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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2016	2016_337581_0013	027481-16	Resident Quality Inspection

Licensee/Titulaire de permis

Better Life LTC Inc.
19 Richvalley Crescent RICHMOND HILL ON L4E 4C8

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528)

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): September 8, 9, 13, 14, 15 and 19, 2016.

During the course of this inspection the following inspections were conducted concurrently:
Critical Incident Inspections
018810-16- related to responsive behaviours
005770-16- related to alleged abuse
026388-15- related to falls prevention
009767-15- related to falls prevention
011909-15- related to falls prevention

Compliant
011153-15- related to personal care

Follow-Up Inspection
008208-15- related to inspection number 2015_265526_0001-CO #001-r.73.(1)
008211-15- related to inspection number 2015_265526_0001-CO #002-s.3.(1)

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Life Enrichment Coordinator, registered nursing staff, registered dietitian (RD), dietary staff, Food Service Manager (FSM), personal support workers (PSW), families and residents.
During the course of the inspection, the inspectors: toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to policies and procedures, meeting minutes, investigative notes and clinical records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **13 WN(s)**
- **6 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
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2015_265526_0001	581
O.Reg 79/10 s. 73. (1)	CO #001	2015_265526_0001	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 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 the plan of care set out clear directions to staff and others who provide direct care to the resident.

The document the home refers to as the care plan identified that resident #013 was to receive an additional 125 mililitres (mls) of fluid with medication pass; however, review of the electronic medication administration record (eMARS) did not include the intervention for additional fluid with each medication pass. On September 13, 2016, RPN #105 administered medications to the resident without an additional 125mls of fluid. Interview with RPN #107 and the RD confirmed that the intervention for additional fluid was no longer necessary as the resident was currently meeting their fluid requirements with supplements, but the intervention was not removed off the written care plan. (528) [s. 6. (1) (c)]

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

each other.

Review of the plan of care for resident #064 identified they fell on an identified day in May 2015 and sustained an injury. Review of the Minimum Data Set (MDS) assessment in August 2015, did not identify they had an injury in the last 180 days; however, the Resident Assessment Protocol (RAP) during the same time period indicated they did have an injury in May 2015. Interview with registered staff #115 stated the resident did fall and sustained an injury and confirmed that the MDS and RAP assessments were not consistent with each other. [s. 6. (4) (a)]

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

A. Resident #012 was observed on September 9, 2016, positioned in a tilted wheelchair with a physical device and no chair alarm in place. Review of the written plan of care and progress notes identified they required a chair alarm to prevent falls. Interview with registered staff #100 stated the chair alarm was not on the wheelchair; however, was documented in the progress notes and written plan of care as an intervention for falls prevention. Registered staff #100 confirmed the care set out in the plan of care was not provided to the resident related to the application of the chair alarm.

B. On the morning of September 14, 2016, resident #013 received a glass of juice for morning snack. Review of the plan of care identified the resident was to receive 125 millilitres of a nutritional intervention three times a day with snacks. Interview with PSW #107 revealed that kitchen staff usually prepared and labeled the supplements but, due to time constraints, did not that day. PSW #107 confirmed that resident #013 should have received the nutritional intervention which was available on the snack cart; however, it was not provided. (528)

C. On September 13, 2016, resident #060 was observed in bed with one falls intervention in place. Review of the plan of care indicated that they were to have two falls interventions in place when in bed. Interview with registered staff #113 stated the resident was at risk of falling out of bed and confirmed that both falls interventions were to be in place and their planned care was not provided. (581) [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 plan of care set out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

According to Critical Incident Submission (CIS) #2408-000001-16, on an identified day in February 2016, there was alleged staff to resident abuse between PSW #120 and resident #066 when the resident sustained an injury while receiving care.

Review of the home's investigation notes indicated the resident did sustain an injury when PSW #120 used excessive force while providing care. Interview with resident #066 stated on an identified day in February 2016, they were sitting in their wheelchair when PSW #120 was rough while providing care. The following day they noticed the injury and reported the incident to the DOC. Interview with PSW #120 stated they did touch the resident several times on the day of the incident in an attempt to provide care. They confirmed the resident did have an injury on the same location they were touching and they apologized to the resident for the injury. Interview with the Administrator and the DOC confirmed that as result of the home's investigation allegations of abuse was substantiated. The home did not protect resident #066 from physical abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's policies identified that when a resident had fallen, registered staff were to assess the resident using the following clinically appropriate assessment instruments:

i. The home's policy, "Resident Falls Prevention Program-Steps to Follow Following a Fall", dated October 2015, indicated when a resident had fallen, the registered staff would complete a Falls Review (Post Fall Huddle Assessment) and Falls Risk Assessment.
ii. The home's policy, "Head Injury Routine" (HIR), dated June 2016, indicated that all resident who actually and potentially may have sustained an injury to their head following a fall that was witnessed or not witnessed must have a head injury routine initiated immediately. The HIR was to be completed every 15 minutes for the first hour, every 30

minutes for the next 2 hours and hourly for the next four hours and if stable every four hours until 72 hours after the suspected head injury has been reached. Document assessments and all interventions taken on the progress notes, resident incident report and on the Neurological Assessment Flow Sheet.
iii. Evaluate and monitor resident for 72 hours after a fall on every shift and document in the progress notes.
iv. Complete the Fall Risk Assessment after a fall, during the quarterly and annual review and when there was a significant change in the resident's condition.

A. Resident #060 sustained two unwitnessed falls on two identified days in August 2016. Review of the plan of care identified the following:

i. The post fall huddle assessment was not completed after the fall on an identified day in August 2016.
ii. The HIR was not initiated post both unwitnessed fall as required by the home's policy.
iii. The post falls follow-up note was not completed after the first fall on an identified day in August 2016, on night and evening shift and after the second fall on an identified day in August 2016, on evening shift. The post falls notes were only completed, one out of nine shifts after the second fall on an identified day in August, 2016.
iv. The falls risk assessment was not completed after the second fall on an identified day in August 2016.

Interview with registered staff #100 confirmed that resident #060 was not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home's Resident Falls Prevention Program and the Head Injury Policy after they sustained two falls.

B. Resident #064 sustained two unwitnessed falls on an identified day in September 2015, resulting in an injury. Review of the plan of care identified the following:
i. The post fall huddle assessment was not completed after the second fall.
ii. The HIR was not completed after both falls.
iii. The post falls follow up note was not completed on an identified day in September 2015, on day shift, on all three shifts on the following day in September 2015 and on the following day in September 2015, on day shift.
iv. The falls risk assessment was not completed after the second fall on an identified day in September 2015.

Interview with registered staff #100 confirmed that resident #064 was not assessed using

a clinically appropriate assessment tool that was designed for falls as outlined in the home's Resident Falls Prevention Program and the Head Injury Policy after they sustained two falls and an injury.

C. Resident #062 had a unwitnessed fall on an identified day in May 2015 and sustained an injury. Review of the plan of care identified that the HIR was initiated post fall, but not all sections were completed. Interview with DOC confirmed the HIR was not fully completed as required by the home's policy. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances for the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with a range of continence care products based on their individual assessed need.

A. During the course of the inspection, resident #011 was noted to require the assistance of staff for toileting related to urinary frequency but that sometimes the resident toileted themselves or put self on toilet and called for assistance. Review of MDS assessment from June 2016, revealed the resident was continent of bowels and incontinent of bladder with some control present. As a result, the resident used a continence product, which the family supplied, since admission into the home in 2014. Interview with the substitute decision maker (SDM) for the resident confirmed that the resident required a specific continence product and was not aware that the home would provide one for the resident, therefore paid out of pocket to supply the resident with the product. Interview with PSW #108, PSW #104 and registered staff #105 confirmed that resident #011 wore a specific continence product and the home did not provide them. (528)

B. Review of the MDS continence assessment from March and June 2016, indicated that resident #017 was frequently incontinent of bowel and bladder, was on a toileting program and would self-toilet at times. On a specified day in September 2016, they were observed wearing a specific colour pad and pads were observed in the resident's drawer. Interview with the SDM stated resident #017 was wearing a specific continence product upon admission to the home and continued to wear that product which was supplied by the family until they were finished and then they were provided specific colour pads by the home. SDM stated the resident and family would prefer they wore a specific continence product but was informed by the home they did not provide that product from some staff and the resident did not qualify for that specific product from other staff. Interview with PSW #123 stated the resident did wear a specific continence product that the family provided but when they stopped bringing in the product, the resident was provided from the home a specific pad. Review of the plan of care indicated the resident wore a day pad on day and evening shift and a brief on night shift and were to wear a specific continence product when going out of the home. Interview with registered staff #119 and review of the home's decision tree for the assessment of the use of a specific continence products indicated that if the resident was frequently incontinent of bowel continence and were more than light to moderately incontinent, specific continence products were not appropriate and were not supplied by the home. The home's decision tree for the use of specific continence products did not promote residents' independence, comfort, dignity and preference. Registered staff #119 confirmed the home did not provide a specific continence product once the family stopped providing them other when they left the home for an outing and was unaware that it was the resident's and families preference to wear a specific continence product. [s. 51. (2) (h) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with a range of continence care products based on their individual assessed need, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 10 per cent of body weight, or more, over 6 months were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

The plan of care for resident #011 identified that the resident was at a moderate nutritional risk with a specific goal weight range. It was also documented that the resident sometimes refused meals. From February to August 2016, resident #011's weight had decreased over 10 per cent over six months and out of the resident's weight goal range. Review of the plan of care did not include an interdisciplinary assessment and no actions were taken. The following month, the resident was noted to loose more weight and a referral to the registered dietitian (RD) by registered staff, noting the resident was refusing meals. Interview with the RD identified that the resident's weight was below the goal weight and in July 2016, specific snacks were added to the resident's care plan to ensure the resident would eat the snack. The resident continued to lose weight and since the significant weight loss in August and September 2016, no additional interventions had been put in place, as registered staff had not alerted the RD of the significant weight loss until September 2016. (528) [s. 69. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with a change of 10 per cent of body weight, or more, over 6 months are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act was applied by staff in accordance with any manufacturer's instructions.

On an identified day in September 2016, resident #012 was observed seated in their wheelchair with a specific device applied that was too loose, approximately five fingers breadth away from the resident's body. The resident was unable to release the device when asked. Interview with registered staff #118 confirmed that the resident required the specific device as a PASD and it was not applied according to manufacturers instructions, two fingers breadth away from the resident's body. [s. 111. (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 a PASD used under section 33 of the Act is applied by staff 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. 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 was complied with.

The home's policy, "Hazardous Food and Beverage Temperatures", revised February 2015 and reviewed December 2015, identified that "all hazardous cold food and beverages [should] be stored at a maximum of four degrees celsius and served no greater than five degrees at point of service and consumed within an hour from the time it is removed from cold storage." Dietary staff were to record food and beverage temperatures prior to serving residents and if any hazardous items were not within acceptable range the Food Service Manager (FSM) or designate was to be notified. Furthermore, the policy directed the FSM to review food and beverage temperature records on a monthly basis and any corrective action taken if food or beverages were found to be outside acceptable temperatures, were to be forwarded to the Administrator.

Review of the homes Food and Fluid Temperature Records for August and September 2016, revealed the following:
i. In August 2016, there were ten meals where dietary staff recorded the temperature of milk over five degrees celsius and no corrective action was documented.
ii. In September 2016, there were four meals where dietary staff recorded a milk temperature over five degrees and no corrective action was documented.
iii. Interview with the FSM confirmed that monthly reviews of Food and Fluid Records were completed but the focus was on completion of temperatures and not whether corrective action was documented.
iv. Interview with dietary staff #100, dietary staff #111 and dietary staff #112 confirmed that if milk had a temperature over the acceptable range, the item was refrigerated or could be reserved using refrigerated milk that was within the acceptable range.
v. Interview with the FSM and the Administrator confirmed that the home's policy was not complied with when dietary staff did not document corrective action taken for milk temperatures recorded above the acceptable range and when the monthly review did not include corrective action. [s. 8. (1) (b)]

WN #8: 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy, "Prevention and Elimination of Abuse and Neglect of Residents", last reviewed January 2016, directed that any person must report witnessed or suspected abuse to the Administrator or the Ministry of Health and Long Term Care (MOHLTC) ACTION Line. The Administrator or delegate was to immediately report to the MOHLTC every suspected or confirmed incident.

A. Ontario Regulation 79/10 Section 2(1) defined "physical abuse [as] (c) the use of physical force by a resident that causes physical injury to another resident."
B. On a specified day in June, 2016, a resident to resident physical altercation occurred between resident #017 and resident #031. The resident was immediately assessed and review of the progress notes identified that evidence of injury was not present until the following day. The home did not report the incident to the MOHLTC until three days after an injury was confirmed. Interview with the DOC confirmed that they were not aware of the injury until they returned to work and therefore, the incident was not reported immediately. [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

In January 2015, the family of resident #030 provided the home with two written letters of complaint concerning the care of a resident. Interview with the DOC identified that the concerns were investigated by the home and follow-up was completed with the complainant; however, the written letters were not forwarded to the Director to date. [s. 22. (1)]

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

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to review the menu cycle with Residents' Council.

A review of the Residents' Council meeting minutes confirmed that the menu cycle was not reviewed during the council meetings. The Life Enrichment Coordinator stated that the menu cycle was reviewed in the food committee meetings but confirmed they were not reviewed as part of the Residents' Council meetings. [s. 71. (1) (f)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

A review of the Residents' Council meeting minutes identified that the meal and snack times were not reviewed during the council meetings. The Life Enrichment Coordinator confirmed that the meal and snack times were reviewed with the food committee meetings but confirmed they were not reviewed as part of the Residents' Council meetings. [s. 73. (1) 2.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Review of the Resident Council meeting minutes identified that the Resident Council did not have input in developing and carrying out the satisfaction survey,and in acting on its results. The Administrator stated that they made changes to the survey after receiving input from the 2015, satisfaction survey but confirmed they did not bring the changes to the Resident Council prior to to the satisfaction survey being distributed in June of 2016. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

In January 2015, the family of resident #030 provided the home with two written letters documenting care concerns. The information was received by the DOC, investigated and follow up correspondence was sent to the complainant approximately six days later. Review of the home's 2015 Complaints Log did not include a documented record of the complaint. Interview with the DOC confirmed that the written complaints from the family of resident #030 was not documented in the 2015 Complaints Log. [s. 101. (2)]

Issued on this 13th day of October, 2016

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

Original report signed by the inspector.