Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de sions 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
May 2, 2016	2016_267528_0006	008910-16	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400 HAMILTON ON L8R 2K3

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

MACASSA LODGE
701 UPPER SHERMAN AVENUE HAMILTON ON L8V 3M7

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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585), YULIYA FEDOTOVA (632)

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): March 30, 31, 2016 and April 1, 4, 5, 6, 7, 8, 12, 2016.

This inspection was done concurrently with Critical Incident System Log #'s 002482 -15, 020404-15 and 009377-16 related to abuse, 004547-14, 006462-14, 015233-15 and 009280-16 related to falls, 005761-14 and 019618-15 related to misappropriation of funds; Complaint Inspection Log #'s 023958-15 related to food quality and food production, 000651-16 related to abuse and falls.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Resident Assessment Instrument (RAI) and Restorative Care Coordinator, Nurse Managers (NM), Food Service Director (FSD), Food Service Supervisors (FSS), Registered Dietitian (RD), Director of Building Services, Physiotherapist (PT), Occupational Therapist (OT), physiotherapy assistant (PTA), Administration Assistant (AA), Supervisor of Resident Services, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), cook, dietary aides, housekeeping staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_210169_0008	528

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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home's policy, "Transfer Between Long Term Care Home, Complex Continuing Care Facility or Hospital", last reviewed October 14, 2015, stated "in the shifts following transfer home to Lodge the Registered Staff will assess resident condition and make required changes to plan of care to accurately reflect current status and health needs. Resident will have q shift charting x 3 days".

In November 2015, resident #015 returned from hospital with a new diagnosis. Review of progress notes revealed the resident was not assessed on three out of nine shifts. RN #101 stated the home's expectation was to assess the resident each shift for three days and confirmed the home did not follow their home's policy when the resident returned from hospital. (585)

B. The home's "Fall Management Program, NM 03-02-08", last revised January 2016, identified for post fall assessment and management that registered staff would "initiate head injury routine for all unwitnessed falls and monitor every hour for the first four hours and then every 4 hours for 24 hours post fall for signs of neurological changes; and document using follow-up note to the fall note in Point Click Care (PCC) each shift for a minimum of 24 hours".

Resident #024 sustained multiple falls between December 2015 and March 2016.
i. The resident did not have Head Injury Routine (HIR) initiated after their unwitnessed falls on three occasions and HIR's were not completed and documented for two falls, as confirmed by registered staff #113.
ii. The resident did not have a follow-up note documented in PCC each shift for a minimum of 24 hours after the three falls, as confirmed by registered staff #113.
Registered staff #113 confirmed the Falls Management Program was not consistently complied with as required post fall. (581)

C. The home's policy "Bed rails, 01-01-07", last revised August 7, 2015, identifeid that a Bed Rail Risk Assessment was to be completed within seven days admission into the Lodge. In addition, registered staff were to completed another assessment in response to changes in bed rail use or request.

i. In August 2015, the Bed Rail Risk Assessment for resident #012 identified that the resident required no rails when in bed. In September 2015, registered staff documented the resident was using both rails; however, a new Bed Rail Risk Assessment was not completed. Interview with the registered staff #101 confirmed that the Bed Rail Risk Assessment was not completed when their was a change in bed rail use, as required by the home's policy.

ii. In August 2015, the Bed Rail Risk Assessment for resident #013 identified that the resident required both standard bed rails for mobility and positioning. In January 2016, a longer rail was added to one side of the bed. Review of the plan of care did not include a Bed Rail Risk Assessment. Interview with registered staff #101 confirmed that the Bed Rail Risk Assessment was not completed when their was a change in bed rail use as required by the home's policy. (528)

D. The home's policy, "Hydration - FS-09-01-22", revised July 1, 2012, stated "beverages, including water, will be provided for all residents as indicated in the policy". The policy outlined "daily fluid intake is generally provided through three meals and three nourishment passes", which included 125 mL (4 oz) of water at noon meal.

On April 1 and 6, 2016, during a lunch observation in a specified dining room, dietary staff #109 was observed providing fluids to residents; however no water was observed on their beverage cart. Dietary staff #109 reported in an interview that water was provided when requested by the resident. Interview with the RD who reported water was to be provided to residents at meals, not just upon request, and the home's hydration policy was not complied with. (585)

E. The home's policy, "Involuntary Weight Change, FS-09-01-18", revised July 1, 2012, outlined the home's the monthly weight process:

"Day 1-6: RHA staff will weigh, (reweigh if +/- 2.5 kg) and record in POC
Day 7: RN confirms all weights are completed
Day 8: RN runs report for weight change and requests re-weighs as required
Day 9: Reweighs completed, recorded in PCC
Day 10: RD refers to PCC for re-weighs and deletes initial weights as needed
Day 11: RD initiates follow-up/documentation"

i. Resident #014's plan of care indicated they were a nutritional risk. In March 2016, the resident experienced weight loss over one month after their weight was documented by a

PSW. In March 2016, the RD requested a re-weigh twice. The reweigh was not completed by the tenth day of the month or after two requests from the RD, as required in the policy.

ii. Resident #022's plan of care indicated they were at a nutritional risk. In March 2016, the resident was identified as experiencing weight loss over one month after their weight was documented by a PSW. Several days later, the RD assessed the resident and requested a re-weigh. No weight was taken until April 2016, which revealed they experienced further weight loss.

iii. Resident #067's plan of care indicated they were at a nutritional risk. In March 2016, the resident experienced weight loss over one month after their weight was documented by a PSW. The follow day and then again two weeks later, the RD assessed the resident and requested a re-weighs; however, a re-weighed did not occur until April 2016.

The RD confirmed that the home did not follow their policy for monitoring involuntary weight changes for resident #014, #022 and #067. (585) [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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

In January 2016, resident #083 sustained an injury when PSW #120 was transporting resident #083 in their wheelchair. Interview with PSW #120 confirmed that the resident indicated they had pain at the same time they felt resistance while pushing the wheelchair, which made them stop. Interview with registered staff #108 confirmed that she assessed the resident and the wheelchair after the incident and the foot rest was not applied correctly and had come undone. Interview with NM #150 confirmed that all staff and vounteers were to ensure the resident's were in a safe position prior to transporting a resident. PSW #120 did not ensure that resident #083 was in a safe position prior to transporting the resident to the shower resulting in superficial injury and pain. (528) [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff used safe transferring and positioning devices or techniques when assisting residents, 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 failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, 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 was specifically designed for skin and wound assessment.

On two days during the course of the inspection, resident #022 was observed with small scratches to the top of their hand. Review of the plan of care including but not limited to, progress notes and point of care documentation, did not include any documentation of altered skin integrity to the resident's hand. Interview with RPN #104, confirmed that the area was not assessed and documented in plan of care, as required by the home's policy. (528) [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In December 2015, registered staff documented an area of altered skin integrity had reoccurred for resident #017. In January and February 2016, registered staff documented the same area open, and in March 2016, the area was noted to be worsening. Review of the plan of care from December 2015 to March 2016, did not include weekly wound assessments for the area of altered skin integrity. Interview with registered staff #120 confirmed that resident #017 had a reoccurring area of altered skin integtiry related to pressure which was to be assessed weekly by registered staff using the Wound Assessment Flowsheet in PCC, as outlined in the home's "Skin and Wound Care Program, NM-03-08-14", last revised January 2016; however, was not completed. (528) [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #4: 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: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that course by course service of meals for each resident was included as part of their dining and snack service.

On April 5, 2016, during an observation of supper in a specified dining room, residents at three different tables were served dessert before they had finished their main course. One resident stated they had not finished their main course and was observed with half of their sandwich in their hand. FSS #147 confirmed all residents in the dining room were to be served course by course. (585) [s. 73. (1) 8.]

2. The licensee has failed to ensure that proper techniques were used to assist a resident with eating, including safe positioning.

A. On April 6, 2016, during lunch in a specified dining room, resident #102 was observed seated in a tilt wheel chair in a reclined position, receiving total assistance with eating by

PSW #122. Interview with PSW #122 stated the resident could receive assistance in either a reclined or upright position. RPN #123 reported the resident was to be seated upright when eating and confirmed they were in an unsafe feeding position. (632)

B. Resident #065's plan of care stated they were to be in an upright feeding position for eating. On April 5, 2016, during supper in a specified dining room, resident #065 was observed seated in a tilt wheel chair in a reclined position, receiving total assistance with drinking and eating by PSW #151. The PSW was observed standing, leaning over an over bed table while providing fluid to the resident from a glass. PSW #151 reported they did not use appropriate techniques to assist the resident. RPN #115 confirmed the resident was to be seated in an upright position when eating. (585)

C. Resident #064's plan of care stated the resident had swallowing difficulties. On April 5, 2016, during supper in a specified dining room, resident #064 was observed seated in a tilt wheel chair in a reclined position, receiving total assistance with eating by PSW #152. RPN #115 reported the resident was to be seated upright when eating and confirmed they were in an unsafe feeding position. (585) [s. 73. (1) 10.]

3. The licensee failed to ensure that their dining and snack service included use of appropriate furnishings and equipment in resident areas, including comfortable dining room chairs and tables at an appropriate height to meet the needs of all residents.

On April 5, 2016, during dinner and April 6, 2016, during lunch, resident #066 was observed seated in their wheelchair eating with their chin parallel to the height of the table. PSW #153 reported the resident had been seated in the observed position for approximately one week as the resident was unable to comfortably transfer into a dining chair. The resident stated they would be more comfortable if their table height was lower. FSS #147 confirmed the resident was not provided a table that was an appropriate height to meet their needs to eat comfortably. (585) [s. 73. (1) 11.]

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 proper techniques are used to assist a resident with eating, including safe positioning, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15(1)(a) of the Act, procedures were developed and implemented for cleaning and disinfection of resident care equipment, including tubs and lift chairs, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Instructions in the home for the cleaning of tubs and tub chairs stated, "after each use, use tub water wand to rinse all debris, soap, etc., from tub using hot water, cover all surfaces of tub chair and tub with pre-diluted disinfectant from wand, using tub brush, brush disinfectant over all surfaces of tub. Use a facecloth to apply disinfectant to surfaces of tub chair (remember the underneath side of chair)., leave product on for 10 minutes. Return and rinse all surfaces of chair and tub as well. Dry tub chair. Ready for next use".

On March 30, 2016, in the morning, during an initial tour of the home:

i. In the D wing spa room, white scum/debris sizing approximately one foot by one and a half feet was observed around the drain and on the side of the tub in the D home area spa room. The debris was also observed on the underside of the tub chair. PSW #138 confirmed the room was ready for use; however the chair and tub were unclean.

ii. In the E1 wing spa room, white dry debris was observed on the underside of the tub chair. The rest of the tub appeared dry and clean. PSW #134 confirmed the chair was unclean. On April 6, 2015, PSW # 139 reported that on March 30, 2016, the tub was not cleaned right after use as staff were busy. [s. 87. (2) (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 as part of the organized program of housekeeping under clause 15(1)(a) of the Act, procedures are developed and implemented for cleaning and disinfection of resident care equipment, including tubs and lift chairs, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31(3) of the Act, that staff applied the physical device in accordance with any manufacturer's instructions.

On March 31, 2016, resident #81 was observed seated in a tilted wheelchair with a lap belt that appeared that to be loose: approximately, five fingers width between the belt and the resident's torso. Review of the plan of care included an Assessment for Use of Restraints dated March 2016, that identified the resident required the front fastening seat belt while in the wheelchair for safety.
On March 31, 2016, the RN #101 confirmed that lap belt was loose and applied with the space of 5 fingers width between the belt and the resident's torso and the widths needed to be two fingers width instead. (632) [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31(3) of the Act, that staff apply the physical device in accordance with any manufacturer's instructions., to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

In October 2015, new medication orders for an antipsychotic were written for resident #084; however, were transcribed into resident's #012's chart. Review of the electronic medication adminsitration record (eMAR) identfied that resident #012 was administered three doses of the antipsychotic. Interview with RPN #103 confirmed medication orders from a consultation report for resident #084 were transcribed in error in resident #012's chart. Interview with NM #150 confirmed that the medication administered to resident #012 was not prescribed for the resident; and although no negative outcomes were assessed, the administration was a medication incident. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A. In August 2015, the Minimum Data Set (MDS) assessment for resident #022 indicated they did not demonstrate verbally responsive symptoms during the assessment review period. In November 2015, their MDS assessment indicated they demonstrated verbally responsive symptoms that were easily altered and their was no change in their behavioural symptoms compared to the August 2015 MDS assessment. In February 2016, their MDS assessment indicated they demonstrated verbally responsive symptoms that were not easily altered and that there was no change in their behavioural symptoms compared to the November 2015, MDS assessment.
Review of point of care documentation completed by PSWs as well as progress notes revealed the resident demonstrated verbally responsive behaviours during the review periods. PSW # 131 and RPN #104 reported they were aware that the resident demonstrated verbally responsive symptoms. The RAI coordinator confirmed the assessments completed by staff were not consistent with or complemented each other. (585)

B. The Minimum Data Set (MDS) Assessment from December 2015 identified that resident #012 had impaired vision but did not have any visual appliances (for example, glasses). However, the Resident Assessment Protocol (RAPS) from December 2015, described that the resident wore glasses daily and all the time. Interview with RPN #103, confirmed that the resident did have glasses, and the MDS and RAPS Assessments from December 2015, were not consistent with each other. (528

C. Review of the plan of care indicated that resident #040 fell in June 2015 and sustained a fractured. Review of the MDS assessment in September 2015, did not identify that the resident had a fracture in the past 180 days. Interview with the RAI Coordinator confirmed the MDS assessments and the post fall assessment were not consistent or complemented each other. (581)

D. Review of the MDS assessment completed in July 2015, indicated resident #026 was occasionally incontinent of bladder and in October 2015, was noted they were frequently incontinent of bladder. Interview with the RAI Coordinator stated there was a change in their urinary continence between quarterly assessments; however, was coded as no change. RAI Coordinator confirmed that their assessments were not consistent with each other and should have been coded as a deterioration. Review of the MDS assessment in January 2016, identified that resident #026 was occasionally incontinent of bowel; however, the bowel assessment in January 2016, indicated the resident was continent of bowels. Interview with the RAI Coordinator confirmed that the two assessments were not consistent or complemented each other. (581)

F. Review of the plan of care identified that resident #040 fell in May 2014 and sustained an injury. Review of the MDS assessment in October 2014 revealed they fell in the past 30 days but did not indicate that the resident had a fall in last 180 days. Interview with registered staff #121 confirmed the resident did have a fall with injury and that the MDS assessment and the post fall assessment were not consistent with each other. (581)

G. Review of the plan of care revealed that resident #046 fell in May 2014 and sustained multiple injuries. Review of the MDS assessment in August 2014, indicated they fell in the past 30 days but did not identify that the resident had a fall in the last 180 days. Review of the RAPS in August 2014 identified that the resident had fallen and sustained fractures in May 2014. Interview with registered staff #121 confirmed the resident did have a fall and fracture and that the MDS assessment and RAP were not consistent or complemented each other related to their fall. (581)

H. Review of the MDS assessment in July 2015, indicated that resident #011 was frequently incontinent of bladder and in October 2015, identified they were incontinent of bladder; however, were coded no change in urinary continence. Review of the MDS assessment in January 2016, revealed the resident was frequently incontinent of bladder and was coded no change in urinary continence when there was an improvement. Interview with RAI Coordinator confirmed there was a change in their urinary continence and the assessments were not consistent or complemented each other. (581)

I. Review of the MDS assessment in March 2016, indicated that resident # 024 fell in the past 30 days. Review of the RAP in March 2016, and progress notes identified that they had fallen five times in the past three months. Interview with the RAI Coordinator confirmed that the resident had fallen in the past 31-180 days and that the MDS assessment and RAP were not consistent or complemented each other related to falls. (581) [s. 6. (4) (a)]
2. The licensee failed to ensure that the resident was assessed and the plan of care was reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

Review of the written plan of care for resident #013 indicated they were transferred using a sling mechanical lift and extensive assistance with two staff. Review of the Lift and Transfer assessment in March 2016, identified that a sling was not required for transferring and the resident was a sara lift for transfers. Interview with PSW #129 and PSW #148 stated the resident was transferred with the sara lift with extensive assistance with two staff. Interview with registered staff #120 confirmed that the written plan of care was not updated when the resident's care needs changed related to transfers. (581) [s. 6. (10) (b)]

WN #9: 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

i. On March 30, 2016, during an initial tour of the home, soiled utility room 2E14 was found unlocked and unattended. Oxivir TB surface cleaner and disinfectant cleanser IV were observed in the room.

ii. On March 30, 2016 and April 8, 2016, staff washroom 1E16 was found unlocked and unattended as confirmed by registered staff #101. No resident-staff communication and response system was observed in the washroom.

The Director of Building Services confirmed both rooms were non-residential areas and were to be kept closed and locked when not being supervised by staff. (585) [s. 9. (1) 2.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

In April 2016, the bed system for resident #13 was observed to have one three quarter bed rail and one quarter bed rail. Review of the home Entrapment Audit from October 2014, identified that the resident's bed system passed entrapment for all zones when two one quarter bed rails were on the bed. Review of the plan of care identified that in January 2016, the resident's bed system was changed and one three quarter rail was placed on the bed. Interview with the resident and registered staff #120 confirmed that the resident used a quarter bed rail and one three quarter bed rail when in bed at night. Interview with the DOC confirmed that when the bed rail on the resident's bed was changed, the bed system was not reassessed for all potential zones of entrapment. (528) [s. 15. (1) (a)]

WN #11: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

During the course of the inspection, resident #013 stated that staff got them up too early in the morning and that they preferred to stay in bed longer before breakfast. Review of progress notes confirmed that in November 2015, the resident complained to staff that they did not want to get up at the time staff were assisting the resident out of bed. Review of the plan of care revealed that the resident was on a list as an alternative resident to get up by the night shift staff and did not indicated the resident's sleep patterns and preferences. Interview with PSW #129 stated that the resident got up on night shift two times a week and the other days was transferred out of bed to their wheelchair at a later time. Registered staff #120 stated they were unaware that the resident did not want to get up early in the morning by the night staff and confirmed there was no interdisciplinary assessment of the resident's sleep patterns and preferences. (581) [s. 26. (3) 21.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care, as required under section 33(4) of the Act.

On April 5, 2016, resident #012 was observed to be seated in a wheelchair that was tilted in a reclining position greater than 45 degrees. Review of the plan of care identified that the resident had required the tilted wheelchair for two years; however, in 2015 the resident's substitute decision maker (SDM), requested that the chair not be tilted. Interview with RPN #103 confirmed that resident was tilted in the chair for positioning and comfort despite the fact that the SDM no longer consented to the wheelchair being tilted in a reclined position. (528) [s. 33. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 5 and 7, 2016, fresh fruit was listed on the planned menu for the morning nourishment pass.
i. On April 5, 2016, whole fresh fruit was observed, however no pureed item was noted. Dietary staff #114 confirmed there was no pureed option of fresh fruit available.
ii. On April 7, 2016, dietary staff #145 also reported there was no pureed option of fresh fruit available. FSS #146 confirmed that fresh fruit was part of the morning nourishment menu and the home did not have fresh puree fruit available for the nourishment pass. [s. 71. (4)]

WN #14: 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,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

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 the food production system, at minimum, provided for preparation of all menu items according to the planned menu.

On April 6, 2016, the planned menu for lunch listed fresh fruit in season for dessert. During an observation of lunch in the A2 dining room, commercially prepared diced honeydew melon (ingredients: honeydew, water, sugar, citric acid, ascorbic acid, sodium benzoate, potassium sorbate) was served to residents, as confirmed by dietary staff #124. Review of the home's recipe for the honeydew directed staff to use whole fresh melons. Interview with the Food Service Director confirmed that commercially prepared melon was served, which was not prepared according to the planned menu. [s. 72. (2) (d)]

2. The licensee 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.

A. In August 2015, a complaint was submitted to the Ministry of Health and Long-Term Care regarding concerns that vegetables were soft, mushy and light in colour.

B. Review of the home's food council meeting minutes revealed concerns/feedback regarding vegetables:
i. In November 2015, residents identified that that vegetables continued to be too watery
ii. In January 2016, one resident expressed that spinach was too mushy and watery

C. On April 1, 2016, during lunch in the E2 dining room, broccoli served appeared light green in small pieces approximately half an inch to an inch long. The item as sampled fell apart without chewing. Resident #063 stated the broccoli was too small and overcooked.

D. On April 5, 2016, during supper in the 3CW dining room, resident #060 reported that vegetables served in the home were soggy and resident #061 reported vegetables were mushy. Peas were served at the meal appeared shrunken and light in colour. Resident #062 reported the peas did not look appetizing.

Interview with FSS #146 confirmed vegetables should not be mushy or overcooked and confirmed the items were not prepared, stored and served in a way that preserved taste, nutritive value, appearance and food quality. (585) [s. 72. (3) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

In January 2016, allegations of mistreatment by staff to resident #083 were brought forward to the home, by a family memeber. The SDM of resident #083 was immediately notified of the allegations and, as a result, the home was investigating the allegations. The home's investigation notes confirmed that the allegations were not substantiated; however, did not include documentation that the SDM of resident #083 was notified of the results of the investigation. Interview with NM identified that the family member who brought the allegations forward was notified of the results of the investigation, and not the SDM for resident #083. [s. 97. (2)]

WN #16: 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. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept each of review and analysis of trends of the improvements made in response to every written or verbal complaint made to the licensee or staff member.

On July 27, 2015, a written complaint was made to the home as confirmed by the DOC. Review of the home's record of written and verbal complaints did not include any documentation of the analysis of trends or improvements made in response to complaints. Interview with DOC identified that the analysis of complaints was completed on an ongoing basis, however, no written record was kept of the review. [s. 101. (3)]

Issued on this 26th day of May, 2016

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

Original report signed by the inspector.