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
Direction de l'amélioration de la performance et de la conformité

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 19, 2015	2014_251512_0020	T-064-14	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - RICHMOND HILL
170 Red Maple Road RICHMOND HILL ON L4B 4T8

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

TILDA HUI (512), DIANE BROWN (110), JULIENNE NGONLOGA (502), NATASHA JONES (591)

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): October 21, 22, 23, 24, 27, 28, 29, 30, 31 and November 3, 2014.

Additional inspection related to the following Log#s were also completed during this inspection:
1) T-523-13, complaint,
2) T-668-13, critical incident,
3) T-1248-14, complaint.

During the course of the inspection, the inspector(s) spoke with the director of administration(DOA), director of care(DOC), associate director of care(ADOC), registered nurse(RN), registered practical nurse(RPN), personal support worker(PSW), registered dietitian(RD), food services manager(FSM), environmental services manager(ESM), social worker, maintenance staff

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **4 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).

Findings/Faits saillants :

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

On October 28, 2014, at 10:00 am, the inspector observed resident #031 sitting in a wheelchair in the television (TV) lounge.

Review of the resident's plan of care dated August 8, 2014, indicated that the resident uses a walker for ambulation.

Interview with an identified nurse indicated that the resident uses a wheelchair for ambulation and that the care plan had not been updated to reflect the resident's present mobility status. The nurse confirmed that the plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care is based on the resident's needs

and preferences.

Observations made on October 21 and 27, 2014, noted that resident #002 was wearing a pair of white cotton gloves.

Review of the resident's plan of care did not include the use of cotton gloves for any particular reason.

Interview with an identified PSW revealed that the resident told the PSW that his/her fingers are cold and needs the gloves for warmth and comfort. Interview with an identified registered nursing staff indicated the resident has sensitivity on his/her fingers due to diabetic neuropathy, and confirmed that the resident's plan of care should include the use of cotton gloves to meet the needs and preferences of the resident. [s. 6. (2)]

3. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Interview with resident #003 indicated that the resident prefers having his/her showers early in the afternoon, and he/she will refuse the shower if it is offered in the evening.

Record review indicated that the resident required assistance with showers twice weekly on Tuesday and Friday evenings. Record review and staff interviews confirmed that the resident had regularly refused showers in the past even with a lot of encouragement.

Interview with an identified PSW indicated that the resident usually sits in the lobby and asks staff to assist him/her with his/her shower as soon as the PSW enters the building for the PSW's evening shift that starts at 3 p.m. The PSW also indicated that the resident has not refused taking showers since the PSW started assisting him/her with his/her showers in the afternoon instead of in the evening.

The resident’s plan of care does not include an assessment of the resident's needs and preference, and the resident's preference to receive assistance with his/her showers in the afternoon. [s. 6. (2)]

4. The licensee 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.

Record review indicated that resident #007 is incontinent of urine and continent of bowel. Review of the progress notes dated October 2, and September 23, 2014, revealed that an identified registered nursing staff identified the resident as being totally incontinent of bowel.

Staff interview indicated that the resident is incontinent of bowel and urine. An identified PSW indicated that when the resident's spouse comes, he/she speaks in the resident's own non-English language and guides the resident to the toilet to void. Other times when the resident's spouse does not visit, the resident voids in his/her bed. The PSW also indicated that the PSW leaves the resident's washroom's door open as a reminder to the resident to use the toilet when he/she feels the need.

The staff did not collaborate with other staff members by sharing strategies to promote continence for the resident, and these strategies were not included in the resident's plan of care. [s. 6. (4) (a)]

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 set out clear directions to staff and others who provide direct care to the resident, the plan of care is based on an assessment of the resident, resident's needs and preferences, and 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, to be implemented voluntarily.

WN #2: 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 is complied with.

Interview with resident #032 indicated that he/she has been self administering an identified topical medication.

Record review of the resident's physician order for the medication did not include instructions for self-administration by the resident.

Record review of the policy titled Medication Management-Resident Self Administration, number V3-1050, revised March 2012, states that residents may self-administer their medications only upon a physician's order.

Interviews with an identified registered staff and the DOC confirmed that the resident was self-administering the medication without a physician's order and that the home's policy was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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 the resident exhibiting altered skin integrity, including pressure ulcers, 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.

Record review noted that resident #001 was identified with the following altered skin integrity and weekly skin assessments were not conducted:

1) From October 17 to October 28, 2014 when a stage 3 pressure ulcer was identified at the coccyx, measuring 0.7 x 0.5 c.m.
2) On June 26, 2014, when a skin tear was identified on the right shin with bruising measuring 0.5 x 0.3 c.m.
3) Between June 10 to June 26, 2014, when a skin tear was identified on the buttocks measuring 0.5 x 0.8 c.m.

Interview with an identified RPN on the unit confirmed that the weekly skin assessments were not conducted for the above mentioned periods for the resident with altered skin

integrity. [s. 50. (2) (b) (i)]

2. Record review of resident #021 indicated that the resident developed a redness on his/her upper lips and upper chest on September 14, 2014. There was no evidence of any skin assessment conducted on the resident by registered nursing staff using a clinically appropriate assessment instrument upon identification of altered skin integrity after September 14, 2014.

Interviews with an identified registered nursing staff and the DOC confirmed that a skin assessment was not conducted when the resident was noted to have redness on his/her lips and upper chest. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are assessed by a registered dietitian who is a member of the staff of the home, and have any changes made to the plan of care related to nutrition and hydration implemented.

Record review revealed that resident #001 had the following altered skin integrity identified:
1) A skin tear was identified on June 10, 2014, on the buttocks measuring 0.5 x 0.8 cm,
2) A skin tear was identified on June 26, 2014, on the right shin with bruising measuring 0.5 x 0.3 cm.

Record review did not reveal any evidence of a referral being made to the registered dietitian (RD) for the altered skin integrity.

Interview with an identified RPN on the unit confirmed that no RD referral was made in June 2014, after the skin tears were identified. [s. 50. (2) (b) (iii)]

4. A review of resident #021's record indicated that the resident developed a redness on his/her upper lips and upper chest on September 14, 2014. There was no evidence of any referral made to the RD by registered nursing staff upon identification of altered skin integrity after September 14, 2014. There was no evidence of any changes made to the plan of care related to nutrition and hydration been implemented.

Interviews with an identified registered nursing staff and the DOC confirmed that a referral to the RD was not made when the resident was noted to have redness on his/her lips and upper chest. Therefore the resident was not assessed by the RD after

September 14, 2014. [s. 50. (2) (b) (iii)]

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 resident exhibiting altered skin integrity, including pressure ulcers, 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, to ensure that the resident exhibiting altered skin integrity, including skin tears are assessed by a registered dietitian who is a member of the staff of the home, and have any changes made to the plan of care related to nutrition and hydration implemented, to be implemented voluntarily.

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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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 the designated staff member to co-ordinate the infection prevention and control program possesses education and experience in infection prevention and control practices.

Interview with the associate director of care who is the lead for the infection prevention and control program indicated that the lead does not possess formal education in infection prevention and control practices including infectious disease, data collection and trend analysis, reporting protocols, outbreak management, and cleaning and disinfection.

Interview with the DOC confirmed that the home will be sending the lead to receive education in the above mentioned areas. [s. 229. (3)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

1) Interview with an identified PSW on the first floor noted a nail clipper cabinet in the clean utility room where an individually labeled nail clipper for each resident is kept inside each caddy. The inspector observed cut nail pieces in two of the caddies. The PSW indicated that residents' nails are cut weekly, and nail clippers used are soaked in a solution provided by maintenance staff. The PSW was not able to provide the name of the chemical. The PSW also indicated that the nail clippers are soaked for a day after every other use.

Interview with an identified PSW on the second floor indicated that individually labeled nail clippers for residents are to be rinsed in soap and hot water after each use, then wiped dry and put back into the storage cabinet.

2) Observation was made on October 23, 2014, at 4:55 p.m. on first floor outside room #117 which has a contact precaution sign on the door. When the inspector asked an identified PSW the reason for the precaution, the PSW said the resident has been having loose stool for two days and was kept on contact precaution. The PSW further explained that for contact precaution, staff have to put on gloves, mask and gown before going into the resident's room to provide care. Personal protective equipment (PPE) were observed stored in a cabinet outside the resident's door. At the time, an identified PSW student was observed inside the resident's room waiting at the washroom door for the resident who was in the washroom. The PSW student had a pair of gloves on his/her hands and no other PPE. The PSW student put his/her right gloved hand on the door frame while waiting. The PSW asked the PSW student to come out of the resident's room. The PSW student explained that he/she had removed the resident's soiled incontinent brief with his/her gloved hands. The PSW indicated that nursing staff have been informed not to

provide care in the resident's room until they put on PPEs including mask, gown and gloves.

Interview with the DOC confirmed that PSW students have been trained with all infection prevention and control practices including use of PPEs and they should be aware of the proper use of the PPE's.

3) Observation made on October 31, 2014, at 11:50 a.m. on third floor outside the elevator. An identified PSW was observed holding a bag of soiled incontinence briefs with a pair of disposal gloves in his/her hand walking towards the soiled utility room. The PSW proceeded to open the door of the room by pressing on the key pad to unlock the door with one hand with glove turned down half way on his/her hand, and turned the handle on the lock pad to open the door with the other gloved hand. The PSW then disposed of the bag inside the bin in the room. The PSW was observed wearing a disposable surgical mask under his/her chin. The inspector asked PSW what he/she had done with his/her gloved hands prior to disposing the soiled incontinence briefs. The PSW stated that he/she had toileted a resident inside the washroom in the unit and put the soiled diaper in the bag and came out to dispose of the bag in the same pair of gloves. The PSW stated that he/she had folded down his/her left glove half way so he/she used his/her thumb and one finger to press on the key lock, and the PSW stated that his/her ungloved part of his/her left hand was clean. The PSW explained the reason for wearing the surgical mask because the PSW was coughing, so he/she put on the mask while changing the resident and forgot to take the mask off afterwards.

Interview with the DOC confirmed that mask should not be worn under the chin, and that the PSW should have removed soiled gloves, and performed hand hygiene before touching any common area furnishing.

4) Observation made on October 20, 2014, at 10:30 a.m. on first floor in the shower room noted one unlabeled tooth brush, three unlabeled hair combs with hair on them, and a can of shaving cream on a care cart. It was confirmed with an identified PSW that residents have their own individually labeled personal care items. The PSW was not sure why the unlabeled items were sitting in the shower room.

5) Interview with an identified PSW on October 21, 2014, at 2:15 p.m. revealed that the PSW has been providing mouth care to resident #008 in the morning by brushing his/her teeth. When asked which toothbrush was used, the PSW went with the inspector to the tub room and took an unlabeled tooth brush out of the linen cupboard. The PSW

indicated that when it is shower day for the resident, he/she would do everything at the same time for the resident including mouth care, and would use the unlabeled tooth brush and tooth paste in the tub room. [s. 229. (4)]

Additional Required Actions:

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

WN #5: 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, its furnishings and equipment are kept clean and sanitary.

Observation made on October 20 and 27, 2014, revealed that five dining rooms chairs on the third floor and 10 dining room chairs on the first floor dining room were soiled and stained.

Record review indicated that all dining room chairs were scheduled to be cleaned on October 7, 2014.

Interview with maintenance staff indicated that the chairs were cleaned as per schedule. The maintenance staff conducts daily audits to remove soiled and stained chairs for housekeeping staff to power wash. At the time of inspection, the maintenance staff indicated that he/she had not completed the audit during the week of October 27, 2014, and planned to resume the first week of November 2014.

Interview with the ESM confirmed that the chairs were stained and needed to be cleaned. [s. 15. (2) (a)]

WN #6: 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 can be easily seen, accessed and used by residents, staff and visitors at all times.

1) Observation on October 20, 2014, at 10:20 a.m. in the first floor dining room noted two call bells in the room, one was located beside the sink with a scraping cart and a garbage bin right in front of it. The call bell hanging down from the wall is not accessible for residents who are in wheelchairs or walkers because the residents cannot lean over the scraping cart and garbage bin.

Interview with an identified RPN confirmed that that the residents would not be able to reach the call bell to activate it at its current location.

2) Observation made on October 20, 2014, at 11 a.m. in the main floor activity room revealed a call bell installed on the wall next to the door. The call bell cord was coiled around and clipped onto the bottom of the call bell which could not be activated by residents especially those in wheelchairs.

Interview with an identified PSW confirmed that the call bell cord was usually hung down

along the wall. The PSW stated that someone must have been playing with the call bell cord. The PSW removed the clip on the cord and left the cord in a hanging position.

3) Observation made on October 21, 2014, at 10 a.m. noted that resident #008 was sitting in a tilted wheelchair beside the bed in his/her room. The tilted wheelchair with the resident was placed near the end of the bed facing the television. The call bell cord was noted clipped onto the head of the bed on the railing about two feet away from the resident's wheelchair. Resident would not be able to reach back past the wheelchair to activate the call bell when needed.

The inspector brought to the attention of an identified PSW who confirmed that the resident would not be able to access and use the call bell in its current location as the cord was too short. The PSW indicated that he/she would contact the maintenance staff to extend the cord so the resident would be able to reach it.

The inspector returned at 2:30 p.m. and noted that the call bell cord has been lengthened and placed on the bed beside the resident sitting in the tilted wheelchair. The call bell is now accessible by the resident.

4) Observation made on October 23, 2014, at 11:00 a.m. noted in resident 009's room that resident's bed was located in the corner with one side of the bed against the wall lengthwise. A call bell was located at the end of the bed near a window with cord about 24 inches long which was long enough to reach the end of the bed. The resident would not be able to reach the call bell cord when lying in bed with his/her feet close to the window.

Interview with an identified PSW confirmed that the resident would not be able to activate the call bell when lying in bed with his/her head against the wall and his/her feet near the window. [s. 17. (1) (a)]

WN #7: 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:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming.

Record review indicated that resident #007 is continent of urine and incontinent of bowel, feeds self but requires one staff to assist with set up and encouragement at meal times, and displays resistive and inappropriate sexual behaviors. The resident was not referred to the behavioral support ontario (BSO) team.

Staff interview indicated that the resident is incontinent of urine and bowel, needs to be fed, and requires total care.

The resident's plan of care is not developed based on the resident's type and level of assistance required for feeding and toileting. [s. 26. (3) 7.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed by the method of his or her choice, including tub baths, showers, and full body sponge baths, unless contraindicated by a medical condition.

Interview with resident #003 indicated that the resident received assistance with shower twice per week, but prefers to have bath.

Record review indicated that the resident required assistance with shower twice weekly, Tuesday and Friday evenings.

Interview with the ADOC indicated that the resident was not asked about his/her preference for bathing during the development of the plan of care and was not bathed by the method of his/her choice. [s. 33. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, and physical assistance to help a resident who cannot for any reason brush his or her own teeth.

Observation made on October 21, 2014, at 10:30 a.m. noted that resident #008 had unclean mouth with food debris on his/her lips, and was drooling saliva onto a wet cloth placed underneath his/her chin. The resident has diagnosis of Parkinson's disease and is totally dependent on all aspects of personal care including mouth care. A dry, clean and apparently new toothbrush was noted in the medicine cabinet in the resident's washroom. At an interview, the resident stated that he/she has been receiving mouth care once or twice a week.

Interview with an identified PSW on first floor who provides care to the resident on October 21, 2014, indicated that the PSW had provided mouth care to the resident by brushing his/her teeth. When asked which toothbrush was used, the PSW took the inspector to the tub room on the floor and took an unlabeled tooth brush out of a tooth paste container inside the linen cupboard. When the inspector asked the PSW the reason for not using the toothbrush in the medicine cabinet in the resident's washroom, the PSW indicated that when it is shower day for the resident, he/she would do everything at the same time including mouth care, and use the tooth brush and tooth paste in the tub room. The inspector asked if the PSW had brushed the resident's teeth this morning, the PSW responded by saying "yes". When asked if the resident had a shower or bath today, PSW said "No, he/she had the shower yesterday".

Review of the bath list revealed that the resident's shower days were scheduled on Monday and Friday mornings which indicated that the resident did not have a shower on Tuesday October 21, 2014, and therefore did not receive any mouth care in the morning of October 21, 2014, as stated by the PSW.

Interview with the DOC confirmed that the mouth care was to be provided to the resident twice daily, once in the morning and once in the evening. [s. 34. (1) (a)]

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

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is offered a minimum of three meals daily.

Record review revealed that resident #002 is at high nutritional risk. The resident's current diet is modified diabetic with regular texture and thin fluids. The resident has multiple food preferences and variable oral intakes of meals.

Interview with the resident indicated that he/she does not like the food from the home, but is getting food from his/her family.

On October 20 and 27, 2014, resident #002 was observed eating lunch which consisted of subway sandwiches and spaghetti with meat sauce respectively, provided by his family. The resident was not offered lunch during those two days.

Staff interview indicated that the resident is offered breakfast and dinner, and is not offered lunch, because one of the resident's children brings food every day. At lunch time the resident's private sitter will warm the food and feed the resident. An identified PSW indicated that the home rely on the sitter to request lunch for the resident if needed, otherwise staff do not offer nor serve lunch to the resident. Interview with the dietary aide confirmed that he/she always serves egg, two toast, and coffee for breakfast to the resident and does not serve lunch because one of the resident's children provides lunch every day. [s. 71. (3) (a)]

2. The licensee has failed to ensure that an individualized menu is developed for the resident if their needs cannot be met through the home's menu cycle.

Record review revealed that resident #002 is at high nutritional risk, with a current

modified diabetic diet with regular texture and thin fluids; has multiple food preferences and variable oral intakes of meals, chewing difficulty with some foods but does not want a modified textured diet. The resident's body max index (BMI) is 23.7 and current weight is 68.5 kilogram (kg) below the goal weight of 69.4kg - 84.0 kg.

Interview with the RD indicated that based on the current menu and the resident's intake, the resident is receiving 1200Kcal from the home's menu, which is 70 per cent of his nutritional needs. The RD confirmed that the home is not meeting the nutritional needs of the resident and indicated that an individualized menu was not developed based on the resident's preference and acceptance.

Interviews with an identified dietary aide and PSW indicated that there was no individualized menu for the resident. The FSM confirmed that an individualized menu was not developed for the resident. [s. 71. (5)]

WN #11: 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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(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 there are appropriate furnishings and equipment in resident dining areas, including tables at an appropriate height to meet the needs of all residents.

Observations made during lunch services on October 21 and November 3, 2014, noted resident #014 sitting low in his/her wheelchair at the dining room table with shoulders aligned with the dining room table height. The table height was not appropriate to meet the resident's needs. [s. 73. (1) 11.]

2. Observations made during lunch services on October 21 and November 3, 2014, noted resident #017 sitting low in his/her wheelchair at the dining room table with shoulders aligned with the dining room table height. The table height was not appropriate to meet the resident's needs.

Interview with an identified registered nursing staff confirmed that both the residents were sitting too low for feeding and the table heights were not appropriate for the residents. [s. 73. (1) 11.]

3. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

Observation made on October 20, 2014, during lunch service on the third floor dining room revealed that resident #015 was served pureed chicken soup at 12:05 p.m. The soup sat in front of him/her at the table until 12:19 p.m. when staff became available to assist with feeding.

On the same day, resident #016, and resident #018 were also served pureed chicken soup at 12:14 p.m. Staff became available to assist with feeding at 12:24 p.m.

The residents are served meal before staff is available to provide assistance. [s. 73. (2) (b)]

WN #12: 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 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 current process for determining satisfaction involves the use of the stage one questions from the abaqis, in addition the home has two questions using a scale from one to ten regarding satisfaction and recommendation.

Interview with the administrator confirmed that the current process completed within the home is the abaqis's resident and family interview respectively, and the home does not have another survey to measure satisfaction with services. [s. 85. (1)]

WN #13: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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 for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response has been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Interview with resident #006 revealed that several verbal complaints were made to an identified registered staff, an identified PSW, and management regarding constant noises and disruptive behaviours of other residents on the unit but responses were not provided to the resident by the home.

Interviews with an identified registered staff and an identified PSW confirmed that the resident had made the above mentioned verbal complaints.

Interview with the DOA confirmed that responses had not been provided to the resident indicating what the home had done to resolve the complaints, or that the home believed the complaints to be unfounded and the reasons for the belief. [s. 101. (1) 3.]

2. 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

Interview with resident #006 revealed that several verbal complaints were made to an identified registered staff, an identified PSW, and management regarding constant noises and disruptive behaviours of other residents on the unit without any action taken by the home.

Interviews with an identified registered staff and an identified PSW confirmed that the resident had made the above mentioned verbal complaints, the complaints were not resolved within 24 hours after they were made, and the complaints were not documented.

Interview with the DOA confirmed that the verbal complaints were not documented. [s. 101. (2)]

WN #14: 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 administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Interview with resident #032 revealed that he/she has been self-administering an identified topical medication.

Record review of the physician’s order for the topical medication did not include instructions for the resident to self-administer the medication.

Interview with an identified registered staff confirmed that the physician's order did not include the required instructions for the resident to self-administer the medication. [s. 131. (5)]

Issued on this 19th day of January, 2015

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

Original report signed by the inspector.