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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 7, 2016	2016_484646_0004	016345-16	Resident Quality Inspection

Licensee/Titulaire de permis

KRISTUS DARZS LATVIAN HOME
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

KRISTUS DARZS LATVIAN HOME
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

IVY LAM (646), ANGIE KING (644), JENNIFER BROWN (647), JULIEANN HING (649), ROMELA VILLASPIR (653)

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): August 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 2016.

The following inspections were completed concurrently during this Resident Quality Inspection (RQI): Critical Incident Inspection: Log #017979-16 related to the prevention of abuse and neglect, Complaint Inspection: Log #003537-14 related to pest control.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nutrition Manager (NM), Quality Lead, Registered Dietitian (RD), Resident Assessment Instrument (RAI) Coordinator, Program Support Coordinator, Environmental Manager (EM), Maintenance staff, Cooks, Dietary Aides, Registered Nurses (RN), Registered Practical Nurses (RPN), Health Care Aides/Personal Support Workers (HCA/PSW), Activation Aides, Housekeepers, Residents' Council President, Residents, and Substitute Decision-Makers (SDM).

During the course of the inspection, inspectors reviewed resident health records, staff schedules, minutes of Residents' Council meetings, monthly resident activity calendar, maintenance logs and audits, dietary cleaning schedules, and relevant home policies and procedures.

Conducted initial tour of the home and completed observations related to dining, medication administration, provision of resident care delivery and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of the home's policy titled "Narcotic Counts and Storage", last revised November 13, 2015, under the procedure section stated "Upon receipt of a new narcotic or controlled drug the unit narcotic count sheet will be updated with the current order indicating the amount of narcotic on hand at time of receipt. If the drugs arrive with a pre-populated sheet from the pharmacy, the nurse must confirm the amount of drug received and document this on the form."

The inspector and RPN #109 reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication and observed two blank pre-populated unit narcotic records for an identified resident, prescription of an identified medication for a second identified resident, prescription of another identified medication, and four full medication cards that had been in the narcotic storage bin.

Interview with RPN #109 confirmed the individual narcotic sheet should be completed upon receipt of any narcotic/controlled drugs to accurately reflect the current supply. Interview with the DOC indicated that when all narcotics and controlled drugs are received in the home they are documented on the pre-populated narcotic sheet and authorized by the receiving registered staff member. The DOC further confirmed that the above mentioned policy is the current practice of the home and is required to be complied with.

2. Review of the home's policy titled "Medication Reconciliation", last reviewed on August 3, 2016, under procedure #10 stated "Upon readmission to the home from a hospital stay, the registered staff are to review all medications the resident was taking in the hospital, all orders for medications to continue in the home and then compare these to the previous medications the resident was taking in the home prior to hospital admission."

Review of resident #006's clinical records indicated that he/she was hospitalized for a specified period, with an identified discharge diagnosis.

Review of the resident's Medication Administration Record (MAR) prior to his/her hospitalization, indicated that he/she had received an identified medication once daily at

lunch.

Review of the discharge prescriptions/medication reconciliation document on a specified date in March 2016 from the hospital and the re-admission medication reconciliation form completed in the home on a specified date in March 2016, indicated a discrepancy in the dosage of the medication. The order for the identified medication “daily and repeat as previous" from the hospital had been transcribed as “daily twice daily" on the re-admission medication reconciliation form that had been completed in the home.

Review of resident #006's August 2016 MAR, indicated the resident had been receiving the identified medication twice daily since March 2016. During an observation on August 18, 2016, the inspector noted that the identified medication had been in resident #006's medication strips twice daily.

During an interview, RPN #124 confirmed that there had been an error in the transcription of the identified medication. RPN stated that the order from the hospital was once a day, not twice a day. RPN also confirmed that since March 2016, the resident had been receiving the medication twice a day, one in the morning and once in the afternoon. Interview with RN #125 confirmed that it had been a medication error, and that the order from the hospital for the identified medication was once a day, not twice a day. Review of an email correspondence from RN #142 who completed the medication reconciliation upon resident #006's readmission to the home, stated that the order for the identified medication twice daily from the patient medication discharge plan had been the one he/she clarified with the home's physician. Review of the patient medication discharge plan document revealed that it was not to be used as a prescription.

DOC confirmed that it had been the home's expectation that staff followed the medication reconciliation policy.

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 the home's policies titled "Narcotic Counts and Storage" and "Medication Reconciliation" are complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

This inspection had been initiated in response to a complaint received by the Ministry of Health and Long-Term Care. A review of the complaint indicated that there had been concerns related to pest control in the kitchen, specifically mouse droppings and fruit flies in the kitchen storage area.

The following observations were noted in the dry storage area located in the kitchen:
- August 15 and 16, 2016 -- spilled white crystals/powder on the floor behind plastic storage bins and numerous particles of dry food on metal catch pan under a metal rack.
- August 18, 2016 -- spilled white crystals/powder on the floor behind plastic storage bins remains. Metal rack had been removed from the dry storage room.

Interview with the EM and NM confirmed the housekeeping staff are responsible for cleaning the storage room floor daily.

The NM accompanied the inspector to the kitchen storage room and confirmed that the storage bins are required to be pulled out to allow for cleaning and the dietary staff are responsible to remove any spilled food particles on dietary equipment.

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

This inspection was conducted as a result of observations completed during stage one of the RQI relating to resident home areas.

The following observations completed on August 11, 2016, of the home, furnishings and equipment identified the noted areas below:
- Lower door frame corner guard was broken with jagged edges for an identified resident's room,
- Mirrored medicine cabinet loose on the wall in resident washroom in the same room,
- Grab bar in front of toilet rusty for one resident's washroom,
- Wall damage close to floor in another resident's washroom.

During an interview with PSW #100 it had been revealed that he/she reported the loose mirrored cabinet to the housekeeper on the home area on August 11, 2016, after an identified inspector identified it.

An interview with housekeeper #127 indicated that he/she immediately called on his/her walkie talkie to the maintenance department on August 11, 2016, to request the mirrored cabinet be secured to the wall and additionally verbally informed the EM of the need to repair.

An interview with the EM confirmed that he/she had been made aware of the loose mirrored cabinet on August 11, 2016, and had verbally requested the maintenance staff to repair it.

On August 15, 2016, an identified inspector observed the mirrored cabinet to be loose and not firmly attached to the wall. The inspector reported this potential risk immediately to the nursing staff who then entered a computerized request to inform the maintenance department. It had been observed by the inspector in the afternoon on August 15, 2016,

that the mirrored cabinet had been repaired and firmly affixed to the wall.

During an interview with the EM it was revealed that the home has a computerized log/reporting system in place to request a repair which was accessible to all staff. The EM further indicated that the staff are able to request an emergency repair through the use of a walkie talkie however, there was no log or reporting system for such requests.

The EM accompanied an identified inspector during a tour of the additional previously identified areas and he/she confirmed these areas required repair. The EM confirmed that he had not been aware of the rusty grab bar in one resident's room or the wall damage in another resident's room, but he/she indicated that these areas were in need of repair. Further, the EM also indicated he/she had been aware of the chipped door frame of an identified resident's room and was also aware of many others in the home that required repair.

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, furnishings, and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours strategies are developed and implemented to respond to these behaviours.

The home submitted a Critical Incident Report (CIS) for abuse/neglect related to an allegation of resident to resident abuse. A review of the CIS revealed that on a specified date in June 2016, resident #014 entered another resident's room. The resident was removed immediately by staff.

Interview with RN #129 who had worked on the specified date in June 2016, stated resident #014 had frequently been observed wandering up and down the hallway. RN #129 reported hearing screaming coming from the room of resident #013. He/she responded immediately and found resident #014 in a specified location with resident #013 when he/she entered the room. RN #129 immediately removed resident #014 from the room.

Interview with resident #013 indicated he/she woke to find resident #014 in a specified area in his/her room, touching a specific area of his/her body. Resident #013 immediately yelled for help. Resident #013 denied feeling any pain and admitted to feeling scared until staff arrived.

Clinical review of progress notes from resident #014's time of admission to the specified date in June 2016, revealed multiple documented incidents of agitation, and wandering in the hallways and into other residents' rooms.
Further review of the progress notes failed to identify any other incidents where resident

#014 had demonstrated any inappropriate touching of an identified nature towards any other residents. Interviews with PSWs #138, #141 and RN #129 indicated that resident #014 had frequently wandered not only in the hallway but also in other resident rooms.

A review of the written plan of care prior to the incident on the specified date in June 2016, revealed that there was a plan of care focus for impaired mood state as evidenced by specific facial expressions, wandering and agitated behaviours. There had been no documented strategies for staff to manage the resident's wandering behaviour throughout the home and into other resident rooms.

A further review of the written plan of care revised after the incident on the specified date in June 2016, failed to identify strategies to manage the wandering behaviour.

On a specified date in June 2016, a referral was made to Behavioural Support Ontario (BSO) for resident #014.

Interview with the DOC indicated the home discussed residents with responsive behaviours during Responsive Behaviour Committee meetings, and the purpose of these meetings was to identify and track incidents, and to strategize with the home area staff on how to manage the responsive behaviours in the home. The last meeting of this committee was held on a specified date in March 2016. The DOC indicated that resident #014 was not discussed at that meeting.

The DOC further confirmed that there had not been any strategies developed or implemented to respond to resident #014's wandering behaviour.

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 strategies are developed and implemented to meet the needs of residents with responsive behaviours in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

During stage one of the RQI, it was identified that residents had not been having their heights measured and recorded annually.

A review of the most current heights recorded on Point Click Care (PCC) indicated that as of August 16, 2016, heights for the following residents had not been taken or recorded:

- Resident #053, #008, #055, and #059's heights had not been taken since 2011
- Resident #063, #052, #056, #060, #041, #062, and #005's heights had not been taken since 2012

- Resident #061 and #064's heights had not been taken since 2013
- Resident #051, #001, and #042's heights had not been taken since 2014
- Resident #054's height had not been taken since an identified date in January 2015
- Resident #057's height had not been taken since an identified date in May 2015
- Resident #058's height had not been taken since an identified date in June 2015.

A review of the home's policy titled "Resident Services Manual, Section 6: Assessment and Vital Signs, Subsection: 6.1" dated July 2012, indicated that the "Resident's height will be measured on admission and documented on the weight graph". It had also been indicated that "The PSW is responsible to ensure that the resident's height is obtained annually and the Registered Staff is responsible to ensure the information is documented in the resident's record".

Interview with RPN #113 stated that the residents' heights were taken by RPNs upon admission. The RPN also confirmed that the heights had not been taken annually for residents, as heights were only taken when residents were admitted to the home.

Interview with RPN #111 stated that the heights were taken by RNs upon admission. Interview with RN #116 stated that the heights were taken by PSWs upon admission, and when the RD requested an additional height measurement.

Interview with the DOC confirmed that the height measurements had not been taken annually for residents. The DOC stated that the home's existing policy on heights, directed staff to obtain residents' heights on admission and annually. The DOC further stated that the home's expectation was for staff to comply with the policy.

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 residents' heights are measured and recorded annually, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach and actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises the resident's health status

During stage one of the RQI, resident #005 was triggered for unplanned weight loss. A record review indicated that resident #005 experienced significant unplanned weight loss over one month. Record review of resident #005's health records did not identify any assessment completed by the RD related to the resident's significant unplanned weight loss over one month.

Interviews with RPN #111 and RN #116 told Inspector that it has been the home's practice to weigh residents on the first bath day of the month and have weights entered in PCC by the seventh of the month. RPN #111 and RN #116 further stated that residents with a weight gain/loss of 2kgs or more are referred by the nursing staff to the RD for an assessment.

During interview RN #116 told Inspector that a referral should have been sent to the RD after resident #005 had experienced weight loss. RN #116 and NM confirmed that no referral had been sent to the RD and therefore resident #005 had not been assessed after the unplanned weight loss.

RD confirmed that he/she had not received a referral for the unplanned weight loss and therefore had not assessed resident #005's weight loss.

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 weight changes for all residents are assessed using an interdisciplinary approach and actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During stage one of the RQI, an identified inspector observed that resident #051 kept over the counter (OTC) drugs in his/her bedroom.

During observations on August 10 and August 18, 2016, four types of identified OTC drugs were found on his/her bedside table. Review of resident #051's August 2016 MAR indicated that there were no physician's orders for the OTC drugs that had been found on resident #051's bedside table.

Review of the home's policy titled "Self-Administration of Medications" last reviewed on July 7, 2016, indicated that "A physician's order is required for the administration of medication including self-administration. A separate physician's order must be written permitting the resident to self-administer medications and keeping it at bedside. Attending physician/registered staff would assess the resident's cognitive and functional ability to self-administer medication".

Interview with RPN #111 confirmed that resident #051 did not have a physician's order on the MAR or Treatment Administration Record (TAR) for the drugs that had been observed in his/her room. RPN #111 confirmed that there should have been an order for the identified drugs and stated that he/she would follow-up with the physician and resident #051.

Interview with the DOC confirmed that the registered staff of the home were required to complete an assessment and obtain a physician's order for residents who self-medicate.

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 residents who self-medicate receive an assessment and a physician's order, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

During stage one of the RQI, resident #002 triggered related to his/her dental care lacking.

Observation of resident #002 revealed that he/she had his/her own teeth. It had been observed that resident had some missing teeth, and that decay was noted on the remaining teeth.

Review of resident #002's most recent Minimum Data Set (MDS) assessment with a specified lock date on August 2016, indicated that the resident had dentures.

Review of resident #002's written plan of care completed on a specified date in June 2016, indicated that staff were to provide oral care and denture cleaning in the morning, evening and as needed daily.

Review of the mini kardex sheets within the PSW binder located on a specified residents' care unit, indicated that resident #002 used dentures. The electronic kardex on PCC indicated that the resident had his/her own teeth.

Review of resident #002's most recent dental assessment completed on a specified date in January 2016, indicated that resident had his/her own teeth.

Interview with RPN #109 stated that resident #002 had dentures. Interview with PSW #114 confirmed that resident had a few teeth, and that he/she did not wear dentures.

Discrepancies had been found among the different records used by the direct care providers for this resident.

Interview with the DOC acknowledged that there were discrepancies among the above noted documents. The DOC also stated that all three shifts were expected to review written plans of care to ensure they are accurate and current.

2. During stage one of the RQI, resident #003 triggered related to his/her dental care lacking.

Interview and observation of resident #003 confirmed that he/she wore a specified type of dentures. Resident further stated that he/she did his/her own oral hygiene.

Review of resident #003's written plan of care initiated on a specified date in November 2015, indicated there was a focus in the resident's written plan of care for supervised personal hygiene and oral care, and the intervention directed the staff to provide intermittent supervision and limited assistance for personal hygiene. Review of the electronic kardex on PCC, indicated that staff were required to provide intermittent supervision and limited assistance for the residents' personal hygiene.

Review of the mini kardex sheets within the PSW binder located on a specified residents' care unit, stated that resident #003 wore dentures and that he/she was independent with care.

Interview with PSW #114 confirmed that the resident had dentures and that the PSW provided denture care twice daily.

RPN #109 confirmed that with regards to resident #003's oral care, he/she had a specified type of dentures and that the written plan of care indicated the resident required intermittent supervision and limited assistance for personal hygiene.

Discrepancies were found among the different records used by the direct care providers for this resident.

Interview with the DOC acknowledged that there were discrepancies among the above

noted documents. The DOC also stated that all three shifts were expected to review written plans of care to ensure they are accurate and current.

3. Interviews and observations during the initial dining observation identified discrepancies among the different resource materials related to resident #044's nutrition plan of care.

The records reviewed included the written plans of care from nursing and dietary, the mini kardex sheets, the electronic kardex on PCC, and the dining seating list.

Records reviewed that indicated resident #044 received extensive feeding assistance were the resident's:
- Point of Care (POC) eating focus
- Dietary plan of care on PCC
- Electronic kardex on PCC stated that the resident requires assistance by one staff for eating and staff encouragement to eat.

Records reviewed that indicated resident #044 was independent with eating was:
- The mini kardex sheets within the PSW binder located in the nursing station of the identified resident’s home area

Records reviewed that indicated resident #044 received a modified textured diet were:
- Dietary plan of care on PCC
- Diet seating list in the kitchen.

Interview with RPN #124 on August 18, 2016, who provided feeding assistance for resident #044 stated that the resident received foods of an identified unmodified texture and required total feeding assistance. RPN further indicated that he/she was able to check the mini kardex sheets, PCC, and the diet list located in the kitchen to see the resident's diet.

Interview with RN #125 revealed resident #044's current diet order in physician's order tab in PCC, stated the resident was to have a modified texture diet. RN further confirmed that the information on resident #044's mini kardex sheets was incorrect as the resident required assistance with eating and was not independent with his/her eating.

Observation on August 18, 2016, revealed that resident #044 had received a modified texture entree at lunch, and RPN #124 provided total feeding assistance. The inspector

interviewed RPN #124 to clarify the diet texture that resident #044 received and RPN confirmed that resident #044 was having an identified modified texture diet, and that he/she was unaware of when the diet order was changed from an unmodified texture.

Interview with the NM confirmed that resident #044 was to receive a modified texture according to the current diet seating list.

Interview with the DOC confirmed that it was the home's expectation that staff were made aware of updates and changes to residents' care and were kept aware of residents' written plan of care.

4. During stage one of the RQI, resident #002’s family interview triggered concerns regarding staff not providing appropriate feeding assistance to resident #002 and that pieces of food were too big for resident #002.

Review of resident #002's dietary plan of care related to nutritional risk focus on a specified date in August 2016, revealed staff was to provide resident #002 with total feeding assistance.

In another section of the same written plan of care related to eating/nutrition focus, the resident was to receive extensive feeding assistance.

Observations of resident #002 on August 15, and 16, 2016, revealed that the resident received extensive feeding assistance, and the resident was able to eat an identified food item on his/her own when it was placed in his/her hands.

Interviews with PSW #103 and RPN #109 revealed that resident #002 received extensive feeding assistance at mealtimes.

Interview with RD revealed that the resident was to receive total feeding assistance based on his/her assessment of the resident's needs. The RD further confirmed that the written plan of care did not provide clear direction regarding the resident's feeding assistance.

Interview with the DOC revealed that the home was aware that there had been issues with residents' plans of care. The DOC further confirmed that it was the home's expectation that staff were made aware of updates and changes to residents' care and were kept aware of residents' written plan of care.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written hot weather related illness prevention and management plan for the home that met the needs of the residents was developed and implemented in accordance with evidence-based practices and if there were none, in accordance with prevailing practices.

During the RQI, resident #009 stated to the inspector his/her room felt hot and he/she felt a lack of energy.

Review of the home's policy titled "Hot Weather Related Illness Management" stated the policy will go into effect when the temperature outside is 29 degrees Celsius or greater. The policy indicated that the environmental department will inform all departments of the need to implement the "Hot Weather Related Illness Management" program when the temperature within the home was 29 degrees Celsius, and monitor the internal temperature several times throughout the 24 hour period in residents' rooms and where the residents spend most of their time.

According to the Ministry of Health and Long-Term Care "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes" dated July 2012, it is recommended that homes plot the temperature and humidity reading on the chart outlined in appendix B in order to determine the humidex reading. Humidex determines how stifling the air feels rather than obtaining temperature or humidity alone.

Humidex levels between 30 to 39 degrees Celsius may lead to feelings of discomfort and the start of symptoms related to heat illness. It further indicates that the home should monitor the indoor air temperature and humidex at various times throughout the day so it remains cooler and less humid than the outdoor air conditions.

Interview with the EM indicated that the temperature within the home had been monitored every second day from the thermostat and humidity reader by the nursing station on each floor and not in the residents' rooms. EM advised that when the temperature reaches 28 or 30 degrees Celsius and the humidity above 70 he/she would advise the staff in each of the departments in the home in order to implement necessary procedures. The EM also confirmed that temperature and humidity recordings had not been correlated to determine the humidex in the building and was not being recorded daily throughout the day.

Interview with the ED confirmed that the temperature and the humidity were being monitored but had not been correlated to determine the humidex in the building.

WN #9: 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,
(a) preserve taste, nutritive value, appearance and food quality; and 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 preserve taste, nutritive value, appearance and food quality.

During stage one of the RQI at the lunch meal service on August 9, 2016, two identified inspectors observed residents had been served an identified food item on paper napkins that were used to hold the cutlery in the small satellite dining rooms. Observations conducted in the large dining room revealed that residents were served the same food item on side plates at the same lunch service.

Another observation on August 15, 2016, revealed that residents in a specified residents' dining room were served the same identified food item on napkins during the lunch service. Observations conducted in another specified residents' dining room revealed that residents were served the food item on side plates at the same lunch service.

Interview with HCA #105 in a specified residents' dining room revealed that residents were served the identified food item on napkins at lunch.

PSW #100 in the specified residents' dining room revealed that the identified food item was served on plates when the plates were available. The PSW was unable to provide an explanation for the use of napkins instead of side plates for the food item at lunch.

Interview with Dietary Aide #104 confirmed that the identified food item should be placed on side plates for residents receiving regular and a specific modified texture diets.

Interview with NM revealed that side plates were available for both dining rooms. He/she confirmed that the home's expectation was for residents to be served the identified food item on side plates for both dining rooms and not on napkins.

WN #10: 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 had failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

On August 16, 2016, at 0930 hours, an identified inspector and RPN #109 observed an identified piece of jewelry belonging to an identified resident and an extra ink cartridge for the ePEN stored with the narcotic/controlled drugs in the narcotic bin in the third floor medication cart.

Interview with RPN #109 confirmed that the narcotic/controlled drugs storage bin should only be used exclusively for drugs and drug-related supplies and further indicated that the above mentioned items should not have been stored there.

Interview with the DOC further confirmed that the narcotic/controlled drugs storage bin should only be used for the storage of drugs and drug-related supplies.

WN #11: 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 infection prevention and control program.

On August 17, 2016, an identified inspector observed an identified medication pass for resident #065 on an identified home area.

RPN #113 did not complete hand hygiene between the simultaneous activities he/she did within the pass. RPN #113 entered the resident's room and obtained specified laboratory measurements for resident #065, provided the identified medications, and returned to the medication cart to prepare a specified medication. He/she then returned to the resident's room and administered the specified medication.

RPN #113 did not sanitize his/her hands prior to obtaining resident #065's laboratory measurements and administering the various routes of medications.

Interview with the DOC confirmed that the home's expectation was for staff to sanitize their hands before and after administering medications, and in between residents.

Issued on this 21st day of December, 2016

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

Original report signed by the inspector.