on an identified date in March 2016, that indicated residents were not receiving proper care in the dining room, staff fed residents too quickly, did not provide them any juices, threw out residents' juices, ate snacks that were intended for residents during snack services, and that a specified staff member did not follow the rules of the home in terms of residents' care.

The Inspector conducted a dining room observation on May 2, 2018, at 1230 hours on an identified home area. The Inspector observed resident #025 was assisted for eating. The Inspector observed the caregiver feed the resident, wiped the resident's mouth using a clothing protector, scraped food from the resident's skin around the mouth area, and used the same spoon to continue feeding the resident.

During an interview, Caregiver #117 said they had been working with this resident for a specific time period and understood that use of the resident's clothing protector to wipe the resident's mouth, and use of a spoon to scrape food from the resident's skin around the mouth area was not best practice in order to maintain the resident's dignity and respect.

During an interview, PSW #111 stated that they did not notice Caregiver #117 using a clothing protector to wipe the resident's mouth or a spoon to scrape food from the resident's skin around the mouth area, otherwise they would have stopped the private caregiver and explained the correct process to assist the resident, and that these actions during feeding assistance were not appropriate to maintain the resident's dignity and respect.

During an interview, RPN #113 stated that the above mentioned actions from the caregiver were not appropriate in order to maintain the resident's dignity and respect.

In an interview, Food Service Supervisor (FSS) #119 and the Food Service Manager (FSM) stated that staff were required to maintain residents' dignity and respect at all times and should not have performed the above mentioned inappropriate actions while assisting residents. [s. 3. (1) 1.]

2. The Inspector conducted a dining room observation on May 2, 2018, at 1230 hours on an identified home area. The Inspector observed resident #026 was assisted by Caregiver #116. The resident made specific verbalizations when Caregiver #116 was trying to encourage and assist the resident to eat. At the same time, the Inspector observed three staff members making eye contact with each other and smiling at the resident's verbalizations which were exhibited as a result of a responsive behaviour.

During an interview, Caregiver #116 stated that the resident has this behaviour and confirmed that they observed staff smiling inappropriately at the resident's verbal behaviour, and that staff should have maintained the resident's dignity and respect.

During interviews, PSW #111 and RPN #113 stated that this kind of action toward the resident was not appropriate and that staff are required to maintain residents' dignity and respect at all times.

Interviews with RPN #113 and the FSM indicated that staff are required to maintain residents' dignity and respect at all times. [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 to ensure that the following rights of residents are fully respected and promoted: 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, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was documented: the provision of the care set out in the plan of care.

A review of resident #025's written plan of care indicated that the resident required assistance with bathing, and staff were to bathe the resident on two identified days and shifts each week.

A review of the flow sheet documentation identified missing documentation on ten identified dates in March, April and May, 2018.

Interviews with PSWs #152, #153, and RPN #113 stated that according to the care plan the resident was bathed twice a week, but sometimes staff forgot to document. They stated further that based on the home's policy, staff were required to complete the documentation for the above mentioned days. [s. 6. (9) 1.]

2. A review of resident #030's written plan of care indicated that the resident required assistance for bathing, and staff were to bathe the resident on two identified days and shifts each week.

A review of the flow sheet documentation identified missing documentation on 12 identified dates in March, April and May, 2018.

During interviews, PSW #151 and RPN #113 stated that according to the care plan the resident was bathed twice a week, but sometimes staff forgot to document. They stated further that based on the home's policy, staff were required to complete the documentation for the above mentioned days. [s. 6. (9) 1.]

3. A review of resident #032's written plan of care indicated that the resident required assistance for bathing and staff were to bathe the resident on two identified days and shifts each week.

A review of the flow sheet documentation identified missing documentation on an identified date in March, 2018.

During interviews, PSW #154 and RPN #113 stated that according to the care plan the resident was bathed twice a week, but sometimes staff forgot to document. They stated further that based on the home's policy, staff were required to complete the documentation for the above mentioned day.

During an interview, the DOC stated that all residents are bathed twice a week and staff are required to complete the documentation. [s. 6. (9) 1.]

4. During the resident quality inspection (RQI), resident #005 triggered for nutrition and hydration.

A review of the resident's written plan of care indicated that the resident required a specific level of assistance for eating. The resident was on an identified therapeutic diet. Staff were to provide the diet as per the order and monitor nutritional intake.

A review of the resident's food and fluid intake record indicated that the food and fluid intake was not documented for identified meals and snacks for an identified period of time in April, 2018.

During interviews, PSW #100 and RPN #113 stated that resident #005 goes to the dining room and eats their meals at the identified mealtime, and the food and fluid intake for the above mentioned dates should have been documented. RPN #113 indicated that sometimes regular staff were not working on the floor, and that staff failed to complete the documentation.

During interviews, FSS #119 and the FSM indicated that the food and fluid intake should

have been documented by the staff for the above mentioned time period. [s. 6. (9) 1.]

5. The licensee has failed to ensure that the plan of care for resident #002 was reviewed and revised when the resident's care needs changed.

During the RQI, resident #002 triggered for minimizing of restraining. Observations made by the Inspector on multiple occasions during both stage one and two of the RQI revealed that resident #002 used an identified type of mobility device and assistive mechanism on the unit.

Review of resident #002's written care plan for mobility as of April 26, 2018, indicated that the resident did not require assistance for mobility and ambulated independently with an assistive device. The written care plan failed to indicate use of the specific mobility device and assistive mechanism. Further review of the resident's progress notes indicated that the resident had been using the mobility device since an identified date in March 2017, when the resident's status changed and they were no longer able to ambulate on the unit.

In an interview, PSW #127 stated that resident #002 could no longer ambulate on the unit, had been using an identified mobility device since approximately one month earlier, and that the care plan they referred to still stated that the resident ambulated independently on the unit.

Interviews with RPN #105 and physiotherapist (PT) #126 confirmed that the resident required the identified mobility device and assistive mechanism, and that resident #002's care plan should have been revised to include use of the identified mobility device as a personal assistance services device (PASD) when the resident's care needs changed. [s. 6. (10) (b)]

6. The licensee has failed to ensure that the plan of care for resident #011 was reviewed and revised when the resident's care needs changed.

Review of an identified critical incident system (CIS) report submitted to the MOHLTC on an identified date in July 2016, indicated that resident #011 sustained a fall leading to an identified injury on an identified date in June 2016 while a PSW was assisting the resident with an activity of daily living (ADL) with the resident in a standing position.

A review of resident #011's progress notes revealed that PT #126 had recommended an

identified safety device for the resident on an identified date in March 2016, due to the resident's risk for falls. Consent was received from the POA at that time, and two of the identified safety devices were received by the PT and endorsed to nursing staff on an identified date in April 2016. A review of the resident's written care plan dated May 12, 2016, failed to reveal an intervention for the safety device.

In an interview, PT #126 stated that when the identified safety device is endorsed to nursing staff, it is the registered staff's responsibility to update the nursing care plan so that all direct care staff are aware of the change and the resident's status. An interview with RPN #113 indicated that resident #011's written care plan was never updated to indicate that the resident required the safety device.

An interview with the DOC confirmed that when a resident requires a specific safety device it should be outlined in the written plan of care, and that the resident's care plan should be revised when their care needs change. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of the care set out in the plan of care is documented; and that the residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

The MOHLTC received a complaint on an identified date in March 2016, that indicated residents were not receiving proper care in the dining room, staff fed residents too quickly, did not provide them any juices, threw out residents' juices, ate snacks that were intended for residents during snack services, and that a specified staff member did not follow the rules of the home in terms of residents' care.

On May 29, 2018, at 1030 hours, the Inspector went to an identified home area to observe snack service. The Inspector identified three residents still eating breakfast and PSW #122 assisting those residents. The Inspector asked PSW #111 whether the snack service was already over. PSW #111 indicated no, and went to the servery to get the snack cart. At this time the dietary aide did not have a snack cart ready. By the time the snack service was started it was 1050 hours. The Inspector followed PSW #111 and observed the snack service. During the observation, the Inspector identified that there was only one jar of juice on the cart, regular cranberry juice. During snack service, PSW #111 did not review the snack menu provided on the snack cart and did not ask the dietary aide for any information about the snack menu. PSW #111 was observed to have served regular cranberry juice to most of the residents on the unit.

A review of the snack menu indicated to serve diet cranberry juice to residents on a specific diet and regular cranberry juice to residents without an identified condition. Interview with PSW #111 confirmed that there was only regular juice provided in morning snack and did not realize that the diet juice was missing on the cart since it was provided by the dietary aide, and that they served regular juice to all residents including residents with a specific diet order.

In an interview, dietary aide #159 stated that they checked the menu before providing a snack cart to the PSW, however, as per the Inspector's observation, the diet cranberry juice was not provided on the cart.

PSWs #151, #111, #122, RPNs #113, #121, and the DOC stated in interviews that the posted menu should have matched with the food and fluids served to residents.

In interviews, FSS #120, #119 and the FSM stated that the dietary aide should have checked the menu before preparing the snack cart for residents and provided all foods and fluids based on the menu, that the PSWs should have checked the menu prior to serving residents, and acknowledged a risk for residents on a specific type of diet receiving regular cranberry juice. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal and snacks, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

The MOHLTC received a complaint on an identified date in March 2016, that indicated residents were not receiving proper care in the dining room, staff fed residents too quickly, did not provide them any juices, threw out residents' juices, ate snacks that were intended for residents during snack services, and that a specified staff member did not follow the rules of the home in terms of residents' care.

The Inspector conducted a dining room observation on May 2, 2018, at 1230 hours on an identified home area. The Inspector observed that resident #027 was served food at the dining table while the resident was sleeping. The Inspector did not see any encouragement provided from staff to wake the resident up and remind them to start eating. Later on, when the Inspector questioned PSW #112, the PSW mentioned that the resident was usually able to feed themselves, however required lots of encouragement. The staff member took the plate from the dining table and gave it to the dietary aide to keep it warm. The PSW stated they would try to offer it to the resident at a later time. The dietary aide took this plate and placed it on the steam stable with other food which was kept on the steam stable to be served to the residents. The Inspector did not observe the staff to have offered resident #027 the kept meal before the end of the dining service. At the time the plate was returned to the servery, the meal service was not completed, and the actions of the dietary aide could have led to cross contamination.

In an interview, dietary aide #159 said that later on they had thrown the food that came from the resident's table into the garbage, and that they had extra food available for the resident since the dining service on the adjacent unit was not finished by that time.

During interviews, PSW #111, RPN #113, and FSS #119 stated that food should not go from the resident's table to the steam table as it was an infection control issue, it may lead to cross contamination, and that this was not best practice.

During an interview, the FSM indicated that once the dietary aide had received the lunch plate from the PSW to keep it warm for a later use, the dietary aide should have covered the plate and placed it in the refrigerator instead of placing it on the steam table with other food to be served, and that the dietary aide's actions were not the best practice to prevent any cross contamination. (500) [s. 72. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #5: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home have received retraining in infection prevention and control (IPAC) as required by this section.

A review of the home's 2017 IPAC Refresher training record indicated that 100 per cent of staff did not receive the IPAC Refresher education. Eleven per cent of RNs, 12.5 per cent of RPNs, and 31.5 per cent of PSWs did not receive this education.

During an interview, the DOC indicated that the home was trying their best to educate all staff members annually, however not all registered staff were retrained. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff at the home receive retraining in infection prevention and control as required by this section, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

The MOHLTC received a complaint on an identified date in March 2016 that indicated residents were experiencing a specific type of outbreak from using shared personal items in the tub room on an identified unit.

On May 29, 2018, at 1415 hours, the Inspector observed PSW #123 coming out of one of the resident's rooms, walking in the hallway, wearing gloves and going to the garbage room.

During an interview, PSW #123 indicated that they provided personal care to a resident and had to go to the garbage room, and therefore the gloves were not removed inside the resident's room after providing personal care to the resident.

A review of the home's policy #13.16, entitled Gloves, revised April 2017, indicated that gloves were to be removed immediately after direct care was provided to the resident and should not have been worn in the hallway. [s. 229. (4)]

2. On June 7, 2018, at 1127 hours, the Inspector observed PSW #156 coming out of one of the resident's rooms, walking toward the end of the hallway wearing a yellow disposable gown.

During an interview, PSW #156 indicated that they provided personal care to a resident, and should have removed the gown inside the resident's room rather than continuing to wear it in the hallways after providing personal care to the resident.

During interviews, PSW #151, RPNs #121 and #113, and the Facility and Environmental Services Manager stated that staff should not have worn gloves or gowns in the hallways after providing personal care to residents. They were required to remove gloves and gowns inside the resident's room. [s. 229. (4)]

3. The MOHLTC received a complaint on an identified date in March 2016, that indicated residents were not receiving proper care in the dining room, staff fed residents too quickly, did not provide them any juices, threw out residents' juices and ate snacks that were intended for residents during snack services, and that a specified staff member did not follow the rules of the home in terms of residents' care.

On May 29, 2018, at 1030 hours, the Inspector went to an identified home area to observe snack service. The Inspector observed that three residents were still sitting at an identified table having breakfast in the dining room. PSW #122 was observed assisting two of the residents with feeding. The Inspector observed PSW #122 with their mouth full, eating something while assisting the residents. The Inspector did not observe PSW #122 getting up from their position and performing hand hygiene.

During an interview, PSW #122 indicated that they did not get an opportunity to go for a break since that morning, and they had a food item from a previous day in their pocket. PSW #122 also reported they had a specific health condition and were required to have breaks at regular times, and were experiencing dizziness, so they ate the food item while providing feeding assistance to residents in the dining room. PSW #122 acknowledged that it was not appropriate and they have to follow IPAC practices at all times.

During interviews, RPNs #113 and #121 and the DOC confirmed that they were not aware that PSW #122 had a specific health condition and a requirement to go for breaks at regular times.

Interviews with PSW #156, RPN #121, and FSS #119 confirmed that eating while

assisting residents in the dining room was not appropriate, it is an IPAC issue and they are required to follow IPAC practices all the time.

Interviews with PSW #111, FSM, and the DOC confirmed that staff should not eat in the dining room while assisting residents, and staff are required to maintain IPAC practices at each meal in the dining room. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

An identified CIS report was submitted to the MOHLTC on an identified date in September 2016, for an incident that occurred 17 days earlier on an identified date in August 2016, with regards to a PSW staff neglecting a resident's immediate care needs for an unspecified length of time. Record review indicated that the home's investigation notes into the allegation of neglect were dated two days after the incident.

During an interview, the DOC confirmed that the allegation of abuse should have been immediately reported to the MOHLTC. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of safety risks with respect to the resident.

A review of an identified CIS report submitted on an identified date in August 2016, indicated resident #055's Power of Attorney (POA) came to the home on a second identified date in August 2016, and administered a specific amount of an identified medication to the resident during a specific time period. The time the medication was given to the resident was unknown. The resident's POA reported to the charge nurse on the unit what they had done and advised that the resident had an identified administration device in place. Approximately one hour later the resident had a fall; no injuries were noted.

A review of the resident's plan of care after the above mentioned incident did not indicate that any safety risks were identified by the home, nor interventions to mitigate risk or prevent recurrence following the incident.

Interviews with RPNs #105 and #135 confirmed that resident #055's plan of care did not identify any safety risks, and that interventions or strategies were not implemented by the home after this incident to prevent recurrence. An interview with RPN #135 indicated that staff were to ensure that the incident did not happen again, however, the resident was not being monitored and there were no interventions identified to prevent recurrence. The RPNs who worked full time on the unit confirmed that the resident's care plan had not been updated after the incident, and no interventions or monitoring was implemented by the home. According to RPN #105, when the resident's POA visited, privacy was provided and the resident's door was kept closed.

An interview with the DOC confirmed the resident's plan of care had not been updated and safety risks were not identified to prevent recurrence. The DOC also stated they had spoken with the resident's POA who stated they would not do this again. [s. 26. (3)]

WN #9: 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.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

An identified CIS report was submitted to the MOHLTC on an identified date in August 2016, in regards to an unsafe transfer of resident #042 with identified transferring equipment.

Record review of the home's investigation notes into the incident indicated staff #128 stated they made a bad decision and knew they were not supposed to transfer resident #042 on their own, but did transfer resident #042 by themselves with the equipment.

Record review of a letter to PSW #128 from an identified date in September 2016, indicated PSW #128 received disciplinary action related to the incident and failure to adhere to the home's lift policy. This letter also indicated PSW #128 received and signed for education provided by the home on an identified date in February 2016, which advised that any violation to the policy and improper use of any transferring equipment would be subject to disciplinary action.

Record review of resident #042's written plan of care in effect at the time of the incident indicated that resident #042 required assistance for transferring from one position to another related to specific cognitive and physical limitations. This written plan of care also indicated two persons were required for physical assistance when resident #042 was transferred with the identified equipment.

Record review of the home's policy #06.19, Use of Mechanical Lifts, revised July 2017, indicated there must be at least two staff members when performing lifts and transfers using any lifting device.

In an interview, PSW #128 stated they transferred resident #042 alone with the transferring equipment and they were aware of the home's policy which indicated that two people were required to transfer a resident with the identified equipment.

In an interview, the DOC said PSW #128 agreed they transferred resident #042 with the equipment on their own, and that PSW #128 should have followed the home's policy and

used two people to transfer the resident with the identified equipment. [s. 36.]

2. The licensee has failed to ensure that the staff used safe positioning techniques when assisting residents.

An identified CIS report submitted to the MOHLTC on an identified date in July 2016, indicated that resident #011 sustained a fall leading to an identified injury on an identified date in June 2016, while a PSW was assisting the resident with an ADL with the resident in a standing position. Further review of the report stated that the staff member was educated to let the resident sit down before assisting with this activity, and would receive a letter to this effect.

An interview with RPN #125 indicated that on the identified incident date at an identified time, resident #011 was observed wandering the corridors without proper footwear. The RPN requested that PSW #124 assist the resident to put on proper footwear for falls prevention. RPN #125 stated that PSW #124 reported to them immediately following the incident that they had assisted resident #011 while the resident was in a standing position and the resident fell. RPN #125 stated that resident #011 sustained an identified injury as a result of this fall.

A review of resident #011's progress notes confirmed that resident #011 was transferred to hospital later on the same day and diagnosed with a specific injury requiring treatment.

In an interview with PSW #124 on May 31, 2018, they stated that they were familiar with resident #011 and that the resident frequently wandered in the hallways, but that they were not the regular caregiver for resident #011 and could not recall an incident when the resident fell during provision of care. A review of the PSW's employee file failed to reveal the identified letter from the home. A review of the home's resident unit planner for the period April to June 2016 confirmed that PSW #124 was working on the identified unit and shift on the date of the incident.

Interviews with PSWs #112, #155, RPNs #113 and #125 confirmed that direct care staff should assist residents with the identified ADL in a safe position. RPNs #113 and #125 both stated that they felt the incident could have been avoided.

An interview with the DOC confirmed that the positioning technique used by PSW #124 to assist resident #011 while the resident was in a standing position was unsafe.

The severity of this finding was actual harm; the scope was isolated. The home's compliance history related to the issue was reviewed and it has been confirmed through inspection that the non-compliance has been addressed and rectified by the home since the time of its occurrence in June 2016. As such, a compliance order is not warranted at this time. [s. 36.]

WN #10: 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: 1. Communication of the seven-day and daily menus to residents. 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 has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: communication of the seven-day and daily menus to residents.

The MOHLTC received a complaint on an identified date in March 2016, that indicated residents were not receiving proper care in the dining room, staff fed residents too quickly, did not provide them any juices, threw out residents' juices, ate snacks that were intended for residents during snack services, and that a specified staff member did not follow the rules of the home in terms of residents' care.

On Friday, May 4, 2018, at 0830 hours, the Inspector went to an identified home area to observe breakfast services. The posted daily menu indicated the menu posted for the previous day, "Thursday".

During an interview, dietary aide #157 stated that the evening shift dietary aide was responsible for changing the menu before the end of their shift, and day shift dietary aides were required to check to see if the menu was posted and whether it was posted for the right day.

On May 29, 2018, at 1030 hours, the Inspector went to the same home area to observe a morning snack service. The Inspector observed the menu board was missing a week-at-a-glance (seven-day) menu, and that the frame on the menu board was blank. There was only one daily menu posted, winter week 4, Tuesday.

Interviews with PSWs #151, #111, #122, RPNs #113, #121, FSSs #120, #119, the FSM, and the DOC stated they should always have menus posted on the board, including a daily menu and seven-day menu reflecting the right day. [s. 73. (1) 1.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The MOHLTC received a complaint on an identified date in March 2016, that indicated residents were not receiving proper care in the dining room, staff fed residents too quickly, did not provide them any juices, threw out residents' juices, ate snacks that were intended for residents during snack services, and that a specified staff member did not follow the rules of the home in terms of residents' care.

a) The Inspector conducted a dining room observation on May 2, 2018, at 1230 hours on an identified home area. The Inspector observed that resident #027 was served food at the dining table while the resident was sleeping. The Inspector did not see any encouragement provided from staff to wake the resident up and remind them to start eating. Later on, when the Inspector questioned PSW #112, the PSW mentioned that the resident was usually able to feed themselves, however required lots of encouragement. The staff member took the plate from the dining table and gave it to the dietary aide to keep it warm. The PSW stated they would try to offer it to the resident at a later time. The dietary aide took this plate and placed it on the steam stable with other food. The Inspector did not observe the staff to have offered resident #027 the kept meal before the end of the dining service.

A review of resident #027's written plan of care indicated staff were to provide constant encouragement, remaining with the resident during meals, and were to provide an identified level of assistance, as necessary.

During interviews, PSWs #111, #151, #152, #153, RPN #113, FSS #119, the FSM, and the DOC indicated that staff should have encouraged the resident to eat, and offered an alternative food choice for the resident to eat their meals.

b) During a dining room observation on May 2, 2018, at 1230 hours on an identified home area, the Inspector observed resident #029 was not eating. The Inspector did not observe any encouragement provided by the staff. The Inspector saw PSW #112 cut up the resident's food. The resident was also given specific assistive devices. Resident #029 was not eating their meal for more than 20 minutes. Upon questioning by the Inspector, resident #029 indicated that due to a specific diagnosis they cannot do anything on their own. The Inspector asked the staff why the resident was not eating, and if the resident was offered an alternative food choice. Staff then offered the second choice to the resident. The resident was not encouraged to eat prior to the Inspector reporting the matter to the PSW.

A review of resident #029's written plan of care indicated that the resident required assistance for eating due to identified impairments. Staff were to assist the resident when the resident was fatigued.

During interviews, PSWs #111, #151, #152, #153, #154, RPN #113, FSS #119, the FSM, and the DOC indicated that staff should have encouraged the resident to eat, and offered an alternative food choice for the resident to eat their meals.

c) On Friday, May 4, 2018, at 0830 hours, the Inspector went to an identified home area to observe breakfast services. At around 0915 hours, the Inspector observed resident #031 to have been provided an identified diet texture on a regular plate and Caregiver #155 asking a PSW to provide an identified assistive device.

A review of resident #031's written plan of care and diet sheet indicated that the resident required an identified level of assistance for eating and staff were to provide food of an identified texture in a specific device.

An interview with Caregiver #155 confirmed that the resident required food of an identified texture in a specific assistive device at all meals.

A review of the home's policy #5.3, entitled Steps to Meal Service, revised May 2017, indicated staff were to provide assistive devices as individually required.

During interviews, PSW #151, RPNs #121, #113, FSS #119, and the FSM stated that dietary aides have all assistive devices for residents and were required to provide assistive devices as per the diet sheet and written plan of care to residents. [s. 73. (1) 9.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that subject to subsection (3), the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

An identified CIS report was submitted to the MOHLTC on an identified date in September 2016, for an incident that occurred 17 days earlier on an identified date in August 2016, with regards to a PSW staff neglecting a resident's immediate care needs for an unspecified length of time.

Record review of the home’s investigation notes dated two days after the incident, indicated PSW #128 stated that when RPN #129 asked them if they provided the identified care for resident #042, PSW #128 stated they had not yet done so because they were waiting on another PSW who was going on their break to assist. PSW #128 indicated they identified resident #042's need for care so they put resident #042 in their room and transferred resident #042 from their assistive device to bed so resident #042 would be more comfortable until the required care was provided. The home's investigation notes also indicated PSW #128 received disciplinary actions related to neglect of resident #042.

In an interview, the DOC stated that a report of this allegation of abuse/neglect was not submitted to the MOHLTC within 10 days, as required by the legislation. [s. 104. (2)]

2. An identified CIS report was submitted to the MOHLTC on an identified date in September 2016, for an incident that occurred 20 days earlier on an identified date in August 2016, with regards to staff neglecting to provide identified personal care to a resident.

Record review of the home’s investigation notes dated five days after the incident, indicated that PSW #128 stated they did not provide the identified care to resident #043. The investigation notes also indicated PSW #128 received disciplinary action for the allegation of abuse/neglect against resident #043.

In an interview, the DOC stated that a report of this allegation of abuse/neglect was not submitted to the MOHLTC within 10 days, as required by the legislation. [s. 104. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A review of an identified CIS report submitted to the MOHLTC on an identified date in July 2016, indicated that resident #011 sustained a fall leading to an identified injury on an identified date in June 2016, seven days earlier, while an unidentified PSW was assisting the resident with an identified ADL while the resident was in a standing position.

A review of resident #011's progress notes indicated that the resident was transferred to hospital on an identified date in June 2016, at an identified time. The physician's note from the following date, less than 24 hours later, confirmed that resident #011 was diagnosed with an identified injury and that an identified treatment had already been

performed.

In an interview, the DOC confirmed that the Director was not informed within the required time frame regarding the resident’s significant change in status, and that their understanding was that they had 10 days to notify the Director. [s. 107. (3) 4.]

2. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (1), (3) or (3.1) that they shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: a description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident.

A review of an identified CIS report submitted to the MOHLTC on an identified date in July 2016, indicated that resident #011 sustained a fall leading to an identified injury on an identified date and time in June 2016 while an unidentified PSW was assisting the resident with an ADL while the resident was in a standing position. Further review of the CIS report stated that the PSW staff member was educated to have the resident sit down before assisting with this activity to promote resident safety, and would receive a letter to this effect.

Interviews with RPNs #113 and #125 identified the involved PSW as PSW #124. An interview with PSW #124 indicated that they could not recall the incident. A review of PSW #124’s employee file failed to reveal the identified letter from the home. A review of the home's resident unit planner for the period April to June 2016 confirmed that PSW #124 was working on the identified unit and shift on the date of the incident.

An interview with the DOC confirmed that they completed the CIS report, that PSW #124 was the PSW staff member present at the time of the incident, and that the CIS report did not provide the Director with the names of all staff who were involved in the incident as required. [s. 107. (4) 2. ii.]

Issued on this 2nd day of August, 2018

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

Original report signed by the inspector.