Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 28, 2014	2014_235507_0011	T-069-14/T-288-14	Resident Quality Inspection

Licensee/Titulaire de permis

MARIANN NURSING HOME AND RESIDENCE
9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1

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

MARIANN HOME
9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1

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

STELLA NG (507), ANN HENDERSON (559), SUSAN SEMEREDY (501), TIINA TRALMAN (162)

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): June 5, 6 & 9, July 15, 16, 17, 18, 21 & 22, 2014.

Follow up inspection Log # T-288-14 was also inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), resident assessment instrument (RAI) coordinator, director of environmental services (DES), dietary manager (DM), program manager (PM), physiotherapist (PT), registered dietitian(RD), registered nursing staff, personal support workers (PSWs), cook, dietary aides (DAs), residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observation in home and resident's areas, conducted observation in care delivery processes, conducted observation in food production, conducted observation in meal services, reviewed the home's records, policies and procedures, reviewed minutes of the Family Council, Resident's Council and Food committee and reviewed residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On an identified date, the inspectors observed two identified spa room doors open and unsupervised. Equipment and supplies were kept in the spa rooms. Interview with an identified registered staff and personal support workers (PSWs) confirmed that the doors should be closed and locked at all times when unattended. The identified PSW then closed and locked the door to one of the above mentioned identified spa rooms.

On another identified date, the inspector observed one of the above mentioned identified spa rooms door open and unsupervised. The inspector spoke with another identified registered staff who indicated when the spa room is not in use it should be closed and locked. Shortly thereafter, the inspector observed the second identified spa room door unlocked and the spa room unattended. The inspector informed the director of care (DOC) and another identified registered staff.

Five days later, the inspector observed both above mentioned identified spa room doors unlocked and unsupervised. Interviews with an identified registered staff and PSW indicated the door to the spa rooms should be closed and locked when not in use.

In all the above mentioned unlocked and unattended spa rooms, the inspector was able to gain access to the lift equipment and hot water from the tap. Furthermore, residents are at risk for falls associated with equipment and supplies kept on the floor in the spa rooms that were open and unattended by staff. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On an identified date, the inspector observed the residents' call bells in an identified resident room behind the beds and inaccessible to residents. An identified registered staff was notified and call bells were placed on the bed.

The resident's call bell in another identified resident room was found draped behind the bed on the floor. There was no functioning call bell on the bed, and the resident was not in bed.

The resident's call bell in the third identified resident room was found on the floor by the resident's bed. The resident was in bed asleep and did not have access to the call bell.

On another identified date, the inspector observed the call bell cord in an identified spa room shower stall short and unable to activate the call station, as a component was missing. The registered staff immediately replaced it with a longer cord. Another call bell between the shower stall and the tub was found with the cord wrapped around the call bell system and it was unable to activate the call station. The registered staff

was informed and corrective actions were taken. [s. 17. (1) (a)]

2. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed, toilet, bath and shower location used by residents.

On an identified date, the inspector observed that a call bell was not available in an identified resident room. Instead a posey alarm was plugged into the call bell socket, and the inspector was not able to activate the resident-staff communication and response system.

Interview with the DOC confirmed that the posey alarm should not replace the call bell, and a call bell was not available in the above mentioned identified resident room. [s. 17. (1) (d)]

3. On the same day, the inspector observed that a call bell was not available in another identified resident room. Instead a posey alarm was plugged into the call bell socket, and the inspector was not able to activate the resident-staff communication and response system.

An identified registered staff and the management of the home were informed and corrective action was taken. [s. 17. (1) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home is equipped with a resident-staff communication and response system that:
1. can be easily seen, accessed and used by residents, staff and visitors at all times, and
2. is available at each bed, toilet, bath and shower location used by residents, to be implemented voluntarily.

WN #3: 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,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

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).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle is approved by a registered dietitian who is a member of the staff of the home.

The dietary manager (DM) confirmed that the current menu cycle has not been approved by a registered dietitian (RD) who is a member of the staff of the home. [s. 71. (1) (e)]

2. The licensee failed to ensure that the menu cycle is reviewed by the Residents' Council.

The DM confirmed that the menu cycle has not been reviewed by the Resident's Council. [s. 71. (1) (f)]

3. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

On an identified date, at the lunch meal in an identified dining room, the inspector observed that staff serving meals in the dining room did not offer the alternate dessert sherbet in accordance with the planned menu. The inspector observed that residents

at four tables were offered only the first choice dessert. [s. 71. (4)]

4. On the same day, during the lunch meal service in the same identified dining room, the inspector observed a lack of directions to staff portioning standard, therapeutic and texture modified menu items as identified in the recipes available for the planned menus. For example:
A smaller #12 serving (80mL) utensil was used to serve regular texture carrot salad for which a #8 serving (125mL) utensil was to be used according to the available standardized recipe. A larger #12 serving (80mL) utensil was used to serve regular texture cottage cheese for which a #16 serving (60mL) utensil was to be used according to the available standardized recipe.

There was no direction for portioning menu items as there were no available therapeutic and texture modified menus to guide staff.

Interview with the dietary aide (DA) revealed there was no available reference for portioning menu items at point of meal service. Interview with the DM confirmed that currently, the home does not have a process in place that includes identifying portions to be served for therapeutic and texture modified diets for both meals and snacks. [s. 71. (4)]

5. The licensee failed to ensure that an individualized menu is developed for a resident whose needs cannot be met through the home's menu cycle.

Record review revealed that an identified resident is to receive a therapeutic diet.

Interview with the RD revealed that due to gradual weight change, the above mentioned identified resident is now to receive modified portions. Interview with the DM revealed that he/she will need to clarify what is meant by modified portions as neither the staff nor DM could demonstrate an understanding of portion sizes for an order for modified portions. Both the RD and DM confirmed that an individualized menu was not developed for this resident to identify specific appropriate menu items based on the combined dietary interventions and the resident's preferences. [s. 71. (5)]

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 the ensure that the following are complied with:
1. the menu cycle is approved by a registered dietitian who is a member of the staff of the home,
2. the menu cycle is reviewed by the Residents' Council,
3. the planned menu items are offered and available at each meal and snack, and
4. an individualized menu is developed for a resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system, at a minimum, provides for standardized recipes and production sheets for all menus.

During the lunch meal production observation on an identified date, not all standardized recipes and production sheets were available for the planned lunch meal.

Record review and interviews with the DM and cook confirmed that standardized recipes and production sheets are not in place for the homes' 21 day / 3 week menu cycle including but not limited to diabetic, standard, diabetic restricted, standard enriched, reducing, diabetic restricted/reducing, and for textures including regular, minced, and pureed, as well as small portions, large portions.

Because the system is not in place, there is no way to ensure that taste, nutritive value, appearance, and food quality are preserved. [s. 72. (2) (c)]

2. The licensee failed to ensure that all menu substitutions are communicated to residents and staff.

On an identified date, the inspector observed that menu substitutions for the luncheon menu were not posted in the main dining room nor communicated to residents.

An interview with the DM confirmed that menu substitutions for the luncheon menu on the above mentioned identified date, were not posted nor communicated to residents in an identified dining room. [s. 72. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system, at a minimum, provides for standardized recipes and production sheets for all menus and all menu substitutions are communicated to residents and staff, to be implemented voluntarily.

WN #5: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes the proper technique to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date, the inspector observed in an identified dining room at lunch, an identified volunteer assisting an identified resident with eating while sitting on a non-adjustable high stool. The resident had to raise his/her head to receive food. The resident requires full feeding assistance. An identified PSW was also seated on a non-adjustable high stool while feeding two other identified residents. Both residents were observed to raise their heads to receive food.

Interview with registered staff and PSWs revealed that there is a lack of appropriate seating for staff and volunteers. The registered staff confirmed that all staff must be seated with the residents at eye level to ensure safe feeding techniques are applied.

Review of the home's nutrition-feeding techniques policy revised September 2013, indicates that when assisting a resident with eating, staff need to be seated at

resident's eye level so that the resident does not have to lift his/her head (tilting back will open the air way). [s. 73. (1) 10.]

2. The licensee failed to ensure that the home has a dining and snack service that includes the appropriate furnishings and equipment in resident dining areas, including 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.

On an identified date, the inspector observed in an identified dining room at lunch, an identified volunteer assisting an identified resident with eating sitting on a non-adjustable high stool. The resident had to raise his/her head to receive food. The resident requires full feeding assistance. An identified PSW was also seated on a non-adjustable high stool while feeding two other identified residents. Both residents were observed to raise their heads to receive food.

Interview with registered staff and PSWs revealed that there is a lack of appropriate seating for staff and volunteers. The registered staff confirmed that all staff must be seated at the appropriate level with the residents at eye level to ensure safe feeding techniques are applied. The registered staff indicated that the home has ordered additional stools for feeding assistance. The DOC confirmed that an order has been placed but the stools have not been received as of July 22, 2014. [s. 73. (1) 11.]

3. The licensee failed to ensure that no resident who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident.

On an identified date, the inspector observed in an identified dining room at lunch, an identified resident was seated at the dining table and was served his/her hot entrée. The resident was not eating and there was no assistance/encouragement provided nor monitoring during the inspector's observation period of 13 minutes. The inspector inquired with an identified PSW who indicated he/she was not aware that the resident was not assisted by his/her assigned PSW.

The above mentioned identified resident is at nutritional risk for refusal to eat, and requires intermittent encouragement and physical assistance to eat.

An identified registered staff confirmed that the identified resident should be assisted upon receiving his/her meal. The resident's meal was not reheated and the resident

appeared uninterested in eating the meal despite encouragement from staff. Staff then transported the resident out of the dining room. [s. 73. (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 the home's dining service includes the following:
1. proper technique to assist residents with eating, including safe positioning of residents who require assistance,
2. the appropriate furnishings and equipment in resident dining areas, including 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, and
3. no resident who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee failed to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance.

On an identified date, the inspector observed scratch marks on doors and door frames in common areas throughout the building.

Record review and interviews with the director of environmental services (DES) and the administrator revealed that areas of concern were identified in a five-month period prior, but no remedial action was taken related to needed interior repairs including walls, baseboards, windows, doors and tiles and painting in resident rooms and common areas.

Furthermore, the DES and the administrator confirmed that there is no schedule in place to address the above areas of concern. [s. 90. (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 there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

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

On an identified date, the inspector observed an identified PSW clearing dirty dishes from the tables during the lunch meal, who dropped a dirty spoon by the dirty dish

cart, picked it up, placed it with other dirty dishes and returned to assist a resident with eating without washing or sanitizing hands.

Interview with the identified PSW confirmed he/she did not wash or sanitize hands after clearing dirty dishes and before continuing to assist with feeding residents and was not aware that this was necessary. [s. 229. (4)]

2. On an identified date, the inspector observed an identified registered staff on an identified floor put the gloves on and approach an identified resident to complete his/her treatment. The identified resident was wiping his/her nose with a Kleenex. Upon approaching the resident, the identified registered staff wiped the resident's nose with a clean Kleenex and threw the used Kleenex in the garbage bin. The registered staff then completed the treatment without changing gloves or washing hands.

Interview with the identified registered staff confirmed that he/she should change gloves and wash hands prior to completing the treatment.

On the same day, the inspector observed an identified registered staff administering medications to two identified residents in an identified dining room. The identified registered staff took two individual and labelled medications from the medication cart on another identified floor to the identified dining room. The registered staff gave one medication to the first identified resident at the dining table. The registered staff then realized he/she took the wrong medication for the second identified resident. The registered staff went back to the identified floor, got the correct medication, and then returned to the identified dining room. The registered staff gave the medication to the second identified resident at the dining table. The identified registered staff was observed fixing his/her hair during the elevator ride and the registered staff did not wash his/her hands prior to giving medication to both above mentioned identified residents.

Interview with the identified registered staff confirmed that he/she should perform hand hygiene between giving medications to residents, but did not do so.

On another identified date, the inspector observed another identified registered staff administering medication to the third identified resident after assisting the physician in examining the fourth identified resident. The registered staff did not perform hand hygiene before giving the medication to the third identified resident.

Review of the home's Hand Hygiene Policy and Procedure, revised October 2013, states that all staff are to practice hand hygiene including before administering a medication by any route and between tasks and procedures on the same resident to prevent cross-contamination of different body sites. [s. 229. (4)]

Additional Required Actions:

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

WN #8: 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 the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation section 50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a RD 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.

The home's policy titled Skin Care and Pressure Ulcer Management, dated September 2013, states that residents with stage 2 pressure/wound ulcer to be referred to dietitian for recommendations on supplements and laboratory investigations. This policy is not in accordance with the regulation that states the RD is to make an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown. [s. 8. (1) (a),s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

During the lunch meal production observation on an identified date, not all recipes and production sheets were available for the planned lunch menu. Further review revealed that standardized recipes and production sheets as well as the therapeutic menus for the homes' 21 day / 3 week menu cycle were not available. Interviews with the DM and Cook confirmed that standardized recipes and production sheets as well as the therapeutic menus for the homes' 21 day / 3 week menu cycle were not available.

The lack of an organized program of dietary services, including recipes and production sheets results in the home being unable to demonstrate that they meet the daily nutrition needs of the residents. [s. 11. (1) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home and furnishings are maintained in a safe condition and in a good state of repair.

On an identified date, the inspector observed the closet door in an identified resident's room was not latched onto the top and bottom rails. The closet door was placed side way at the entrance of the closet.

Interview with the DES confirmed that the unlatched closet door should be fixed and it was unsafe to leave the closet door unlatched. [s. 15. (2) (c)]

WN #11: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Record review revealed that an identified resident has a stage 3 ulcer and requires dressing changed.

Interview with the DOC confirmed that the head to toe skin assessment template is used for all skin and wound assessment.

Interview with an identified registered staff confirmed that skin and wound assessment for the identified resident's ulcer is to be conducted every week while changing the dressing. However, registered staff are not using the head to toe skin assessment template every time when they conduct the skin and wound assessment for the identified resident; instead the head to toe skin assessment template is used as a guide when skin and wound assessment is conducted. As a result, not all required elements for skin and wound assessment listed on the head to toe skin assessment template are being assessed when the skin and wound assessment is conducted. [s. 50. (2) (b) (i)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written strategies including techniques and interventions to prevent, minimize or respond to the responsive behaviours.

The written plan of care for an identified resident does not provide directions to staff regarding responsive behaviours. The identified resident's quarterly review assessment of an identified date, revealed a change in behavioural symptoms related to responsive behaviours. Progress notes related to behaviour between a period of four weeks and three weeks prior to the quarterly review assessment date revealed an increase in the resident's responsive behaviours.

Interviews with an identified registered staff and PSW revealed that the identified resident's responsive behaviours are dependent on the resident's mood and pain level. Staff indicated that the resident's responsive behaviours are easily redirected.

The registered staff confirmed that responsive behaviours, and techniques and interventions to prevent, minimize or respond to the identified resident's responsive behaviours were not included in the resident's written plan of care. [s. 53. (1) 2.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

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

Record review revealed and interviews with the administrator and the DOC confirmed that responses in relation to the concerns raised at an identified date of the Family Council meeting were not forwarded to the program director (PD) in a timely fashion. As a result, the Family Council was not provided with a response within 10 days for the concerns raised during the identified date meeting. [s. 60. (2)]

WN #14: 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 actions were taken when a resident had weight change that compromises his/her health status.

Record review revealed that an identified resident had a slow progressive weight change in a period of 21 months, and is currently above/below his/her limit of goal weight range. A nutrition quarterly assessment made on an identified date, by the RD indicated that nutritional status would be care planned with the intent of decreasing/increasing weight to be within resident's healthy weight range. Review of the plan of care revealed no interventions were care planned.

Interview with RD on an identified date, confirmed the interventions were not care planned as intended. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who received training in relation to infection prevention and control prior to performing their responsibilities, receive retraining annually as required by the regulations.

Record review revealed and interview with the DOC confirmed that four per cent of direct care staff did not receive training in infection prevention and control in 2013. [s. 219. (4)]

WN #16: 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff are provided training in skin and wound care.

Record review revealed and interview with the DOC confirmed that eight per cent of direct care staff did not receive training in skin and wound care in 2013. [s. 221. (1) 2.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
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. 19. (1)	CO #001	2013_168202_0068	507

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

Issued on this 4th day of September, 2014

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