Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 21, 2015 | 2015_370162_0008 | T-1744-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

THE KENSINGTON HEALTH CENTRE
25 BRUNSWICK AVENUE TORONTO ON M5S 2L9

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

THE KENSINGTON GARDENS
25 BRUNSWICK AVENUE TORONTO ON M5S 2L9

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

TIINA TRALMAN (162), SARAH KENNEDY (605), SLAVICA VUCKO (210)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): July 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, and 28, 2015.**

**The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection (RQI):T-964-14 and T-1982-15.**
**The following Critical Incident Intake was inspected concurrently with this RQI: T-1219-14.**

**During the course of the inspection, the inspector(s) spoke with executive director (ED), directors of resident care (DORC), director of quality and risk, clinical care leader, social worker, registered dietitians (RD), personal care aids (PCA), registered practical nurses (RPN), registered nurses (RN), facility supervisor, manager of housekeeping and laundry, facility supervisor, environmental, family council president, resident council presidents, private care givers, substitute decision makers (SDM), residents and family members of residents.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**

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

**13 WN(s)**
**4 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

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

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A record review of an identified resident's clinical record during an identified period of time revealed that the resident exhibited identified behaviours on identified shifts. Furthermore, the resident was not easily re-directed, and refused assistance to be

toileted.

Interviews with an identified PCA and registered staff indicated that the resident responds positively to identified assistance by identified staff.

A review of the resident's clinical record revealed that the resident has medical conditions that affected his/her continence, and identified behaviours.

A review of the resident's written plan of care and interviews with identified registered staff and DORC confirmed that staff did not collaborate in the assessment of the resident requiring identified assistance by identified staff so that their assessments are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the SDM of a resident has been given an opportunity to participate fully in the development and implementation of the plan of care.

A review of an identified resident's clinical record revealed that the report from a specialist of an identified date indicated that the resident was assessed by a specialist who suggested a procedure be discussed with the power of attorney (POA) and to schedule an appointment. An interview with an identified registered staff revealed there was no documentation that the POA was contacted. In the inspector's presence, the registered staff contacted the POA and confirmed that the POA was not informed regarding the specialist's assessment.

A review of the resident's clinical record, progress notes and interview with an identified registered staff confirmed that the resident's POA was not given an opportunity to participate fully in the development and implementation of the plan of care in regards to the resident's condition. [s. 6. (5)]

3. The licensee has failed to ensure that staff and others who provide direct care to a resident, are kept aware of the contents of the plan of care and have convenient and immediate access to it.

An interview with an identified PCA revealed that PCA's have access to the written plan of care in point of care (POC) and the Kardex. A review of an identified resident's Kardex revealed that the resident required total assistance with identified personal care.

A review of an identified resident's written plan of care of an identified date, related to the

section for managing bowel incontinence, indicated that the resident required assistance with toileting at identified times and upon resident request. The written plan of care of an identified date indicated the resident receives specific identified assistance with toileting.

An interview with an identified registered staff and the resident's private caregivers revealed that the routine for toileting the resident is at identified times.

A review of an identified resident's POC Kardex revealed that it does not contain all of the sections of the written plan of care such as the routines for toileting. Interviews with an identified PCA, registered staff and DORC confirmed that PCA's only have access to the POC Kardex, which does not include the comprehensive written plan of care that the registered staff can access. [s. 6. (8)]

4. The licensee has failed to 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 the care set out in the plan has not been effective.

On an identified date and at an identified time, the inspector noted a lingering odour emanating from an identified resident's room. The resident's door was open and the lingering odour was detected as far as the resident's lounge area.

A record review of an identified resident's progress notes during an identified period of time and interviews with an identified PCA and registered staff revealed that the resident prefers to perform his/her continence care. Furthermore, interviews with the above-mentioned staff indicated that they attempt to assist the resident frequently as the resident has issues with managing his/her continence.

A review of the resident's written plan of care, revealed that staff are to perform continence care at identified times. A review of the resident's clinical record revealed that the resident is identified with incontinence related to a medical disorder.

Interviews with identified registered staff and DORC confirmed that the written plan of care was not revised when identified measures were ineffective. [s. 6. (10) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the SDM of a resident has been given an opportunity to participate fully in the development and implementation of the resident's plan of care, and that staff and others who provide direct care to a resident, are kept aware of the contents of the plan of care and have convenient and immediate access to it, that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

On an identified date, an observation revealed that the laundry room located on the main floor of the south building was open for residents and family to use. There was no resident-staff communication and response system in the laundry room.

An interview with the ED indicated that the laundry room located on the main floor of the south building does not have a call bell installed. Furthermore, the ED confirmed that residents of the home have access and use the laundry, and that there is no process in place for residents to be supervised.

Observation and interviews with the ED and identified DORC confirmed that the resident-staff communication and response system is not available in the laundry room located on the main floor of the south building and accessible by residents. [s. 17. (1) (e)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**19. Safety risks. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of an identified resident's communication abilities, including hearing and language.

An interview with an identified resident's private caregivers and an identified registered staff revealed that the resident is unable to communicate due to language barrier. The resident will communicate with staff using hand and facial gestures when he/she needs something, for instance, when requesting to use the toilet, the resident would gesture with his/her hands towards the toilet or would place his/her hand on the area of the body.

A review of an identified critical incident report system (CIS) report revealed that the resident complained to a family member related to an identified care issue.

A review of the resident's written plan of care did not identify a section for communication. A record review of the minimum data set (MDS) resident assessment instrument (RAI) of an identified date, indicated that the resident's mode of expression was speech, that the resident had clear speech, that he/she was able to make herself understood and, that he/she had the ability to understand others.

A review of the resident's clinical record, the written plan of care, and interviews with an

identified registered staff and DORC confirmed that the written plan of care was not in place for the resident regarding communication abilities including language. [s. 26. (3) 3.]

2. The licensee has failed to ensure that an identified resident's plan of care is based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

On an identified date, at an identified time, the inspector noted a lingering odour emanating from an identified room. Interview with an identified PCA revealed that the resident had behaviours related to incontinence.

A record review of the minimum data set (MDS) resident assessment protocols (RAP) of an identified date indicated that the resident manifested behaviours. A review of the resident's written plan of care revealed that a plan of care was not developed based on the assessments.

Interviews with identified registered staff and PCA’s, revealed that the resident manifested behaviours and required frequent monitoring and redirection to the toilet.

Interviews with identified registered staff and DORC confirmed that a written plan of care was not in place for behaviours and incontinence for the resident. Furthermore, the DORC confirmed that the RAP identifying the resident's behaviours and incontinence should be included in the written plan of care with the interventions that staff are practicing. [s. 26. (3) 8.]

3. A record review of the minimum data set (MDS) quarterly assessment resident assessment protocol (RAP) of an identified date, indicated that an identified resident uses side rails daily. Subsequent MDS annual assessment date of an identified date, and quarterly assessment of an identified date, indicated no use of side rails.

Observations over the course of the inspection revealed that the resident’s side rails were engaged when the resident was in bed. Interviews with the resident's private caregiver, identified registered staff and PCA indicated that the side rails were engaged when the resident is in bed, for safety.

A review of the resident's written plan of care revealed that a plan of care was not developed based on the above assessments.

An interview with an identified registered staff confirmed that a written plan of care for side rails was not in place for the resident. An interview with an identified DORC confirmed that the use of side rails should be included in the written plan of care. [s. 26. (3) 19.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment of the resident' communication abilities, including hearing and language, the resident's plan of care is based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination, the plan of care based on an interdisciplinary assessment with respect to the resident safety risks, to be implemented voluntarily.***

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**WN #4: 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 staff participate in the implementation of the infection prevention and control program.

Observation on an identified date revealed that an identified resident was on contact precautions as per a sign posted on the resident's door.

A review of an identified resident's written plan of care revealed that he/she was colonized with an identified infection and contact precautions (gowns and gloves) must be used for all personal care.

During an interview with an identified PCA, it was revealed that the staff no longer followed the contact precaution sign because he/she understood that the resident no longer had the identified infection. An interview with an identified registered staff revealed that the most recent test for the identified resident came back negative, but that staff should still follow the contact precaution measures according to the sign on the door until it is removed.

An interview with the infection prevention and control (IPAC) lead confirmed that staff should follow the contact precaution measures according to the sign on the door until it is removed. The lead indicated that it is his responsibility to inform staff when contact precautions are no longer necessary. The lead confirmed that the staff did not participate in the implementation of the infection prevention and control program. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with all applicable requirements under the Act.

A review of the licensee's policy titled Skin and wound care program, revised October 2011, indicated that the registered staff are to make referrals to the interdisciplinary members such as the registered dietitian, as required. A review of the wound care management guidelines for the registered staff located in the wound care binder on an identified unit, indicated that the registered staff are to forward a referral to the RD for altered skin integrity and greater for a nutritional assessment and recommendations.

A review of an identified resident's clinical record, progress notes and assessment forms revealed that the resident was treated for altered skin integrity on identified areas of his/her body on identified dates. There was no evidence of a referral to the RD for assessment. An interview with an identified registered staff confirmed that a referral was not forwarded to the RD when the resident's skin problems were identified.

A review of the licensee's policy and interviews with the clinical care leader and an identified DORC confirmed that the policy Skin and wound care program is not in compliance with the applicable requirements under the Act, that states, "a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the residents' plan of care relating to nutrition and hydration are implemented." [s. 8. (1) (a),s. 8. (1) (b)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius.

On an identified date, during an interview with a family member of an identified resident revealed that the resident's room was at an identified temperature. A subsequent interview on an identified date, with the family member revealed that the room was often cold.

An interview with an identified registered staff revealed that identified measures as a result of the room temperature are taken. An interview with an identified PCA revealed that the resident complained about feeling cold when getting up from bed.

On an identified date, an interview with the home's contracted facility supervisor indicated that the air system is set to maintain the air temperatures at a minimum of 22 degrees Celsius. The inspector and the home's contracted facility supervisor visited resident #10's room. At an identified time, the home's contracted facility supervisor measured the room's air temperature and confirmed that the room was not maintained at a minimum of 22 degrees Celsius. [s. 21.]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A review of an identified resident's clinical record, physician's notes of an identified date, revealed that the resident had altered skin integrity. A treatment was initiated, at identified times during the day.

An interview with an identified registered staff revealed that on an identified date, the resident had altered skin integrity on an identified area of the body of unknown origin. According to the resident's clinical record, the resident was cognitively impaired and did not recall how the altered skin integrity was sustained. The area was treated.

An interview with an identified registered staff indicated the treatment for the resident's altered skin integrity on identified areas of the body were initiated however no skin assessment was carried out. The staff stated that the practice is to document the skin assessment on the Head to toe assessment form.

A review of the clinical record, the skin assessment forms, and interviews with an

identified registered staff, the clinical care leader and DORC confirmed that the skin assessment was not carried out for the resident's altered skin integrity on an identified area on his/her body. [s. 50. (2) (b) (i)]

2. Observation on July 13, 2015, revealed that an identified resident had altered skin integrity on an identified area on his/her body. A review of the clinical record and head to toe assessments for the resident indicated there was no assessment carried out for the identified altered skin integrity. Interviews with identified registered staff revealed that the resident has had the altered skin integrity for an unidentified period of time. The staff further indicated that the resident was seen by a specialist on an identified date, and the resident may be scratching his/her skin.

A review of the resident's clinical record including the head to toe assessments, and interviews with identified registered staff confirmed that a skin assessment for the identified altered skin integrity was not carried out and was not documented on the head to toe assessment tool. [s. 50. (2) (b) (i)]

3. A review of an identified resident's clinical record indicated during an identified period of time, the resident had altered skin integrity on identified areas on his/her body:
a) A treatment administration record (TAR) indicated a treatment was initiated on an identified date, for one identified extremity whereas the head to toe assessment of an identified date, identified altered skin integrity on two identified extremities.
b) A review of the progress note of an identified date, indicated treatment was carried out on an identified area of the resident's extremity, of an identified size.
c) On an identified date, the resident had altered skin integrity of an identified size, located on his/her body that was treated.
d) The progress notes further indicated that on an identified date, the resident had altered skin integrity on one of his/her extremities that was treated.

An interview with an identified registered staff indicated that the resident was prone to skin problems and frequent skin tears, and confirmed that a skin assessment was not carried out and was not documented on the head to toe assessment form.

A record review including head to toe assessments and interview with an identified registered staff confirmed that the resident did not receive a skin assessment for altered skin integrity on his/her extremities and body. [s. 50. (2) (b) (i)]

4. The licensee has failed to ensure that a resident exhibiting altered skin integrity,

including skin breakdown, skin tears or wounds has been assessed by the home’s registered dietitian.

A review of an identified resident’s clinical record, including physician's notes of an identified ate, revealed that the resident had altered skin integrity. A treatment was initiated, at identified times during the day.

A review of the progress notes and interview with an identified registered staff indicated that on an identified date, the resident had altered skin integrity on one of his/her extremities of unknown origin. The area was treated.

An interview with an identified registered staff revealed that the treatment for altered skin integrity on the resident’s extremity and body were initiated however there was no referral forwarded to the RD for assessment. The identified registered staff indicated the expectation is a referral must be be forwarded to the RD for stage two, three pressure ulcers or more advanced skin problems.

A review of the clinical record, RD notes and assessments, an interview with identified registered staff, the clinical care leader and DORC confirmed that a referral was not forwarded to the RD for the resident's altered skin integrity. [s. 50. (2) (b) (iii)]

5. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of an identified resident’s clinical record, including physician's notes of an identified date, revealed that the resident had swollen and red extremities with altered skin integrity. A treatment was initiated, at identified times during the day.

An interview with an identified registered staff indicated the treatment for the resident’s altered skin integrity on his/her extremities was initiated however no weekly assessment was carried out or documented after the treatment was initiated. The registered staff indicated the expectation is a weekly assessment must be carried out and documented in the progress notes.

A review of the resident’s clinical record, progress notes, interview with an identified registered staff, and the clinical care leader confirmed weekly assessments were not carried out for the altered skin integrity on his/her extremities. [s. 50. (2) (b) (iv)]

6. A review of an identified resident's clinical record indicated during an identified period of time, the resident had altered skin integrity on identified areas on his/her body:
a) A treatment administration record (TAR) indicated a treatment was initiated on an identified date, for one identified extremity whereas the head to toe assessment of an identified date, identified altered skin integrity on two identified extremities.
b) A review of the progress note of an identified date, indicated treatment was carried out on an identified area of the resident's extremity, of an identified size.
c) On an identified date, the resident had altered skin integrity of an identified size, located on his/her body that was treated.
d) The progress notes further indicated that on an identified date, the resident had altered skin integrity on one of his/her extremities that was treated.

An interview with an identified registered staff indicated the expectation is a weekly skin assessment is carried out for pressure ulcers but not for skin tears.

A record review of progress notes, skin assessment forms, and interviews with an identified registered staff confirmed that a weekly assessment was not carried out for the resident's altered skin integrity. [s. 50. (2) (b) (iv)]

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council minutes revealed that the licensee failed to respond in writing to the concerns or recommendations including food quality and menu development, staffing, activity programs, hand hygiene, mealtime assistance, and conversing in a language other than English while on duty, during family council meetings on January 29, 2015, February 26, 2015, March 26, 2015, April 30, 2015, May 28, 2015 and June 25, 2015.

An interview with the Family Council president and the social worker assisting Family Council confirmed that a written response to the above-mentioned concerns or recommendations were not provided in writing within 10 days. [s. 60. (2)]

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**WN #9: 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:**
**4. Monitoring of all residents during meals. 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).**

**s. 73. (2) The licensee shall ensure that,**
**(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. The licensee has failed to ensure that the home has a dining and snack service that

includes monitoring of all residents during meals.

On an identified date, at an identified time, at an identified meal service, in an identified dining room, the inspector observed an identified resident assisted with eating by a private caregiver. The private caregiver was observed eating and drinking the resident's meal and beverages. At the end of the meal, the private caregiver removed the dishes from the dining table.

Interviews with an identified registered staff and PCA's revealed they did not monitor the resident during meal time while the resident was being assisted by the private caregiver. An interview with the private caregiver with translation provided by an identified registered staff confirmed the private caregiver ate the resident's meal because he/she did not want the food to be wasted.

An interview with an identified registered staff confirmed that the resident was not monitored during the meal. [s. 73. (1) 4.]

2. The licensee has failed to ensure that residents are provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On an identified date, during an identified meal service, in an identified dining room, the inspector observed identified residents seated at their dining tables. An identified resident was observed to have his/her entrée in front of him/her while asleep. Another identified resident was also asleep with soup in front of him/her. There were no staff observed to assist or encourage the residents to wake up and eat.

A review of the resident's written plans of care revealed the residents were at high nutritional risk, where one required extensive to total feeding assistance and the other resident required staff to orient his/her meal, cue and provide encouragement to eat, and to remain with the resident during meals.

An interview with an identified registered staff and RD revealed that the identified residents capable of eating independently but required constant encouragement to eat and a staff should have been available to assist the residents with encouragement and personal assistance to eat and drink independently as possible. [s. 73. (1) 9.]

3. The licensee has failed to ensure that any resident who requires assistance with

eating or drinking is not served a meal until someone is available to provide the assistance required by the resident.

On an identified date, during an identified meal service, in an identified dining room, the inspector observed an identified resident asleep with his/her entrée at the dining table. An identified was observed to assist a table mate with eating. Upon inquiring into the resident's status, the identified PCA indicated that the resident required total assistance and will be assisted with eating when he/she awakens. The identified PCA indicated the resident should not have been served his/her meal until a staff was available to assist the resident.

During the observed meal service, the inspector also observed an identified resident seated at the dining table with soup in front of him/her. The resident was observed to be fidgeting with his/her fingers and hands and did not eat his/her soup. There was no staff observed to assist or encourage the resident to eat his/her soup.

A review of the resident's written plans of care revealed the residents were at high nutritional risk and required total feeding assistance.

An interview with identified registered staff and RD confirmed that residents requiring eating assistance are not to be served a meal until someone is available to provide assistance. [s. 73. (2) (b)]

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

A review of the home's 2014 satisfaction survey revealed that there were no questions on the satisfaction survey pertaining to programs provided in the home including skin and wound care, pain management, falls/restraints.

An interview with the home's Director of Quality Improvement confirmed that questions measuring satisfaction with clinical programs provided in the home were not included in the 2014 satisfaction survey. [s. 85. (1)]

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

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(a) cleaning of the home, including,**
**(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and**
**(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures are developed and implemented for cleaning of the home, including resident bedrooms, floors, common areas, and carpets.

On an identified date, the inspector observed a dark residue on the floor at the edge of

the baseboard in an identified resident's room extending from the washroom to the resident's bed. Interview with an identified housekeeping staff revealed that he/she was not aware of the dark moist residue and did not report this to the housekeeping manager.

An interview with the housekeeping manager revealed that she was informed on an identified date by an identified housekeeping staff of the dark residue on the floor of the resident's room, and that action will be taken to remove the baseboards and clean and disinfect area.

On an identified date, the inspector observed that the baseboards in the identified room were removed and the floor was in the process of being cleaned. [s. 87. (2) (a)]

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

On several occasions, during the period of inspection, the inspector noted lingering odours in identified residents' rooms and shared washroom. Interviews with identified registered staff, PCA's, and housekeeping staff, confirmed odours were prevalent and an ongoing issue in the identified rooms and washrooms. Despite regular cleaning measures by housekeeping staff to eliminate odours in the rooms and washrooms, odours were still prevalent.

Lingering odours emanating from an identified resident's room into the hallway and towards the resident lounge were brought to the attention of administration and the housekeeping by staff which resulted in deep (terminal) cleaning on identified dates. However, odours continued to be pervasive.

A review of the home's policy, titled Cleaning Procedures #M10, revised August 2008, does not include procedures for addressing incidents of lingering odours. Interview with the housekeeping manager confirmed that the policy does not contain procedures for addressing incidents of lingering odours.

An interview with the housekeeping manager confirmed that cleaning methods in place to eliminate the lingering odours have not been effective. The housekeeping manager indicated that procedures would be developed and implemented to address the identified odours.

On an identified date, the inspector observed an identified resident's room undergoing a deep (terminal) cleaning. [s. 87. (2) (d)]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Interviews with identified registered staff and PCA revealed that an identified resident addressed his/her concerns regarding odours emanating from an identified area.

An interview with the resident revealed that he/she recalled making his/her complaint, but could not recall to whom or when he/she made her complaint. The resident indicated that he/she could not recall if a staff member of the home followed up with her complaint.

An interview with an identified DORC indicated she was aware of the resident's complaint related to the odours emanating from an identified area but there was no record documenting the complaint. The DORC confirmed that action was taken implementing solid containers to manage the odours from continence products after the complaint was received. The DORC confirmed that the details of the complaint were not documented and that a record of this complaint was not kept in the home. [s. 101. (2)]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**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 O. Reg. 79/10, s. 129 (1).**
**(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. The licensee has failed to ensure that drugs are stored in an area that is used exclusively for drugs and drug-related supplies that is secure and locked.

A review of an identified resident's clinical record contained a note that indicated identified medications are available in an identified area of the resident's room. On an identified date, at an identified time, the inspector observed identified medications in an identified area of the resident's room. An interview with an identified registered staff indicated that the resident's family member requested that the medications be kept in an identified area of the resident's room.

Observation and interview with an identified registered staff confirmed that the medications were not stored in an area exclusively for drugs and drug related supplies, that is secure and locked. [s. 129. (1) (a)]

**Issued on this 28th day of August, 2015**

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

**Original report signed by the inspector.**