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
Dec 9, 2016	2016_382596_0015	029422-16	Resident Quality Inspection

Licensee/Titulaire de permis

341822 ONTARIO INC
28 HALTON STREET TORONTO ON M6J 1R3

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

MAYNARD NURSING HOME
28 HALTON STREET TORONTO ON M6J 1R3

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

THERESA BERDOE-YOUNG (596), ANGIE KING (644), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 5, 6, 7, 12, 13, 14, 18, 19, 20, 21, 24, 25, 26, 2016.

The following Complaint intakes were inspected concurrently with this RQI: 008296 -14, 005338-15, 009714-15, 03122-15, 022980-16.
The following follow up intake 004636-16 was inspected concurrently with this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), director of activation (DOA), environmental services manager (ESM), food service supervisor (FSS), social service worker (SSW), registered dietitian (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary aides (DA), cooks, housekeeping staff, laundry aides (LA), life enrichment aide (LEA), maintenance assistant (MA), Family Council President, Family Council Secretary, Residents' Council President, residents and family members.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, observed meal service, reviewed resident health record, meeting minutes, schedules, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **1 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. 15. (2)	CO #002	2015_417178_0021	596

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. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary
The following resident home areas were identified as unclean and not sanitary during the inspection period:

On October 19, 2016, the following observations were made by inspector #596 and the ESM during a tour of the home:
- thick, sticky black substance on the floor in a resident room.
-build-up of dirt on the baseboard and where the floor meets the baseboards in front of the nursing station and near the elevator on the first floor.
-build-up of dirt on the baseboards near the entrance and windows in dining rooms on the first and second floors.
-build-up of dirt and dust visible in the caulking under the lower cupboards in the first floor dining room.
-bathroom floor grout around the toilet and in front of the sink in another resident room, discolored black with visible build of dirt.The inspector was able to remove some of the dirt with a wet piece of toilet paper, while rubbing firmly.

During the tour of the above areas, the home's ESM agreed that these areas of the home were not clean and sanitary, and required housekeeping attention.

On October 26, 2016, the following was observed by inspector #596 and housekeeper #139:
-old dried fluid on foot board of an identified resident's bed foot board
-build-up of dirt and dust on top of the radiator near the window
-build-up of dirt and dust on the floor behind the headboard of another identified resident's bed and twenty three mouse droppings in the same room

On October 26, 2016, the following was observed by inspector #596 and #644 in a specified resident room:
-build-up of dirt and dust on top of baseboards in residents' shared washroom and around the room, mouse droppings in two corners of the washroom, dried brown substance on the floor beside the toilet and dried sticky substance on the window sill.

Interview with an identified family member revealed that a few weeks ago he/she observed the floor beside an identified resident's bed and the window to be grossly dirty

and sticky, even though housekeepers were expected to clean the residents’ room daily. He/she reported that his/her shoes were sticking to the floor. He/she got the attention of a housekeeper who immediately cleaned the area. The identified family member stated that the identified resident's room was cleaned well only once since admission to the home in July 2016.

Record review of the home's housekeeping schedules for August, September, October 2015 and September and October 2016, revealed that housekeeping hours were reduced from two housekeeping staff Monday to Friday and one housekeeping staff on Saturdays and Sundays to one housekeeper two to three days of the week between Monday and Fridays, two housekeeping staff on Saturdays and one and a half housekeeping staff on Sundays.

Interview with the Administrator revealed that the housekeeping staffing pattern changed in September 2015 with one housekeeper working on Monday, Tuesday and Wednesdays (down from two housekeepers previously), two housekeepers on Friday and Saturday, and one and a half shift on Sundays. Record review of the Administrator's handwritten notes provided to the inspector revealed that the housekeeping staffing mix changed in October 2015 when he/she decreased housekeeping hours from two housekeepers to one on Mondays, Tuesdays, Thursdays and Fridays from 0700-1500 hours, and from one housekeeper to two housekeepers on Saturdays and Sundays with the additional housekeeper working from 0930 to 1330 hours.

Interview with the ESM revealed that the home’s expectation is that housekeepers clean all resident rooms, shower/tubs rooms and corridors daily.

Interviews with personal support worker (PSW) #128, housekeepers #124, #139, #134 reported that there was no deep cleaning schedule for resident rooms even though Fridays were considered deep cleaning days. Housekeeper #139 revealed that the administrative offices and the activity room were deep cleaned on some Fridays, and resident rooms were not. Housekeeper #119 stated that he/she had deep cleaned other common areas of the home, however he/she has never deep cleaned resident rooms.

Interviews with the ESM and Administrator confirmed that the home did not have a deep cleaning schedule, however verbal direction was given to housekeeping staff regarding which areas of the home required deep cleaning when necessary. The ESM and Administrator were unable to confirm when the most recent deep cleaning of resident rooms was completed, and unable to provide any documentation of the same.

Record review of the home's Housekeeping audit- Common areas sign off sheets for October 4, 5 and 6, 2016, did not include staff sign offs for cleaning the second floor shower/tub rooms, and the first floor shower /tub rooms on October 4, 2016.
Record review of the Housekeeper daily audit sheets dated October 4, 2016, for first and second floors including resident room numbers 10 to 24 and 28-43 did not include staff sign offs under the "with Disinfectant cleaner wipe" section. The same on October 18, 2016, for all resident rooms on the second floor.

Interview with housekeeper #124 revealed that he/she did not clean the shower/tub rooms, nor used the disinfectant cleaner wipes in resident rooms as mentioned above on two specified dates in October 2016, as he/she was the only housekeeper working in the home on those dates and unable to clean all resident rooms and common areas of the home. Housekeeper #124 stated that cleanliness of the home has been issue since the cuts in housekeeping hours.

Interviews with PSW #128, an identified family member, housekeepers #124, #139, #134 reported that housekeeping hours were decreased from two housekeeper per floor per day, to one for the whole home a few days of the week, in late 2015. The staff and family member reported that one housekeeper cannot clean the whole home properly.

The home was previously found to be in non-compliance with this requirement on June 5, 2013, during Complaint Inspection #2013_158101_0029, and a Voluntary Plan of Correction was issued. The home was again found to be in non-compliance with this requirement on February 27, 2015, during Resident Quality Inspection #2015_269597_0002, and Compliance Order CO #002 was issued. The licensee has failed to fully comply with the previous non-compliance order CO #002 with a compliance date of March 31, 2015, which was subsequently amended to April 30, 2015. CO #002 was issued for failing to ensure that the home, furnishings and equipment were kept clean and sanitary. The home was found to be in non-compliance with this requirement again during Resident Quality Inspection #2015_417178_0021, and compliance order CO #001 was issued; two of the areas listed above still remain outstanding at the time of this inspection.
Based on the home's compliance history and patterned scope with respect to failing to ensure that the home is kept clean and sanitary, a compliance order and directors referral is warranted.

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

On October 20, 2016 the following observations were made by inspector #596 and the ESM during a tour of the home:
-large area of peeled off paint on radiator in a resident room
-one stained ceiling tile in the first floor east shower room
-wood on the doorway leading to the second floor TV lounge was gouged and scraped
-sticky black substance on the floor in a resident room

During the tour of the above areas, the home's ESM agreed that these areas of the home were not maintained in a good state of repair and required maintenance attention.

The home was previously found to be in non-compliance with this requirement on June 5, 2013, during Complaint Inspection #2013_158101_0029, and a Voluntary Plan of Correction was issued. The home was again found to be in non-compliance with this requirement on February 27, 2015, during Resident Quality Inspection #2015_269597_0002, and Compliance Order CO #002 was issued. The licensee has failed to fully comply with the previous non-compliance order CO #002 with a compliance date of March 31, 2015, which was subsequently amended to April 30, 2015. CO #002 was issued for failing to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. The home was found to be in non-compliance with this requirement again during Resident Quality Inspection #2015_417178_0021, and compliance order CO #002 was issued; one of the areas listed above still remain outstanding at the time of this inspection.
Based on the home's compliance history and patterned scope with respect to failing to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, a compliance order and director's referral is warranted. [s. 15. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures were developed and implemented for (a) cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

On October 19, 2016, the following observations were made by inspector #596 and the ESM during a tour of the home:
-sticky black substance on the floor in a resident room
-bathroom floor grout around the toilet and in front of the sink in a resident room, discolored black with visible build of dirt. The inspector was able to remove some dirt with a wet piece of toilet paper, while rubbing firmly.

During the tour of the above areas on October 19, 2016, the home's ESM agreed that these areas of the home were not clean and sanitary, and required housekeeping attention. The ESM reported that the sticky black substance on the floor of a specified room was floor glue from when the flooring was replaced in April 2016, and stated that it

will be cleaned as soon as possible.

On October 26, 2016, the following was observed by inspector #596 and housekeeper #139:
-old dried fluid on foot board of an identified resident's bed foot board in a resident's room

-build-up of dirt and dust on top of the radiator near the window in room
-build-up of dirt and dust on the floor behind the headboard of another identified resident's bed, twenty three mouse droppings in the same room.

On October 26, 2016, the following was observed by inspectors #596 and #644 in a specified room:
-build-up of dirt and dust on top of baseboards in residents' shared washroom and around the room, mouse droppings in two corners of the washroom, dried brown substance on the floor beside the toilet, dried sticky substance on the window sill.

Interview with an identified family member revealed that a few weeks ago he/she observed the floor beside an identified resident's bed and the window to be grossly dirty and sticky, even though housekeepers were expected to clean residents' room daily. He/she reported that his/her shoes were sticking to the floor. He/she got the attention of a housekeeper who immediately cleaned the area. The identified family member stated that the identified resident's room was cleaned well only once since admission to the home in July 2016.

The home's book keeper #141 provided the inspector with the table of contents for the Housekeeping Services Manual and copies of some policies.
Record review of the following policies from the home's Housekeeping Services manual:
-Housekeeping Standards, document number HSM-C-01, revised Oct 2015
-Resident Room cleaning, document number HSM-C-11, reviewed Oct 2015
-Floor Care and Maintenance Floor Cleaning, document number HSM-C-15-05, reviewed Oct 2015
-Routine Cleaning of A Residents Room- discharge/transfer, document number HSM-C-12, reviewed Oct 2015
-Job Descriptions general policy- document number HSM-B-15-04, revised Oct 2015
-General Cleaning Procedures high dusting, document HSM-C-20-10, reviewed Oct 2015
.
The policies did not address deep cleaning of resident rooms.

Interviews with PSW #128, housekeepers #124, #139, #134 reported that there was no deep cleaning schedule for resident rooms even though Fridays were considered deep cleaning days. Housekeeper #139 revealed that the administrative offices and the activity room were deep cleaned, and resident rooms were not. Housekeeper #119 stated that he/she had deep cleaned other common areas of the home, however he/she has never deep cleaned resident rooms.

Interviews with the ESM and Administrator confirmed that the home did not have a deep cleaning schedule, however verbal direction was given to housekeeping staff regarding which areas of the home require deep cleaning when necessary. The ESM and Administrator were unable to confirm when the most recent deep cleaning of resident rooms was completed, and unable to provide documentation of the same.

The home was previously found to be in non-compliance with this requirement on April 30, 2015, during Resident Quality Inspection #2015_269597_0002 where a Voluntary Plan of Correction was issued.
Based on the home's compliance history and widespread scope, a compliance order is warranted. [s. 87. (2) (a) (i)]

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. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consult regularly with the Family Council, and in any case at least every three months.

Record review of the home's Family Council meeting minutes for 2015 dated April 29, June 23, July 29, September 2, October 7, and December 2, 2015 did not include documentation of consultations between the licensee and the Family Council regularly, and in any case every three months.

Interviews with the Family Council president, secretary, assistant and the home's Administrator revealed that the licensee did not consult regularly with the Family Council, and in any case at least every three months in 2015. [s. 67.]

2. The licensee has failed to ensure that they consult regularly with the Residents' Council, and in any case, at least every three months.

Record review of the home's Residents' Council meeting minutes from July to October 2016, did not include evidence that the licensee had consulted with the Residents' Council at least every three months.

Interview with the Residents' Council president revealed that the licensee had not been consulting with the council.

Interviews with the Residents' Council assistant and the Administrator confirmed that they had not consulted with the Residents' Council. [s. 67.]

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 they consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months, to be implemented voluntarily.

WN #4: 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 has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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.

During stage one of the RQI, and identified resident triggered for weight loss.
Review of the resident's weight history from March to October 2016, revealed the identified resident had significant weight loss of 15 per cent from March to April and 7.5 per cent from April to May 2016.

Review of the resident's health record did not include a dietitian's assessment related to the resident's weight loss.

Interview with the registered dietitian (RD) revealed that he/she had not assessed the identified resident following his/her significant weight loss in April and May, 2016. He/she confirmed that the identified resident had not been assessed using an interdisciplinary team approach. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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, to be implemented voluntarily.

WN #5: 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. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

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

On May 13, 2015, and July 27, 2016, the Ministry of Health and Long Term Care (MOHLTC) Action Line received a complaint related to food production in the home. The complainants stated that residents were eating left-over food from previous weeks, meal portions were small, and the home has an ongoing practice of shortage of food, especially mashed potatoes and vegetables.

On October 14, 2016, at 1422 hours the inspector observed a pan of baked ham dated September 29, 2016, placed in the refrigerator to be stored then thawed.
Review of the week 3 Summer Fall Menu revealed that honey glazed ham was planned for dinner on October 16, 2016.

On October 26, 2016, at 1035 hours the inspector observed cooked ground beef stored in the refrigerator with a production date of October 23, 2016.

Review of the food production record revealed the production sheets had not been prepared for the Summer-Fall menu cycle.

Cooks #117, #118, #136 reported that production sheets had not been used since 2003, and they refered to the daily census during food production.
The food service supervisor (FSS) confirmed that production sheets had not been developed or implemented in the food production system. [s. 72. (2) (c)]

2. The licensee has failed to ensure that all food and fluids were prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.

On May 13, 2015, and July 27, 2016, the MOHLTC Action Line received a complaint related to food production in the home. The complainant stated beverages were being watered down to keep expenses low.

On October 17, 2016, at approximately 1000 hours and 1230 hours the inspector observed a tea pot containing 3 tea bags and full with tea prepared for morning snack and lunch services respectively.

Review of the Residents' Council meeting minutes for August 17, 2016, revealed residents had complained about the taste and freshness of tea and coffee.

Review of the standardized recipe for tea #3216516 revealed staff were directed to place one tea bag per serving into pre-warmed pot, pour fresh boiling water and let steep for three to five minutes, then remove the tea bag.
Interviews with dietary aides (DA) #114, #137 and cook #118 revealed that they had prepared tea by adding two to three tea bags to a tea pot full with hot water, and leaving the tea bag in the pot throughout the meal service. DA #137 further stated that DAs' working in the evening had been adding water in the two per cent milk at dinner time as

the home usually ran short on evenings and weekends.

Interview with the FSS revealed that a full tea pot was equivalent to seven servings and should require seven tea bags instead of three. The FSS confirmed that tea had not been prepared according to the recipe to preserve taste and appearance. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system provides at a minimum, for production sheets for all menus, and that all food and fluids were prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #6: 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 has failed to ensure that staff participated in the implementation of the infection prevention and control program.

On May 13, 2015, and July 27, 2016, the MOHLTC Action Line received a complaint related to pets visiting the home. The complainants stated that two dogs defecated in resident care areas.

Interview with the complainant revealed that he/she had observed the Administrator's dog running in the basement; he/she stated that the dog had defecated and urinated in the activity room. When staff or resident observed the dog's waste, they would inform the Administrator to clean it up.

Interviews with staff members #129, #126, and #134 reported that dogs had defecated in the activation room prior to being trained.

Interview with the Administrator confirmed that the dogs had defecated in the resident area a long time ago. He/she stated that the dogs were properly trained and had been walked outside regularly. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

During stage one of the Resident Quality Inspection (RQI), minimizing of restraining triggered for an identified resident.

On October 12, 2016, inspector observed an identified resident laying in bed with two assist bed rails up.
Record review of the identified resident's written plan of care and kardex under the bed mobility section indicated that resident uses bed rails to move in bed. Half rails up at all times for safety. The Falls Risk section of the written plan of care and the bed rail section of the kardex directed staff to put up one half bed rail (left) when in bed for repositioning and to hold.

Interviews with PSWs #102 and #104 revealed that the resident used two siderails on the bed and the care plan and kardex did not set out clear direction to staff.
Interview with the Director of Care (DOC) and record review of the identified resident's care plan and kardex revealed that they do not set out clear direction to staff regarding resident's use of side rails. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs change or care set out in the plan is no longer necessary.

During stage one of the Resident Quality Inspection (RQI), oral/dental care triggered for an identified resident.

Record review of the identified resident's written plan of care under the mouth care section stated that resident needs no assistance with performing task. Instruct and monitor resident in proper oral hygiene techniques.

Interview with PSW #100 and #103 reported that the identified resident was unable to complete mouth care independently, and required assistance. PSW #103 stated that resident's care plan needed to be updated to reflect that the resident requires assistance with mouth care. [s. 6. (10) (b)]

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 has failed to ensure that procedures related to cleaning of meal production areas was complied with.

On October 25, 2016, at 1445 hours the inspector observed the pot washing sink in the kitchen soiled with food debris and left-overs of greasy food.
Review of the cleaning schedule revealed that the sink and its surroundings area are to be cleaned and sanitized at the end of each shift

Interview with DA #137 confirmed that the sink had not been cleaned and should be cleaned at the end of each shift. He/she also stated that it had been an ongoing concern.

When the inspector brought the concern to the FSS's attention, he/she confirmed that the sink had not been cleaned as per the schedule and the DAs' should have cleaned the sink at the end of the day shift at 1400 hours. [s. 8. (1) (b)]

Issued on this 9th day of January, 2017

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

Original report signed by the inspector.