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

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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
Feb 22, 2016	2015_298557_0019	034143-15	Resident Quality Inspection

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

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

VALERIE PIMENTEL (557), ANN HENDERSON (559), DIANE BROWN (110)

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): December 15, 16, 17, 18, 21, 22, 23, 24, 29, 30 and 31, 2015, January 4, 5, 6 and 7, 2016

The following Critical Incidents were inspected: Intake #020392-15 related to the allegation of resident to resident abuse and Intake # 024964-15 related to a fall with injury. The following complaints were inspected: Intake #024964-15 related to the duty to protect, continence care, falls prevention and skin and wound management, and Intake #036472-15 related to lack of recreational and social programs.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (aDOC), Co-Director of Care (cDOC), Education Coordinator/RAI Coordinator (ECO), Resident and Family Care Worker (RFCW), Life Enrichment Coordinator (LEC), Restorative Care Coordinator (RCC), Environmental Service Supervisor (ESS), Food Service Supervisor (FSS), Clinical Pharmasist (CP), Care Service Coordinator (CSC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physio Therapist (PT), Physio-therapy Assistant (PTA), Housekeeping Support Aide, Restorative Care Aide (RCA), Food Service Worker (FSW), Residents' Council President, Residents and Family members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, recipes, staffing schedules, observation of infection prevention practices and reviewed clinical records and relevant policy and procedures related to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Snack Observation

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

- **11 WN(s)**
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Record review of a Complaint Intake, from September 2015, and a Critical Incident revealed resident #045 had a fall that resulted in a injury.

Record review of the written plan of care for Resident #045 identified the following:

- Toileting focus: he/she used incontenent products while awake and was to use a brief at night and required assistance of one or two staff and on occasion the use of sit-stand lift due to decreased ability to move.
- Bladder and Bowel focus: he/she is toileted with two staff assistance and uses identified sized incontinent product on days and evenings/nights.
- Transferring focus: resident will transfer him/herself a lot of the time and is totally dependent on two staff with the sit stand mechanical lift for all transfers.

Restorative note from October 2015, identified the following - for toileting the staff would need to put the resident in the bed, remove his/her pants and the incontinent product, then engage the resident in a mechanical lift to place him/her on the toilet or commode. Once toileting task completed the staff would need to put the resident back in the bed in order to apply his/her incontinent product and pants and then place back into the assistive seating device.

An interview with identified staff members revealed resident #045 had not worn a specific type of incontinent product since his/her injury in August 2015. The resident is no longer toileted but incontinent care is provided. The identified PSW, RPN and the aDOC confirmed the written plan of care for resident #045 does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

In December 2015, resident #021 requested to speak to an inspector. The same day an interview was held with the resident while he/she was resting in bed. The resident stated he/she did not want a foot board on his/her bed and the staff informed the resident the foot board is causing the altered skin integrity on the resident's lower extremities.

An observation of the bed system revealed no foot board at the time of the interview. The resident indicated the foot board broke a few days ago.

Record review of resident's plan of care and staff interviews revealed resident #021 is cognitive, has a muscular degenerative disease, spends many hours a day in bed and is relatively tall.

An interview with an identified staff member revealed he/she was aware the resident had been complaining for months about pressure on his/her lower extremities from the foot

board.

Record review of the following altered skin integrity notes were documented by a registered staff member.
- September 2015, revealed two areas of altered skin integrity on the resident's lower extremity. The documentation identified the cause of the altered skin integrity was pressure from the foot board. Documentation further revealed a referral was sent to restorative care program for a therapeutic product to reduce the pressure from the foot board.

- October 2015, revealed the continued presence of two areas of altered skin integrity on resident's lower extremity with increased severity on one of the areas. The cause of the altered skin integrity was identified as pressure.

- November 2015, revealed the presence of three healing altered skin integrity areas on the resident's lower extremity. The cause of the altered skin integrity was identified as pressure from the foot board and lying in bed.

- December 2015, a daily progress note revealed the resident's dressings were changed and revealed the resident is happy with the foot board not being on the bed and hopes that it stays off.

Interviews with a registered staff member and the RCC revealed both staff had not spoken with the resident about the presence of the foot board and the option of removing the foot board as part of their assessment.

An interview with the aDOC revealed the resident's preference for not wanting a foot board should have been assessed as part of the wound assessment process and the foot board removed. [s. 6. (2)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so the different aspects of care are integrated and are consistent with and complement each other.

Record review of the December 2015 Activity Calendar, revealed a scheduled bike club at 1000 hours. The restorative care program, oversees the bike club and the program is held in the restorative care room on the main floor.

In December 2015, at 0930 hours resident #009 was observed waiting by an identified home area nursing station. At 1010 hours the resident became agitated and continued to look in the direction of the clock on the wall. At 1029 hours the resident was offered a drink from the snack cart but continued to appear agitated. At 1030 hours the inspector asked resident if he/she was waiting for someone. Resident responded "yes, biking at 1000 hours". At 1036 hours the inspector addressed resident's comment to a PSW who in turned called down to the restorative care department running the program. The resident was escorted to the program at 1059 hours by an identified staff member.

Interview with resident #009 revealed his/her awareness and desire to attend the bike program on Mondays at 1000 hours. Record review of progress notes revealed the resident's substitute decision-maker's (SDM) desire for the resident to attend for health reasons.

Record review of the resident's plan of care for mobility revealed the resident required staff assistance to attend programs off the unit and staff are to encourage attendance to advanced exercise and bike programs.

Interviews with an identified RCA and PSW revealed resident #009 is very aware of the program calendar and timing of programs. Staff interviews confirmed the resident gets agitated and upset if he/she misses a program. Interviews with an identified RCA stated that resident #009 does remind him/her of programs and does not want to be forgotten. He/she further indicated that he/she does escort residents down to the bike program, that the program runs from 1000-1200 hours, but that anyone can bring the resident down.

Interview with an identified registered staff member on an identified home area revealed that up until three weeks ago resident #009 was escorted downstairs to the bike club with a co-resident. Then the arrangement stopped. Staff further shared he/she was unsure who's responsibility it was to porter resident's down to the bike program, that he/she had not observed restorative care staff escorting resident #009 unless they call and there were times when resident #009 did not go because there was no time to take him/her.

An identified registered staff member confirmed there is a lack of collaboration between restorative care and the nursing department to ensure residents including resident #009 are portered to the bike program. [s. 6. (4) (b)]

4. Resident #046 was identified as having inappropriate behaviors, displayed through

verbal and physical means to other residents and/or staff. The home sent a referral to the Mobile Support Team (MST) for an assessment related to these behaviors. MST assessed the resident for a two month period in 2015.

In April 2015, the MST discharge summary for resident #046 identified triggers, cues and strategies for managing the resident's behavior. The following collaborative interventions and approaches were identified by the MST for resident #046 and were noted in a shift summary report from April 2015, with the exception of contacting local authorities to set boundaries:
- remove a specific type of furniture from lounge,
- complete Dementia Observation Screening (DOS) every 15-30 minutes,
- avoid using humor during interactions,
- use authoritative approach, be polite and matter of fact, discuss boundary setting, a consistent approach, and use the same phrases,
- do not engage in physical contact that will trigger inappropriate comments towards staff,
- re-approach use different staff,
- medication/pharmacy review, and
- consider having local authorities reinforce boundary setting with resident.

Record review of the written plan of care for Resident #046 identified the resident acts in a problematic manner characterized by inappropriate verbal and physical behavior and the following interventions were identified:
- document a summary of each episode,
- DOS to monitor behaviours,
- protect other residents if unable to protect themselves, and
- direct resident away from other residents, attempt to safely separate him/her from the resident, and remain in the area to ensure he/she does not return.

The resident’s kardex identified the following:
- allow resident time to respond to directions or requests,
- approach resident slowly and from the front,
- do not argue with resident,
- give resident clear, concise explanation of anything about to occur; avoid information overload since the resident cannot assimilate many details,
- if strategies are not working, leave resident and re-approach in 5-10 minutes,
- protect other residents if unable to protect themselves,
- direct resident away from other resident, attempt to safely separate resident #046 from the resident, remain in the area to ensure he/she does not return,

- try not to reason with resident, and
- use consistent routines, timing and sequencing for activities of daily living (ADL).

Interviews with identified staff confirmed they recalled hearing or maybe had read the information in the shift summary but do not have time to read the care plan or kardex to keep up to date with the information entered, if it is entered. The MST discharge summary, written care plan and kardex were reviewed with the identified staff members and they were not aware of the information and confirmed the care was not integrated or consistent. A registered staff member confirmed he/she knew about the MST discharge summary, however, did not update the written plan of care in order to coordinate the care so that the care is consistent and that it complements each other to potentially reduce the inappropriate behaviors.

Interviews with the aDOC and ECO confirmed that the home's written plan of care, kardex and the MST discharge summary for resident #046 were not integrated, consistent with, nor did they complement each other. [s. 6.(4)(b)]

5. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

Record review of a Critical Incident report revealed resident #046 displayed inappropriate behaviors towards resident #047.

Record review of PointClickCare (PCC) notes identified resident #046 exhibits inappropriate behaviours displayed by verbal and physical means to other residents and or staff and directs staff to complete the DOS tool to monitor these behaviors.

An interview with identified staff and the aDOC confirmed the DOS charting was not completed for resident #046. The aDOC revealed it is the home's expectation that DOS charting must be completed as specified in the plan. [s. 6. (7)]

6. The licensee failed to ensure that the following is documented, the provision of the care set out in the plan of care.

Record review of the plan of care for resident #046 revealed DOS documentation was to be completed every 15 to 30 minutes after an identified responsive behavior in August 2015. The following DOS documentation was incomplete on the following days,
- Day 1 between 0400 hours and 2315 hours,

- Day 2 between 0000 hours and 2145 hours,
- Day 3 between 0615 hours and 2130 hours,
- Day 4 between 0630 hours and 2200 hours,
- Day 5 between 1145 hours and 2345 hours,
- Day 8 between 0730 hours and 2200 hours,
- Day 9 between 1430 hours and 2230 hours,
- Day 12 between 1430 hours and 2200 hours,
- Day 13 between 1430 hours and 2130 hours,
- Day 17 between 0730 hours and 2130 hours,
- Day 18 between 0730 hours and 2130 hours and
- Day 19 between 0730 hours and 2130 hours.

Staff interview with ECO and aDOC confirmed the DOS documentation was not documented every 15–30 minutes as set out in the plan of care for resident #046. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so the different aspects of care are integrated and are consistent with and complement each other, to ensure the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.

In December 2015, resident #028 was tapping on the window from the outside of the building, the resident asked inspector #110 and #559 if they knew how to get back inside "this place". The inspectors alerted staff and the resident was escorted back into the building and RCC stated the resident must have followed a visitor outside.

PCC notes revealed resident #028 as having four previous documented incidents of elopement from the building as follows:
- In April 2015, the resident was found at a nearby intersection,
- In June 2015, the resident was found at the Retirement Lodge,
- In October 2015, the resident was found leaving the home area, and
- In December 2015, the resident was found at the Retirement Lodge.

A registered staff member revealed the dining room fire exit door was not secure and the magnetic locks were not activated.

Review of the plan of care revealed staff are to do 30 minute checks as resident is at risk to leave the home and to ensure the magnetic locks are on and are in good working order.

An interview with the administrator and ESS revealed the dining room door magnetic lock was not reset after a technician had completed work and the home was not aware the dining room door magnetic lock was not reactivated until the inspectors brought to the home's attention the resident had eloped. [s. 9. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked, to be implemented voluntarily.

WN #3: 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 failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

On three occasions in December 2015, and on one occasion in January 2016, resident interviews identified various areas of the home were too cold and not comfortable. On an identified day in December 2015, resident #063 and #064 in an identified home area dining room identified the air temperature was too cold. At the time, the ESS placed a digital thermometer in the area of resident's #063 and #064 table. The temperature was confirmed to be 21.2 degrees Celsius. In the adjacent activity room, the digital thermometer confirmed the air temperature to be 20.8 degrees Celsius.

An interview with an identified staff member, stated that the activity room in an identified home area is often cool and identified six residents, #022, #023, #024, #025, #026, and #027 who will not stay in the activity room for programs because it is too cold.

In January 2016, an identified staff member in an identified home area revealed that resident #059 had stated it was freezing in the dining room at breakfast and wasn't going back. At 1109 hours an activity program was commencing in the identified home area activity room. Upon inspector request the ESS probed the air temperature with a digital thermometer and confirmed the activity room to be 19.9 degrees Celsius. At 1116 hours an identified home area dining room air temperature was taken and confirmed to be 19.7 degrees Celsius. On an identified day in January 2016, at 1245 hours in an identified home area dining room, resident #065 stated it was cold and uncomfortable in the dining room.

The ESS confirmed that the home was not maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

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 maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the program includes the assistance and support to permit the residents to participate in activities that may be of interest to them if they are not able to do so independently.

During the Resident Quality Inspection (RQI) conducted in November and December of 2014; staff interviews revealed residents with cognitive impairment were not taken to programs and weeks went by with no support or assistance to attend an activation program. Furthermore, staff identified it was the same small group of residents that were taken and all residents were not asked or encouraged to go and as a result a written notice and voluntary plan of correction was issued.

During the RQI in December 2015 and into January 2016, staff and family approached inspectors and revealed little had changed in the activity program during 2015.

Review of progress notes and interviews with identified staff members confirmed residents #011, #015 and #026 as cognitively impaired with a Cognitive Performance Scale (CPS) score of five. In an interview, the LEC explained high risk was determined as those residents with a CPS score of four or five and resident's #011, #015 and #026 were identified at high risk.
A review of the current minimum data set (MDS) for activity pursuit's patterns for residents #011, #015 and #026 revealed the following:
- Resident #011 general activity preferences identified in the MDS assessment from October 2015, were cards, exercise and sports and music, walk/wheeling outdoors gardening or plants talking or conversation.
- Resident #015 general activity preferences identified in the MDS assessment from December 2015, were cards, exercise or sports, music, walk/wheeling outdoors, and
- Resident #026 general activity preferences identified in the MDS, assessment from October 2015, were exercise or sports, music, spiritual or religious activities, watching television, talking or conversing.

Interviews with identified staff members revealed they are directed to only bring the more cognitively intact residents to the programs in the large activity room as this is more manageable, therefore, limiting opportunities for cognitively impaired residents to attend an activity that may address their emotional or sensory domain. All staff in the above noted interviews confirmed residents #011, #015 and #026 do not receive assistance or attend appropriate activities for their cognition level.

Resident observations by inspector #559 on the five occasions in December 2015, identified residents #011, #015 and #026 in the nursing station area and staff interviews revealed they had not been provided the assistance and support to participate in activities available in the home.

Record review and an observation by inspector #559 on December 17, 2015, of a large group music activities program, identified 12 residents participating in the program and did not include residents #011, #015, and #026. A family member confirmed residents #011, #015 and #026 were not assisted to the music activity program and stated it is always the same residents left out.

An interview with an identified staff member revealed resident #015 enjoys music; the resident has not been off the floor and/or assisted to the music programs in the large activity room despite his/her interest in music.

The LEC revealed one program audit was completed on January 9, 2015, and there were suggested changes in the portering of residents and confirmed the organized recreational and social activities program fails to include the assistance and support to permit the residents to participate in activities that may be of interest to them if they are not able to do so independently.
[s. 65. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the program includes the assistance and support to permit the residents to participate in activities that may be of interest to them if they are not able to do so independently, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there is an organized food production system in the home that provides for documentation on the production sheet of any menu substitutions.

On December 10, 2015, day one of the unannounced resident quality inspection, a review of the posted lunch menu outside an identified home area dining room revealed a choice of entrée including deli meat sandwiches. An observation at 1200 hours revealed that the sandwiches were roast beef or turkey/ham. An interview with an identified staff member indicated they ran short of roast beef and substituted with other meats. Recipe review of the ingredients for the deli meat sandwich revealed sliced roast beef and turkey on whole wheat bread.

A review of the home's policy Food Production - Revised Date 2014-11-04, indicated the cook will prepare all food items according to daily production schedule and use standardized recipes and will document all menu changes on the production schedules.

Record review of the production schedule for an identified date in December 2015, did not identify a change. Record review of the menu change/sysco shortages sheets failed to identify documentation of a shortage of roast beef.

Interview with the FSS confirmed he/she was not aware of a shortage of roast beef and that the staff had not notified him/her as required and are expected document changes on the production schedule. [s. 72. (2) (g)]

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 there is an organized food production system in the home that provides for documentation on the production sheet of any menu substitutions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Record review of resident #021's plan of care revealed the resident spends most of his/her time in bed as a result of a debilitating diagnosis. The resident's sleep/rest pattern stated the resident stays up late and prefers to sleeps in late.

Staff interviews revealed the resident is well known to vocalize his/her preference to sleep in late and not get up for breakfast. Resident interview revealed that specific staff turn on the overheard lights when assisting his/her roommate between 0630-0830 hours with no regard to his/her preference to sleep.

The inspector observed the main light switch inside the room turns on two light panels, one panel over each resident bed. An interview with an identified staff member confirmed he/she does turn on the overhead light when entering the room to provide care to resident #021's roommate and confirmed he/she is aware resident #021 prefers not to have the overhead light turned on. An interview with another identified staff confirmed resident #009 and his/her roommate have different waking times and resident #009's preference to sleep. The identified staff member stated he/she is able to provide the roommates care and safe access to his/her bed by using the bedside light along with the main hallway light.

The aDOC confirmed there was sufficient light to enter the room for clear and safe access to the roommate's bed without turning on the overhead light. The aDOC further confirmed that staff should not have turned on the lights when providing morning care to resident #021's roommate and doing so is a lack of respect for resident #021's preference. [s. 3. (1) 1.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 failed to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

During the mandatory medication inspection by inspector #559, he/she reviewed the following pharmacy policy entitled "After Hours Emergency Services: 3 step process", Policy #1.4, current revision date March 2009, indicated a 3 step process to direct staff to:
1. Check the emergency medication box,
2. Contact the satellite pharmacy and/or,
3. Contact the after-hours emergency on-call pharmacist.

Record review of the Resident's Individual Narcotic and Controlled Drug Count Sheet revealed and confirmed the following:
- Resident #035 had a narcotic count sheet for an identified medication and it was noted on a date in December 2015, one tablet was borrowed for a different resident and on a second date in December 2015, another tablet was borrowed for a different resident.
- Resident #036 had a narcotic count sheet for an identified medication and it was noted on a date in December 2015, one tablet was borrowed for a different resident and on a second date in December 2015, another tablet was borrowed for a different resident.
- Resident #037 had a narcotic count sheet for an identified medication and it was noted in November 2015, one tablet was borrowed for a different resident and in December 2015, one tablet was borrowed for a different resident.
- Resident #038 had a narcotic count sheet for an identified medication and it was noted in November 2015, two tablets were borrowed for a different resident.

An interview with an identified registered staff member revealed this is not correct and the procedure is to contact the satellite pharmacy or pharmacist on-call.

Record review of the home's policy #1.4 and the resident's individual narcotic and control drug count sheets confirmed the home did not comply with their policy.
[s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure the resident received assistance required to dress appropriately and suitable to the time of day and in accordance with their preferences, in their own clean clothing and appropriate clean footwear.

A record review of the plan of care and interviews with identified staff members revealed resident #015 requires total assistance with dressing and does not have many clothes and one pair of long pants.

In December 2015, the inspector observed the resident in ripped cut off pants sitting by the nurses station, on two other occasions in December, resident #015 was also observed wearing cropped pants and his/her lower legs were cool to the touch.

An interview with an identified staff member revealed the resident has one pair of long pants available.

A registered staff member confirmed the resident had been wearing the ripped cut off pants and it was not appropriate or suitable for the winter season. [s. 40.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the Residents' Council meeting minutes for October and November 2015, revealed 2 areas of concern:
- October 21, 2015, meeting minutes 2 issues/concerns raised 1 - not enough snacks especially in the evening, and 2 - residents asking for pickles served with supper meal and would like beans and wieners with toast.
- November 18, 2015, meeting minutes 1 concern raised – not enough snacks in the evening.

The administrator confirmed the licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to the above concerns. [s. 57. (2)]

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 failed to 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.

Staff interviews and a review of the home's current process for determining satisfaction revealed the home uses the standardized stage 1 questions from abaqis plus three additional questions regarding satisfaction with the facility and likelihood of recommendation by residents and family members.

An interview with the administrator confirmed the home's current survey is an audit and does not determine satisfaction with all programs and services, such as occupational therapy, physiotherapy, continence care, and skin and wound program. [s. 85. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident, including, for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons.

Record review of a Critical Incident, CI2835-000037-15, revealed resident #046 was involved in an incident with resident #047. Interviews with the aDOC and Administrator confirmed the home did not notify the Director that resident #047's substitution decision maker (SDM) was notified of the incident. [s. 107. (4) 3. iv.]

Issued on this 24th day of February, 2016

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

Original report signed by the inspector.