Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2015	2015_265526_0001	H-001789-15	Resident Quality Inspection

Licensee/Titulaire de permis

DALLOV HOLDINGS LIMITED
441 MAPLE AVENUE BURLINGTON ON L7S 1L8

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

MAPLE VILLA LONG TERM CARE CENTRE
441 MAPLE AVENUE BURLINGTON ON L7S 1L8

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

THERESA MCMILLAN (526), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LISA VINK (168)

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): January 6, 7, 8, 9, 12, 13, 14, and 15, 2015.

Follow up inspection H-001003-14, and Critical Incident Inspections H-000868-14 and H-001358-14 were conducted simultaneously during this RQI Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, Environmental Supervisor, Maintenance Supervisor, Food Service Supervisor (FSS), Registered Dietitian (RD), Pharmacist, Dietary Aides, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), residents and family members.

The Long Term Care (LTC) Inspectors also reviewed resident health records, training and education records, policies and procedures, dietary files and menus, and program evaluations. The LTC Inspectors toured the home, observed meal service, residents and staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
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
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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: 1. Communication of the seven-day and daily menus to residents. 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the daily and weekly menus were communicated to residents.

During initial tour of the home on January 6, 2015, it was noted that the weekly menu posted outside the second floor dining room was for "Week 4", which did not correspond with the daily menu. Interview with the dietary aide confirmed that the weekly menu should have been changed to "Week 1" at the beginning of the week to match the daily posted menus. [s. 73. (1) 1.]

2. The licensee failed to ensure that food and fluids being served were at a temperature that was both safe and palatable to the residents.

The home's Food Temperature Log indicated that cold food was to be kept at a maximum of five degrees Celsius. During the course of the inspection, cold food temperatures were taken and noted to be above five degrees Celsius as follows:

i. On January 7, 2015, milk was probed while being served to residents at lunch service on the second floor; milk was 7.4 degrees Celsius.

ii. On January 8, 2015, during the observed lunch meal on second floor at the second sitting, the egg salad sandwich was probed at 9.2 Celsius during meal service. The sandwiches were put in the fridge after first sitting but were not brought down to a safe temperature prior to second sitting service.

iii. On January 9, 2015, temperature of the milk while residents entered the first floor dining room for breakfast was 8.7 degrees Celsius. Cold sandwich temperature during the first sitting at lunch on the second floor was 7.4 degrees Celsius and minced was 10.9 degrees Celsius.

iv. On January 12, 2015, milk served on a table for resident who was not yet in the first floor dining room at lunch was 8.6 degrees Celsius.

The home's Food and Fluid Temp Records for first floor from January 1 to 9, 2015 were noted to be incomplete. Interview with the Food Service Supervisor (FSS) confirmed that the dietary staff were not completing the Food Temperature Logs and cold food temperatures remain a challenge. [s. 73. (1) 6.]

3. The licensee failed to ensure that all residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) A nutrition assessment from December 2014, and the dietary resident list for resident #027, indicated they required assistive devices for eating and drinking. The resident did not receive these devices during lunch meal service on January 6 and 7, 2015. Interview with direct care staff on January 9, 2015, confirmed that direct care staff and registered staff were unaware the intervention was to be in place at all times, for all drinks, until confirmation with the Registered Dietitian (RD) on January 8, 2015.

B) A dietary note from December 2014, and the dietary resident list for resident #042, indicated that the resident required assistive devices for eating and drinking. During lunch service on January 6, 2015, the resident did not receive these devices. Interview with the health care aide (HCA) and dietary aide confirmed the resident should have received these devices. [s. 73. (1) 9.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, was respected.

On an afternoon in 2014, resident #041 was noted to have an unwitnessed fall with superficial injuries. A note was left for the doctor by registered staff.
i. On the evening following the fall, registered staff documented that the resident complained of a new area of pain.
ii. Two days after the fall, the resident was observed to have pain to the same area when transferring and was assessed by the registered nurse. Review of the documented assessment indicated that a requisition was faxed for x-rays and a note was left for the doctor.
iii. Three days after the fall, two registered staff documented the resident's pain intensity was scored at eight out of ten and analgesia was provided. One of the staff members documented that the x-ray requisition was faxed and a note was left for the physican.
iv. On the fourth day, registered staff documented that the resident had severe pain with bed mobility and the resident was transferred to the hospital, the doctor was called at that time.
v. Interview with two of the registered staff confirmed that the requisition for an xray was faxed without speaking to the physician, and four registered staff confirmed they did not call the physician for the resident's new area of severe pain post fall.
vi. The registered nursing staff did not notify the physician of the fall, the resident's ongoing complaints of pain, worsening pain, or the x-ray requisitions completed by nursing staff, until the resident was transferred to the hospital, four days later.

Review of the hospital report confirmed multiple fractures and the resident required bedrest when readmitted to the home. The resident was not cared for in a manner consistent with their needs post fall. [s. 3. (1) 4.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident in relation to the following; s.6 (1) (c)

A) Resident #019 was observed in bed with one three quarter bed rail raised on January 6, 8 and 13, 2015. The written plan of care did not indicate that the resident was to have one three quarter bed rail raised when in bed for bed mobility and positioning. The registered staff and the health care aide (HCA) both stated the resident had one three quarter bed rail raised when in bed and the resident used the bed rail for turning and positioning. The registered staff and the PSW both confirmed there were no clear directions for the bed rail to be raised when the resident was in bed.

B) Review of the written plan of care and Kardex for resident #019 indicated their bed was to be kept in the lowest position and that the bed was not to be lowered at night. Registered staff and HCAs stated that the bed was kept in the lowest position with a crash mat on the floor and a bed alarm in place. Both staff confirmed there were no clear

directions on how the bed was to positioned when the resident was in bed. [s. 6. (1) (c)]

2. The licensee has 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 complemented each other.

A) i) Resident #021's Resident Assessment Inventory Minimum Data Sets (RAI MDS) assessments indicated that the resident was assessed as being occasionally incontinent of bladder in June, 2014, and frequently incontinent of bladder in September, 2014, and December, 2014. The RAI MDS Assessment conducted in September 2014, indicated that there had been no change in the resident's urinary continence, when the assessment of the bladder continence indicated that the resident had a deterioration since the previous quarter's assessment. The Resident Assessment Inventory (RAI) Coordinator confirmed that the assessments of the resident's bladder continence was not consistent with or complemented each other.

ii) Resident #021's continence was assessed in December, 2014, using an instrument specifically designed for continence and indicated that the resident's incontinence was stable over the past six months. The RAI Coordinator confirmed that the resident's continence fluctuated during the previous six months according to the resident's RAI assessments between June and December 2014, was not stable and had changed. They confirmed that assessments of resident #021's continence were not consistent with or complemented each other. (526)

B) Resident #021's RAI MDS assessment completed in June, 2014 indicated that the resident had no behavioural symptoms. The resident's RAI MDS assessment completed in September, 2014, indicated that the resident exhibited inappropriate behaviours four to six days in the past seven days. However, the coding for E5 on the September, 2014, assessment indicated that the resident's behaviours had not changed compared to the previous assessment.

The resident's RAI MDS assessment completed December, 2014 indicated that the resident did not exhibit inappropriate behaviours, but that they exhibited other behaviours one to three days in the past seven days. However, the coding for section E5 indicated that the resident's behaviour had not changed compared to the previous assessment observation period.

During interview with the LTC Inspector, the RAI Coordinator confirmed that resident's

behaviours during the observation periods had changed when comparing RAI MDS assessments conducted June, September and December, 2014. It was confirmed that the conclusions noted in section E5 of these assessments, that there was no change in the resident's behaviour, was not consistent with the assessments that indicated that the resident's behaviour had changed. (526)

C) i) A review of resident #019's plan of care and Kardex indicated they wore glasses. The RAI MDS assessments completed in April, July, and October, 2014, indicated the resident did not wear glasses. The resident was observed on January 8 and 9, 2015 wearing their eye glasses. Interviews with the registered staff and HCAs confirmed the resident wore eye glasses when up and out of bed. The RAI Coordinator confirmed that the resident did wear glasses and there was no collaboration in terms of the assessment and the written plan of care.

ii) A review of resident #019's plan of care and Kardex indicated they had their own teeth. The RAI MDS assessments completed in July and October, 2014 indicated the resident had dentures and/or removable bridge. The registered staff stated the resident did have a partial plate but it was lost between these two assessments. The RAI Coordinator confirmed that the resident no longer had a partial plate and only had their own teeth and there was no collaboration in terms of the assessment and the written plan of care. (581)

D) Resident #018 demonstrated responsive behaviours. The RAI MDS assessment completed in August and May 2014, identified that the resident demonstrated one behavioural symptom during a specified time period, which was not easily altered. The RAI MDS assessment completed in November, 2014, identified that the resident demonstrated three behavioural symptoms, with one not easily altered. This assessment also noted that there was no change in behavioural symptoms since the assessment conducted 90 days ago. Interview with RAI Coordinator confirmed that the assessment completed in November, 2014, was not consistent with the previous observation period's assessment, when it noted that there was no change in status and that the behavioural symptoms should have been coded as a deterioration. Staff did not collaborate with each other in the completion of the assessments as they were not consistent and did not complement each other. (581)

E) Resident #019 demonstrated responsive behaviors. A review of the RAI MDS assessment completed in July, 2014 identified the resident demonstrated three behavioral symptoms. The Resident Assessment Protocol (RAP) completed following this review stated the resident had increased responsive behaviours that included verbal

and physical aggression but identified that the behavioural status had improved over the past 90 days. Interview with the RAI Coordinator confirmed that the resident behavioural status had not improved. Staff did not collaborate with each other in the completion of the assessments as they were not consistent and did not complement each other. (581)

F) Resident #037 was incontinent of bladder functioning, required assistance of staff with toileting and had areas of altered skin integrity.
i) RAI MDS assessments were reviewed related to continence. The MDS coding completed in May, 2014, identified total bladder incontinence. The coding completed in August, 2014, identified that the resident had an improvement in bladder continence, however, also noted that there was no change in urinary continence as compared to the status 90 days prior. The coding completed in November, 2014, noted a deterioration in bladder incontinence, however, still did not identify a change in urinary continence status since the previous assessment. Interview with registered staff, following a review of the identified documents, confirmed that the assessments were not consistent and did not complement each other.

ii) The RAI MDS assessment completed in November, 2014, identified that resident #037 had multiple areas of skin alteration. Prior assessments noted the presence of different stages of altered skin integrity, which was confirmed by staff. The Resident Assessment Protocol (RAP) completed for November 2014, assessment noted the ongoing presence of altered skin integrity with increased severity. Interview with registered staff, following a review of the coding and RAP, confirmed that staff did not collaborate with each other in the completion of the assessments as they were not consistent and did not complement each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #041 was high risk for falls. Interventions for staff included but were not limited to: ensuring the resident was wearing proper non slip footwear. Review of the plan of care indicated that the resident had two unwitnessed falls during a month in 2014, at which times, they were not wearing non slip footwear. Fall incident notes and interview with registered staff confirmed that the resident was not wearing proper footwear at the time of both falls as outlined in the plan of care. (528)

B) The plan of care for resident #031 indicated that the resident was to have nectar thickened fluids of their preference with meals. The resident was to be provided with

minced textured entree and pureed soup and desserts. The resident was also noted to dislike white milk to drink. The plan of care for the resident also indicated that Boost pudding was to be provided with am and pm snack.
i) During the observed pm snack pass on January 13, 2014, the resident was not provided with Boost pudding; the resident received thickened lemonade and a cookie.
ii) During the observed lunch meal on January 13 and 14, 2015, the resident was not provided with their preferred nectar thickened fluids; the resident was provided with nectar thickened water and white milk.
iii) On January 14, 2015, the resident was provided with minced soup with crackers as confirmed with the dietary aide during the meal. (156)

C) The plan of care for resident #021 indicated that the resident was to be provided specified foods at pm snack. During the observed pm snack pass on January 13, 2014, the resident was not provided with the food items as specified. (156)

D) On January 6, 2015, resident #043 was observed by the LTC Inspector to exhibit verbal and physical responsive behaviours. Resident #043's progress notes confirmed that they had exhibited verbal and physical responsive behaviours on 14 days over a two month time period.

The document the home referred to as resident #043's "care plan" indicated that staff were to "initiate PIECES Huddle" if the resident was demonstrating responsive behaviours. Review of the resident's progress notes indicated that the huddle had not been initiated for behaviours on the days noted above. The Director of Care (DOC) confirmed that staff should have initiated a huddle for resident #043 according to the resident plan of care. [s. 6. (7)]

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 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 (6(4)a); and that the care set out in the plan of care is provided to the resident as specified in the plan (6(7)), to be implemented voluntarily.

WN #4: 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 "Pain Assessment and Management", last revised October 2014, directed staff to complete a comprehensive pain assessment including a pain management flow record with pain severity greater then four out of ten, with a change in condition, with onset of pain, with distress related behaviours, or facial grimace.

During a month in 2014, resident #041 was assessed by registered staff, two days post fall, for a new area of pain. The following day, two separate registered nursing staff documented the resident's pain as an eight out of ten and analgesia was administered.

Review of the plan of care did not include a comprehensive pain assessment or pain management flow record following the new pain or severe pain. Interview with registered staff confirmed that the resident was complaining of pain to a new area and a comprehensive pain assessment was not completed as outlined in the policy. (528)

B) The Pain Assessment and Management program, last reviewed October 2014, identified that "the interdisciplinary team will conduct and document a pain assessment" on the "initiation of a pain medication or prn analgesic" and "change in condition with onset of pain".

Resident #046 was noted to have unusual symptoms, including pain, during a month in 2014. These symptoms were communicated to the physician who ordered treatment. The resident was diagnosed with a fracture to the identified area five days after the unusual symptoms were initially assessed. Staff recorded indications of pain in the progress notes, intermittently since the symptoms were first identified. Eighteen days after symptoms were first identified, a Pain Risk Assessment was completed identifying medium risk. Almost two months later, a narcotic was ordered due to additional behaviours associated with pain.

A review of the chart was conducted by registered staff, who confirmed that they were unable to locate a pain assessment tool, or Pain Flow Records for the identified period of time, other than the tool completed 18 days after the initial assessment of symptoms. The staff identified that the assessments were not completed. Management staff confirmed that a pain assessment should have been completed with the onset of new pain and when the narcotic was initiated. (168)

C) The home's "Resident Safety Policy" for "Responsive Behaviour Management Program" issued May 2014 included but was not limited to directing staff to do the following when a resident was exhibiting (complex/difficult) responsive behaviours:
- "Complete all PCC Risk Management Incident Reports for both the aggressor and victim";
- "Notify the Administrator/Director of Care of the situation";
- "Initiate behaviour documentation in the resident's PCC progress notes";
- "Interdisciplinary conference to be planned"; and
- "The interdisciplinary team will analyze behaviours that occurred to identify triggers and consequence of the behaviour if possible".

i) Resident #043's progress notes indicated that the resident had exhibited responsive

behaviours including verbal and physical aggression toward residents and staff on at least 14 occasions over a two month time period. Risk Management Incident Reports were completed for seven of these incidents. The DOC confirmed that Risk Management Incident Reports should be completed for all responsive behaviour incidents. The DOC also confirmed that staff had not complied with the home's policy when the risk reports had not been used to document the incidents. (526)

ii) Review of the resident #043's progress notes indicated that staff had not initiated a huddle for any of the 14 responsive behaviour incidents involving the resident. Two RNs confirmed that huddles should take place following responsive behaviours and that none had taken place for resident #043 since two months prior to the period containing the 14 incidents. The DOC stated that staff had not complied with the home's policy by not convening huddles for resident #043's responsive behaviour incidents. (526)

iii) The DOC stated not being aware of all of resident #043's responsive behaviour incidents. The DOC confirmed that staff had not complied with the home's policy by not informing the Administrator/DOC about all of resident #043's responsive behaviours. (526)

iv) Progress notes indicated that resident #023 exhibited responsive behaviours four times over a seven week period. In addition, the LTC Inspector observed resident #023 exhibiting the same behaviours on at least five occasions; there was no documentation of these incidents in the progress notes or using the home's Risk Management Incident Reports. The DOC confirmed that the responsive behaviours had not been documented using the Risk Management Incident Reports and stated that staff had not followed the home’s policy. (526)

v) Resident #019’s progress notes indicated that on January 7, 2015 the resident was observed by staff exhibiting responsive behaviours. The DOC confirmed that the staff had not complied with the home’s policy when the registered staff did not inform them of the incident and when the Risk Management Incident Report for both the aggressor and victim was not completed. (581)

E) The home's Housekeeping policy for "Area Cleaning Procedures" last reviewed July 2010, directed staff, on a daily basis, to "pour allotment of germicidal detergent into toilet bowl and let stand". On January 6 and 7, 2015, the toilet in the washroom of resident room 205 was noted to have a smear of feces inside the toilet bowl. During interview with the LTC Inspector, a housekeeper stated that the toilet bowl may not be cleaned every

day. The Administrator confirmed the toilet in room 205 should have been cleaned daily and that the home's policy had not been complied with.

F) The home's policy "Resident Falls Prevention Program - Steps to follow following a fall", last revised October 2014, included, but was not limited to the following directions for staff:
- head injury routine would be initiated for actual or suspected (unwitnessed fall) head injuries,
- immediate assessment and treatment,
- physician was to be notified immediately or resident to be sent to hospital for any fall with injury, and
- registered staff were to record resident's worsening or improving symptoms and any treatment that may be needed, each shift for 72 hours.

The home's policy was not followed for resident #041's falls during a month in 2014:
i) During this month, the resident had two unwitnessed falls. Initial assessment after the first fall did not include the initiation of a head injury routine (HIR), as registered staff documented that the resident denied hitting their head. Interview with the DOC confirmed that the HIR should have been initiated for the unwitnessed fall, especially since the resident was cognitively impaired.
ii) Post fall shift assessments were not complete consistently for 72 hours following the resident's first fall, as confirmed by the DOC.
iii) After the unwitnessed fall, the resident sustained a skin tear and began complaining of new pain later that day which continued to worsen over the next four days. The physician was not notified of the fall with injury until the resident was transferred to the hospital, four days later. Registered staff documented that notes were left for the physician, however, the physician was not immediately notified. Interview with the DOC confirmed that the home's policy "Resident Falls Prevention Program - Steps to follow following a fall" was not complied with. [s. 8. (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 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 is (b) complied with, to be implemented voluntarily.

WN #5: 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 when 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 were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #019 was observed in bed with one three quarter bed rail raised on January 6, 8, and 13, 2015. Interview with the registered staff and HCA's stated the resident had one three quarter bed rail raised when in bed for positioning and bed mobility. A review of the resident's written plan of care did not include an assessment of the bed rails being used. The registered staff and RAI Coordinator confirmed that the home did not have a formalized assessment for the use of bed rails in place. (581)

B) A review of resident #025's written plan of care indicated they required the use of one three quarter bed rail in the raised position for bed mobility and repositioning when in bed. On January 9 and 12, 2015, the resident was observed in bed with one three quarter bed rail raised. A review of the resident's written plan of care did not include an assessment of the bed rails being used. The RAI Coordinator and the registered staff confirmed that the home did not have a formalized assessment for the use of bed rails in place. (581)

C) Resident #021's RAI MDS assessment completed in 2014 indicated that the resident used bed rails for bed mobility or transfer. The document the home referred to as resident #021's "care plan" completed 14 days later indicated that the resident repositioned and sat up independently with the use of bedrails. The resident was observed laying in bed with two one half rails in the up position and moving from a laying to sitting position while in bed. Review of the resident's health record indicated that the resident had not been assessed for the use of bed rails. (526)

Interview with registered staff and DOC indicated that the home had not assessed residents in their bed systems when bed rails were in use. The RAI Coordinator also confirmed that the home did not have a formalized assessment completed for the use of bed rails for all residents in the home. [s. 15. (1) (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 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, to be implemented voluntarily.

WN #6: 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 failed to ensure that each resident of the home was 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.

On the evenings of January 10 and 11, 2015, 14 resident's did not receive their scheduled bath on the second floor. Registered staff confirmed that the evening shift on the second floor was short two staff on both January 10 and 11, 2015. Interview with two residents confirmed they did not get their scheduled bath on the weekend due to short staffing. Review of Point of Care (POC) electronic documentation did not include any indication that 14 of the resident's received their scheduled baths. Interview with three direct care staff indicated that, due to short staffing, resident's did not receive any assistance to bathe as scheduled on the evenings of January 10 and 11, 2015. On January 12, 2015, front line staff confirmed with the LTC Inspector that residents who did not receive baths on January 10 and 11, 2015, did not did receive a make up bath. [s. 33. (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 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, to be implemented voluntarily.

WN #7: 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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A) Resident #021 was observed in bed on January 6 and 7, 2014, with two quarter bed rails raised. Review of the clinical record indicated that there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for its use. The DOC confirmed that the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint nor did they have documented consent or approval for the bed rails in place. (526)

B) Resident #019 was observed in bed on January 6, 8, and 13, 2015 with one three quarter bed rail raised. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for its use. The DOC confirmed that the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint nor did they have documented consent or approval for the bed rails in place.

C) Resident #025 was observed in bed on January 9, and 12, 2015 with one three quarter bed rails raised. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rails, nor any documented consents or approvals for its use. The DOC confirmed the resident's bed rails were not assessed to determine if the bed rails were being used as a PASD or a restraint nor did they have a documented consent or approval for the bed rails in place. [s. 33. (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 use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #8: 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 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Resident #037 had a history of multiple areas of altered skin integrity identified in the clinical record and during staff interview. As of January 8, 2015, the resident had only one area of altered skin integrity. A review of the clinical record, including progress notes and the Pressure Ulcer/Wound Assessment Records did not include a reassessment of the area at least weekly by a member of the registered nursing staff. During a five month period in 2014/15, the area did not have a reassessment documented at least weekly on seven occasions. Interview with registered staff reviewed the assessment records and confirmed that the area was to be reassessed at least weekly and that this was not completed as required. (168) [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 (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written policy that promoted zero tolerance of abuse and neglect of residents was complied with. The home's "Resident Safety Policy" for "Prevention and Elimination of Abuse and Neglect of Residents" last reviewed and revised on May 2014 directed that any person "must report witnessed or suspected abuse and neglect" to the Administrator and to the Ministry of Health and Long Term Care (MOHLTC) Action line.

The home's investigation notes indicated that on a day in 2014, resident #021 informed the Registered Nurse (RN) that staff handled them roughly and that they felt emotionally injured by care that had been provided to them. Interview with the RN by LTC Inspector indicated that the resident had health conditions that led to fluctuations in symptoms which may have limited the resident's ability to ambulate.

According to interview with the RN and the home's investigative notes, a HCA answered the resident's call for assistance to use the washroom. The staff left the resident when they assessed that the resident was would require two persons to safely assist the resident to the washroom, stating that they would come back with another staff person. Upon returning to assist resident #021, the two HCAs observed the resident to be crawling on the floor heading toward the washroom. Staff assisted them to a wheelchair and the resident told the HCAs that they were feeling very anxious and upset about what had just happened. The HCA brought the resident to the RN.

Interview by the Long Term Care (LTC) Inspector with the RN confirmed that the RN thought that the incident warranted further investigation to determine if an abuse had been carried out by staff on resident #021. The RN confirmed that they had not notified MOHLTC Action Line according to the home's policy. The Administrator confirmed that the home should have contacted the MOHLTC according to their policy and that the policy had not been complied with. [s. 20. (1)]

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

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius.
i) On January 6, 7, and 12, 2015, resident room 207 was noted to be 21.5 degrees Celsius. On each occasion, residents in the room complained that they felt cold.
ii) On January 13, 2015, the radiator in room 207 was noted to be cold. This was confirmed by the Administrator and Maintenance Supervisor.
iii) On January 14, 2015, LTC inspector observed room 207 to be 20 degrees Celcius. A resident residing in the room complained that the room was cold and that a heater that had been in that room had been removed.
iv) On January 13, 2015, resident room 211 was noted to be 21.5 degrees Celsius and a resident residing there stated that they felt cold.
v) During interview with LTC Inspector on January 12, 2015 a resident who resided in room 205 stated that their bedroom was cold the day before. They asked staff for a heater and were told that none was available.
vi) During the course of the inspection, the hallway and recreation room on the first floor were noted to be below 22 degrees Celsius and one resident interviewed stated that they were cold.

The Administrator and the home's Maintenance policy "List of Equipment and Preventative Maintenance Functions" last reviewed on June 2014 indicated that the home's temperature should be maintained at a minimum of 22 degree Celsius at all times. During LTC Inspector interview with the Maintenance Supervisor on January 14, 2015, it was confirmed that the temperature in the home should a minimum of 22 degrees Celsius. The Maintenance Supervisor described the home's routine and remedial maintenance procedures that included monitoring temperatures in the home. [s. 21.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) i) Progress notes indicated resident #023 was observed exhibiting responsive behaviours on four occasions over a three week period in 2014/15. On a day during this inspection, between 1300 and 1600 hours, resident #023 was observed on at least five separate occasions to be exhibiting responsive behaviours. Staff ran to intervene and redirected the resident to their room. Interview with non registered staff indicated that they did not know what might trigger the resident's behaviour. Review of the resident's health record indicated that the resident had not been reassessed following the four responsive behaviour incidents that occurred over the three week time frame. During interview with LTC Inspector, registered staff confirmed that actions had not been taken to reassess resident #023 following these episodes of responsive behaviours.

ii) Review of resident #023's health record indicated that the resident's responsive behaviours and the resident's responses to interventions observed by the LTC inspector on a day during this inspection had not been documented in progress notes or using the home's Risk Management Incident Reports.

B) Review of the plan of care for resident #018 indicated there was no documentation in the progress notes regarding behavioural symptoms that had occurred over a 13 week time period in 2014/15. The Point of Care documentation from the final six weeks of this time period that was completed by non registered staff, indicated that the resident had 40 incidents of responsive behaviours.

Registered staff stated they were unaware that the resident continued to exhibit responsive behaviours over this six weeks and confirmed there was no assessment or reassessment of the resident and the resident's responses to the interventions were not documented. (581) [s. 53. (4) (c)]

WN #12: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours. The washroom for resident room 205 was observed to smell of urine in the morning and afternoon on January 6, 7, 11, 12 and in the morning on January 13, 2015. The home's Housekeeping policy for "Odour Control" last reviewed May 2013 directed staff to find and remove the cause of the odour and to clean the area with a detergent or disinfectant solution. The Administrator confirmed that the home's odour policy was not implemented if room 205's washroom continued to have urine odours on several occasions during the course of this inspection. [s. 87. (2) (d)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected.

Review of the home's "Resident Safety" policy for "Prevention and Elimination of Abuse and Neglect of Residents" last revised March 2014 indicated that the policy did not contain procedures and interventions to assist residents who had been abused or neglected, or allegedly abused or neglected. The Administrator confirmed this. Two staff persons who were interviewed by LTC Inspector regarding their role in managing situations involving actual or suspected abuse, did not state any actions they would take to assist or support residents who may have or had been abused or neglected. [s. 96. (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On January 7, 2014, the drug destruction box for controlled substances in the second floor medication room was noted to be in a separate single locked box, in a stationary cupboard that did not have a lock. Interview with the Pharmacist confirmed that the drug destruction box was used by staff and that a lock would be added to the stationary cupboard. [s. 129. (1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in accordance with subsection 76(7) of the Act on the application and use and potential dangers of the PASDs in relation to the following; [221(1)6.]
Education records provided by the home indicated that less than twenty percent of the staff who provided direct care to the residents in 2014 received annual training related to minimizing the restraining of residents and this was confirmed by the DOC. [s. 221. (1) 6.]

Issued on this 5th day of March, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA MCMILLAN (526), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LISA VINK (168)
Inspection No. / No de l'inspection :	2015_265526_0001
Log No. / Registre no:	H-001789-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 9, 2015
Licensee / Titulaire de permis :	DALLOV HOLDINGS LIMITED 441 MAPLE AVENUE, BURLINGTON, ON, L7S-1L8
LTC Home / Foyer de SLD :	MAPLE VILLA LONG TERM CARE CENTRE 441 MAPLE AVENUE, BURLINGTON, ON, L7S-1L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BARBARA GOETZ

To DALLOV HOLDINGS LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_275536_0014, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
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).

Order / Ordre :

The licensee shall do the following:

1) Maintain all hazardous foods and beverages including egg salad sandwiches and milk in a safe temperature zone;

2) The home shall review policies, and revise as necessary, regarding maintaining all hazardous cold food and beverage temperatures at a maximum of five degrees Celsius according to the home's policy;

3) All dietary staff shall receive retraining regarding the home's policy to maintain all hazardous cold food and beverages at a maximum of five degrees Celsius;

4) Dietary staff shall consistently complete the Food and Fluid Temperature Records log;

5) Food and fluid temperatures will be monitored and trends evaluated to ensure that hazardous cold food and beverage temperatures are maintained at a maximum of five degrees Celsius;

6) This evaluation will be reviewed monthly and will be documented; steps will be taken to repair the process if food is found to be greater than five degrees Celsius.

Grounds / Motifs :

1. The home was issued a Compliance Order for this area of non compliance on June 23, 2014.

2. The licensee failed to ensure that food and fluids being served were at a temperature that was both safe and palatable to the residents.

The home's Food Temperature Log indicated that cold food was to be kept at a maximum of five degrees Celsius. During the course of the inspection, cold food temperatures were taken and noted to be above five degrees Celsius as follows:

i. On January 7, 2015, milk was probed while being served to residents at lunch service on the second floor; milk was 7.4 degrees Celsius.

ii. On January 8, 2015, during the observed lunch meal on second floor at the second sitting, the egg salad sandwich was probed at 9.2 Celsius during meal service. The sandwiches were put in the fridge after first sitting but were not brought down to a safe temperature prior to second sitting service.

iii. On January 9, 2015, temperature of the milk while residents entered the first floor dining room for breakfast was 8.7 degrees Celsius. Cold sandwich temperature during the first sitting at lunch on the second floor was 7.4 degrees Celsius and minced was 10.9 degrees Celsius.

iv. On January 12, 2015, milk served on a table for resident who was not yet in the first floor dining room at lunch was 8.6 degrees Celsius.

The home's Food and Fluid Temp Records for first floor from January 1 to 9, 2015 were noted to be incomplete. Interview with the Food Service Supervisor (FSS) confirmed that the dietary staff were not completing the Food Temperature Logs and cold food temperatures remain a challenge. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that every resident, including resident #041, is cared for in a manner consistent with their needs, based on assessments completed, when the findings show a change in residents condition following an incident, including but not limited to, ongoing complaints of pain and or decreased mobility.

Grounds / Motifs :

1. The licensee failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, was respected.

On an afternoon in 2014, resident #041 was noted to have an unwitnessed fall with superficial injuries. A note was left for the doctor by registered staff.
i. On the evening following the fall, registered staff documented that the resident complained of a new area of pain.
ii. Two days after the fall, the resident was observed to have pain to the same area when transferring and was assessed by the registered nurse. Review of the documented assessment indicated that a requisition was faxed for x-rays and a note was left for the doctor.
iii. Three days after the fall, two registered staff documented the resident's pain intensity was scored at eight out of ten and analgesia was provided. One of the staff members documented that the x-ray requisition was faxed and a note was left for the physican.
iv. On the fourth day, registered staff documented that the resident had severe pain with bed mobility and the resident was transferred to the hospital, the doctor was called at that time.
v. Interview with two of the registered staff confirmed that the requisition for an xray was faxed without speaking to the physician, and four registered staff confirmed they did not call the physician for the resident's new area of severe pain post fall.
vi. The registered nursing staff did not notify the physician of the fall, the resident's ongoing complaints of pain, worsening pain, or the x-ray requisitions completed by nursing staff, until the resident was transferred to the hospital, four days later.

Review of the hospital report confirmed multiple fractures and the resident required bedrest when readmitted to the home. The resident was not cared for in a manner consistent with their needs post fall. [s. 3. (1) 4.] (528) (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

Service Area Office /
Bureau régional de services : Hamilton Service Area Office