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 prévue le Loi de 2007 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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 20, 2015;	2014_369153_0006 (A1)	T-076-14	Resident Quality Inspection

Licensee/Titulaire de permis

HUNTSVILLE LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

MUSKOKA LANDING
65 ROGERS COVE DRIVE HUNTSVILLE ON P1H 2L9

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

DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

CO #3 was rescinded as a result of an incorrect legislative reference to the corresponding grounds.

A new order, with the same grounds, will be generated and provided to the licensee in a separate inspection report.

Issued on this 20 day of February 2015 (A1)

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

Original report signed by the inspector.

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DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, 2014.

The following complaint logs were completed during this inspection: T-149-13, T-967-14.

The following critical incident logs were completed during this inspection: T-630 -14, T-686-14.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), co-director of care (CDOC), resident and family services coordinator, life enrichment coordinator, restorative care coordinator, food services supervisor (FSS), registered dietitian (RD), environmental services coordinator, staffing coordinator, registered nurses (RN), registered practical nurses (RPN), physiotherapy assistant (PA), personal support workers (PSW), cooks, dietary aide (DA), residents and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

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

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Snack Observation

Sufficient Staffing

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

- **28 WN(s)**
- **21 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs as resident and staff interviews and record review revealed the home is more regularly staffed outside of the home's staffing plan.

On August 11, 2014, the posted schedule included two unfilled PSW day shifts and one unfilled RPN day shift. Home area 2 with one of the unfilled PSW shifts was also affected by a sick call for a PSW day shift on August 11, 2014. The shuffling of shifts resulted in the night PSW from home area 2 staying overtime for 4hrs and a PSW from another unit reassigned to home area 2. The identified PSW that worked on home area 2 revealed that he/she worked short by two PSW's for several hours on Monday, August 11, 2014. A resident and a staff interview revealed that resident #15 waited at least 20 minutes on the toilet after ringing the call bell for staff assistance on the morning of the identified date. The identified resident stated "they are always short

on the weekends but the 11th was the worst I've seen". Staff interview revealed that he/she was unable to give resident #27 breakfast on the identified date.

On August 16, 2014, the posted schedule included two PSW day shifts unfilled on home area 3 and one PSW day shift on home area 1.
On August 16, 2014, staff interviews confirmed that breakfast was not provided to several residents on home area 3 as a result of staff shortages. Staff interview and record review revealed that residents #22 and #23 were not bathed according to their scheduled bath routine related to insufficient staff. The missed baths were not rescheduled.

On August 21, 2014, the posted schedule included one unfilled PSW day shift on home area 3. A staff interview and record review revealed no attempts were made to fill this open shift with no PSW shift replacement record available.
Staff interviews and observations revealed that at breakfast on August 21, 2014, residents #21 and #22 on home area 3 did not receive mealtime assistance according to their plan of care and the morning snack pass was not delivered. Further it was confirmed by staff and resident that resident #25 was not laid down after lunch according to his/her plan of care as there was insufficient staff.

Record review and an interview with staffing coordinator revealed that in August 2014, there was a shortfall of 360 PSW hours and 113 RPN hours that were not filled according to the home's staffing plan and not directed into resident care. In July 2014, there was a shortfall of 356.25 PSW hours and 61.5 RPN hours that were not filled according to the home's staffing plan and also not directed into resident care.

An interview with the DOC, new to the position as of August 11, 2014, stated that if they are short staffed, the staffing coordinator and charge nurse/RN will put out the calls to fill the shift otherwise they do extensions. The DOC was not aware that care was not provided August 11, 16 and 21, 2014. [s. 31. (3)]

2. The licensee has failed to ensure that there is a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of records provided and interview with the administrator confirmed that there is no written annual evaluation of the home's staffing plan and how the home's staffing is meeting residents' assessed care needs and safety needs. [s. 31. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A record review and staff interviews identified that resident #22 did not receive his/her scheduled shower on August 3, 10, 16, 2014. Two baths per week were not provided between August 3,2014, and August 20, 2014, a 16 day period. [s. 33. (1)]

2. A record review and staff interviews identified that resident #23 did not receive his/her scheduled bath on August 1, 12, 19, 2014. Two baths per week were not provided between August 1-19, 2014. An interview with the president of Residents' Council revealed that scheduled showers are not routinely provided as required.
An interview with the DOC revealed a lack of awareness that residents #22 and #23 did not receive their baths twice a week and that staff identified a lack of staff as the reason for not providing the scheduled baths. [s. 33. (1)]

3. Record review, resident and staff interviews identified that resident #20 did not receive his/her scheduled shower August 10 and 17, 2014. Family expressed concern to management on August 17, 2014, that for two weeks in a row two baths were not provided to the resident. Resident was bathed August 18, 2014, in response to the family's concern. Two baths per week were not provided the week of August 10, 2014.
Resident interview revealed that staff shortages were identified on both August 10 and 17, 2014. [s. 33. (1)]

4. Record review and staff interviews identified that resident #04 did not receive his/her scheduled bath between July 30 and August 13, 2014, or for a 13 day period.
An interview with the president of Residents' Council revealed that scheduled baths are routinely not provided as required.
An interview with DOC confirmed that he/she was unaware that this resident was not bathed twice a week and that staff identify unfilled PSW shifts and being short staffed as the issue. [s. 33. (1)]

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 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. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

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

The spring/summer 2014 menu review and approval form, revealed the menu was reviewed by the RD who provided written comments but was not approved by the RD. An interview with the RD revealed the comments were reviewed with the FSS and that no corrective actions took place. The RD had not approved the spring/summer 2014 menu for implementation. An interview with the FSS revealed an assumption that the

RD had provided approval of the menu with some changes, when the RD completed the menu review and approval tool. The FSS confirmed changes were not made to the menu based on the RD's comments. [s. 71. (1) (e)]

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

Interviews with the president of Residents' Council and the council assistant confirmed the menu cycle has not been reviewed by the Residents' Council. [s. 71. (1) (f)]

3. The licensee has failed to ensure that residents are offered a minimum of three meals daily.

Staff interview revealed that resident #21 requires a two person lift and that on the morning of August 19, 2014, staff ran out of time and were unable to get him/her up for breakfast. An identified PSW revealed there are just two choices: either leave the residents waiting in the dining room for breakfast service, or leave residents in bed and start breakfast service on time. The identified staff and resident confirmed that the resident was not assisted from bed for breakfast and a breakfast tray was not provided. Resident #21's written plan of care identifies the resident at high nutritional risk related to low body weight with nutrition interventions to increase energy intake. [s. 71. (3) (a)]

4. Staff interviews and record review indicated that on August 16, 2014, not all residents on home area 3 were offered breakfast. A registered staff on duty reported that the home area was short staffed and that 10 identified residents remained in bed and were not taken to the dining room or offered the planned breakfast meal. A PSW scheduled to work on this shift also confirmed that not all residents were offered breakfast. An interview with the DOC revealed an unawareness of the issue and that some identified residents were not provided a breakfast meal. [s. 71. (3) (a)]

5. On August 11, 2014, the posted schedule included two unfilled PSW day shifts and one unfilled RPN day shift. Home area 2 with one of the unfilled PSW shifts was also affected by a sick call for a PSW day shift on August 11, 2014. The shuffling of shifts resulted in the night PSW from home area 2 staying overtime for 4hrs and a PSW from another unit reassigned to home area 2. The identified PSW that worked on home area 2 revealed that he/she worked short by two PSW's for several hours on Monday, August 11, 2014. Staff interview revealed that he/she was unable to give resident #27 breakfast on August 11, 2014. [s. 71. (3) (a)]

6. The licensee has failed to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

Observations and staff interview revealed that the morning between-meal beverage was not provided to residents on home area 3 on August 21, 2014. The registered staff interviewed identified that the unit was short staffed and staff could either provide showers or provide the morning beverage pass. An interview with the DOC on August 25, 2014, revealed that he/she was unaware that a between-meal beverage was not provided to residents on August 21, 2014, and that an unfilled PSW day shift, according to staff, was the reason the residents did not receive the morning beverage pass. [s. 71. (3) (b)]

7. A record review for resident #24 identified that the family were concerned the resident does not drink enough water and becomes easily dehydrated. Interview with RD revealed that the resident is at risk for dehydration and his/her plan of care required staff to push fluids . A record review and staff interviews revealed that on August 21, 2014, a between-meal beverage in the morning was not provided to the resident. Staff interviews identified that the unit was short staffed and that time was not available to deliver the morning beverage. An interview with the DOC on August 25, 2014, revealed that he/she was unaware that a between-meal beverage had not been provided to residents on August 21, 2014, and according to staff that an unfilled PSW day shift was the reason that resident #24 did not receive the morning beverage pass. [s. 71. (3) (b)]

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

Observations, record review and staff interview identified that on August 13, 2014, the initial day of the unannounced inspection, broccoli slaw was posted as a vegetable choice at lunch. Broccoli slaw was not available. The menu posted included bread to be offered as part of the alternative menu choice, bread was not offered.
Staff interview confirmed items all posted menu items were not offered. [s. 71. (4)]

9. The regular menu posted for the week of August 25, 2014, indicated the following planned menu items:

- Tuesday, lunch, dessert - tapioca pudding

- Wednesday, breakfast - carrot muffin

On Tuesday, August 26, 2014, a lunch observation identified banana pudding was offered. On Wednesday, August 27, 2014, a breakfast observation identified bran muffin was offered.
An interview with the dietary aide/cook confirmed that the tapioca pudding was not prepared and the carrot muffin was unavailable. [s. 71. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been rescinded:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee shall ensure that the rights of residents are fully respected and promoted and every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity.

An identified PSW revealed in an interview that resident #11 had been redirected three times from different rooms during an evening shift in April 2014. On the fourth occasion the resident had foot-propelled his/her wheelchair into another resident's room and the PSW confirmed he/she approached from behind the resident, spoke in a raised voice and grabbed the wheelchair which resulted in the wheelchair stopping abruptly. When interviewed the PSW indicated the action of grabbing the wheelchair abruptly could have been perceived that the PSW was angry at the severely cognitively impaired resident.

Another PSW confirmed overhearing the raised voice and witnessed the other PSW grabbing the wheelchair and redirecting the resident in a manner that was disrespectful towards the resident.

The former DOC confirmed in an interview the PSW was instructed to use a different approach when working with cognitively impaired residents. [s. 3. (1) 1.]

2. The licensee has failed to fully respect and promote the resident's right to be cared for in a manner consistent with his or her needs.

Resident #15's written plan of care identified the resident's need for toileting assistance. A record review revealed that on the day shift of August 11, 2014, home area 2 was short staffed. A resident interview identified that on August 11, 2014, staff were working short and the resident waited a "good 20 minutes" on the toilet for staff assistance. The resident stated "I wasn't happy but I understood they were working short". The staff member working days on home area 2 confirmed that they were working short and that resident #15's call bell rang for approximately 30 minutes. An interview with the DOC states that 20 minutes was too long for a resident to wait for toileting assistance. [s. 3. (1) 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 every resident is cared for in a manner consistent with his/her needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

The inspector observed on August 25, 2014, that resident #12 had very long fingernails and that they were not cut or trimmed. During an interview the resident stated that he/she does own nail care and the resident prefers long finger nails.

A record review of resident #12 revealed there were no activities of daily living for nail care identified in the written plan of care.

Staff interviews with the PSW's and the registered nursing staff confirmed that the written plan of care did not identify that the resident's finger nails do not require to be trimmed or cut, as the resident provides his/her own finger nail care. The written plan of care was not developed for nail care and did not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A review of the written plan of care for resident #15 directs staff to change a continence care device every 6 weeks and to refer to the Treatment Administration Record(TAR) for the dates.
Upon review of the clinical record it was identified that there was no TAR available for July or August 2014, to determine the dates when the continence care device needed to be changed.
Interviews with a RPN and DOC confirmed there was no TAR to refer to and the plan of care did not provide clear directions to staff. [s. 6. (1) (c)]

3. A review of the written plan of care for resident #14 directs staff to change the indwelling catheter every 6 weeks and to refer to the TAR for the dates.
A review of the TARs for July or August 2014, revealed a lack of documentation as to when the indwelling catheter was to be changed.
Interviews with a RPN and DOC confirmed there was no direction for staff in regards to the date for changing the indwelling catheter. [s. 6. (1) (c)]

4. The plan of care for resident #14 reveals that the resident requires total assistance for toileting and is cognitively impaired and not able to request staff assistance.
Resident #14's written plan of care directs staff to provide two-person extensive assistance to toilet with no direction on frequency.
An interview with a PSW revealed that on August 21, 2014, resident #14 did not receive toileting assistance between 6:30a.m. to 2:00p.m. The PSW identified that the resident is normally provided toileting assistance between 11:30a.m. to 12:00p.m. An interview with the resident's POA confirmed that the resident is normally provided assistance with toileting before lunch. The written plan of care for the resident does not provide any frequency direction as to when the resident requires toileting

assistance [s. 6. (1) (c)]

5. The licensee failed to ensure the plan of care is based on an assessment of the resident and the resident's needs and preferences.

A review of resident #16's plan of care under the focus section indicated the resident has an indwelling catheter.
A review of the quarterly assessment dated May 30, 2014, indicated the resident is incontinent of bladder but there is no reference to an indwelling catheter.
Interviews with PSWs and registered staff confirmed the resident does not nor ever did have an indwelling catheter in place since admission to the home.
The registered staff confirmed the error on the plan of care. [s. 6. (2)]

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

Resident #18 had an order prescribed on August 21, 2014 for hot/warm pack to affected area on lower back up to three times a day for two weeks. The registered nurse who transcribed the order wrote wet/warm pack, the order was not second signed. This error was confirmed by the ADOC. [s. 6. (4)]

7. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

A review of the plan of care for resident #10 indicates a fall prevention strategy for a magnetic wheelchair alarm to be clipped to the resident's clothing and activated when the resident is sitting in the wheelchair.
Observations completed throughout the inspection failed to reveal the wheelchair alarm was in place when resident #10 was sitting in the wheelchair.
Interviews with staff and family confirmed the wheelchair alarm was not applied to the resident while sitting in the wheelchair as per the plan of care. [s. 6. (7)]

8. Resident #17 has a physician order for a topical ointment to be applied at 7:00 p.m.
In an interview the RPN confirmed that he/she failed to give the resident the topical ointment at 7:00 p.m. on August 18, 2014, however, he/she signed for giving it on the electronic medication administration record (EMAR). [s. 6. (7)]

9. A review of resident #14's clinical record revealed a physician order to flush foley catheter daily.
A review of the TARs for July and August 2014, revealed the foley catheter was not flushed on the following dates:
July 3, 5, 8, 12,and 27
August 8 and 19.

There was no documentation in the progress notes to indicate a reason why the daily flushing of the catheter did not occur.
Interview with the DOC confirmed there was no explanation as to the reason the daily flushing of the catheter had not been completed as ordered by the physician. [s. 6. (7)]

10. Resident #17 has a physician's order for oxygen at 2 litres per minute via nasal prongs at night only. The resident revealed in an interview that on the evening of August 18, 2014, there had been a power outage and he was unable to use his oxygen concentrator as it requires power to function. The evening PSW informed the resident that there were no portable canisters on the floor and that they were down stairs and he/she was not going to get one. The interview with the PSW confirmed he/she had asked the RN for a portable tank but one was not available. The resident confirmed he/she was very upset that no one had returned and informed the resident there were no portable tanks available.
The RPN confirmed in an interview that when the RPN entered the room, he/she did not notice that the resident did not have oxygen therapy. [s. 6. (7)]

11. A record review identified resident #21, at high nutritional risk has an intervention to provide banana daily, at morning snack, to increase calorie intake. Observations and staff interviews confirmed that the resident was not provided a banana at the morning snack on August 21, 2014. [s. 6. (7)]

12. Resident #25's written plan of care identifies that resident likes to lie down for a rest in the afternoon. A resident interview indicated a desire to lie down from 2:00p.m. to 3:30p.m. each day as the resident finds it too long to sit in the wheelchair from 7:00a.m. until 8:00p.m. The resident also expressed concern that when he/she has to remain in the wheelchair the resident worries about falling asleep and falling out. The resident describes waiting by the door for staff to assist with a transfer to bed, and that it does not always occur as staff are too busy. Resident stated "I need two staff and a lift to help me, I'm a lot of work so that's why". A staff interview confirmed knowledge of resident's preference is to lie down in the afternoon. The staff member stated when they are fully staffed they can help him/her, as the resident is a two person lift and that

usually occurs about three times per week.
A record review revealed home area 3 was short a PSW day shift August 21, 2014. The resident confirmed that staff were unable to transfer the resident to bed after lunch on August 21, 2014. [s. 6. (7)]

13. The licensee failed to 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, the resident's care needs change or care set out in the plan is no longer necessary.

Resident #38 returned from hospital at 5.30p.m. on August 20, 2014,and the progress notes revealed that the resident had returned with a foley catheter. An interview with a RPN revealed the nurse was aware that the resident had a catheter, however, there was no physician's order. A review of the resident's written plan of care revealed that readmission orders did not include an order for the catheter. The charge nurse confirmed the resident returned from hospital with a catheter, there was no order and the care plan has not been updated. [s. 6. (10)]

14. A review of resident #15's clinical record revealed a physician order dated December 12, 2013, to re-start the foley catheter.
A review of the quarterly medication reassessment for the period January 1 to March 31, 2014, failed to reveal the order to re-start the foley catheter.
Interviews with staff and observations revealed that resident #15 had an indwelling catheter in place during this inspection.
Interview with the DOC confirmed the resident should have been reassessed and a physician order obtained for an indwelling catheter. [s. 6. (10) (b)]

15. Resident #18 has medical diagnoses of rheumatoid arthritis and multiple sites of spinal stenosis. The resident's last minimum data set indicated the resident has daily pain. A physician's order on August 21, 2014, instructs staff to apply hot/warm packs to the affected area on lower back up to three times a day as needed for two weeks. The resident was told by a PSW that the home does not supply the packs. The resident found his/her own packs and by noon on August 22, 2014, the packs had not been heated and applied. The PSW assigned for this resident's care was unaware of the new order and confirmed he/she had not been told of the new order at the morning report.
An interview with the resident revealed when he/she wants the packs heated he/she must ask a member of the staff. At the time of the inspection, registered staff had not offered heated packs. The DOC revealed in an interview it is the expectation that registered staff will offer and heat the packs and record the effectiveness. [s. 6. (10)

(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:
- there is a written plan of care for each resident that sets out the planned care for the resident
- the written plan of care sets out clear directions to staff and others who provide direct care to the resident
- the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #6: 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 home failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

The home's policy titled Residents Rights, Care and Services – Medication Management – Destruction, revised on 10/07/2013, states "to provide a system of drug disposal for all medications that are discontinued, unused, expired, recalled, deteriorated, unlabeled and in containers with worn and illegible labels, damaged, incomplete or missing labels; shall be removed from general stock and stored in a safe secure system awaiting drug destruction". The procedure states "on an ongoing basis the registered staff shall: remove from current medication supplies, medications that are discontinued, unused, expired, recalled, deteriorated, unlabeled and in containers with worn and illegible labels, damaged, incomplete or missing labels".

The inspector observed on August 27, 2014, a container with the following prescription creams on the linen cart in home area 3, with the following expired medications and or illegible label:
Resident #078, Topical cream, dated October 7, 2013, with an expiry date of November 20, 2013.
Resident #079, Topical Cream, dated January 22, 2013, with an expiry date of February 20, 2013.
Resident #080, Topical cream, dated May 15, 2014, with an expiry date of August 15, 2014.
Resident #081, Nasal cream for 14 days, prescribed May 8, 2014, that was not discontinued on May 22, 2014.
Resident #082, Topical Cream, prescribed June 20, 2014, with an illegible expiry date.

Record review revealed that the above noted medications had been ordered for the residents and received.

Staff interviews with the registered nursing staff and evening charge nurse confirmed that these medications were expired and should have been removed. The home did not comply with the above mentioned policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home policy related to drug destruction of expired medications is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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 good state of repair.

During the initial tour on August 13, 2014, the following areas were identified not in a good state of repair:

home area 1
- room #133, an end table was observed to be scuffed and the wood stain removed
- the tub room floors have noticeable patches of rust stained flooring

home area 2
- conference room, the wall thermostat has plaster holes around it and the bracket was loose and the cover was missing.
- the tub room floors have noticeable patches of rust stained flooring
- room #258 an end table was observed to be scuffed and the wood stain was removed

home area 3
- room #292 an end table was observed to be scuffed and the wood stain was removed.

The ESM confirmed the above noted areas as not being in a good state of repair. [s. 15. (2) (c)]

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 and furnishings are maintained in a good state of repair, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, 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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

On August 2, 2014, a PSW reported to the registered nursing staff on the day shift that when he/she arrived on duty at 6:00 a.m. resident #20's, call bell was alarming. The PSW responded to the call bell and observed the following: the resident was soaked in urine, the resident wears an incontinent product that was soaked through onto the sheets and the extent of the urination was from his/her armpits to their knees. The resident is competent and has a CPS score of 0 and will ring his/her call bell. The PSW asked why he/she did not ring their call bell for assistance, the residents response was "I did, the PSW would come in and turn it off, when I called to say I needed help he/she just kept walking out of the room without helping me". The resident indicated that eventually the night PSW just removed the call bell. Interview with the PSW confirmed that the resident was left soaked in urine and an interview with the resident confirmed that the PSW walked away and did not come back when he/she asked for help. Interviews with the ADOC and DOC confirmed the PSW neglected the resident. [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 residents are protected from abuse by anyone and shall ensure that resients are not neglected by the licensee or staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated.

During an interview with the DOC, a complaint letter from a staff member alleging abuse to resident #11 in April 2014, was found in a staff member file and the current DOC confirmed that he/she was unaware of this allegation of abuse. The complainant confirmed in an interview that the letter had been given to the former DOC in May 2014. The former DOC confirmed that an investigation had not occurred.

During an interview with the DOC, a second complaint letter from an identified staff member alleging abuse to resident #38 during supper in April 2014, was found in a file beside another letter of alleged abuse and the current DOC confirmed that he/she was unaware of this allegation of abuse. The complainant confirmed in an interview that the letter had been given to the former DOC in May 2014. The former DOC confirmed that the allegation had not been immediately investigated. [s. 23. (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 every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

An interview with an identified PSW indicated the former DOC received a complaint letter in May 2014, alleging abuse of resident #38 during supper in April 2014. The former DOC did not recall receiving the letter from April 2014, however, the opened letter was found in the same file with another complaint dated the same day in the DOC's office, and as a result the DOC confirmed this was not immediately reported to the Director. [s. 24. (1)]

2. On August 4, 2014, information about an incident that occurred on August 2, 2014, involving an incident where a PSW removed the call bell from resident #20 during the night shift. This action prevented the resident from accessing staff assistance for continence care and resulted in the resident having to urinate in the bed. When the incident was reported to the RN in charge a report was not immediately reported to the Director.

Staff interviews with the CDOC and DOC confirmed that the Director was not notified of neglect immediately. [s. 24. (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 a person who has reasonable grounds to suspect that abuse has occurred shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home assessed the resident's nutritional status, including weight and any risks related to nutrition care.

A record review of resident #04 identified that in August 2014, the resident was at high nutrition risk related to weight status as the resident had experienced a weight loss of 3.5 kilograms over the last quarter and 13 kilograms over the past year. Resident's weight in July 2014, was 48.0 kilograms and fell below the resident's goal of a body weight range of 49-60 kilograms. Resident's weight also remained below the goal weight range in August 2014. No changes to the resident's plan of care were implemented by the RD. Record review and an interview with the RD revealed that resident #04's energy needs were not a component of the nutritional assessment. An estimated nutritional requirement for resident #04's energy needs was not calculated and compared with resident's estimated nutritional intake. As a result, it was unclear to the RD if adequate energy to compensate for unplanned weight loss and maintain a goal body weight was being offered. [s. 26. (4) (a),s. 26. (4) (b)]

2. A record review of resident #10 identified resident at high nutrition risk related to low body weight with a weight gain goal of 40 kilograms. Resident's weight in August 2014, was 34.3 kilograms and was below 40 kilograms over the past year. Observations and staff interviews revealed that the resident takes only cereal at breakfast and soup at lunch.
A record review and an interview with the RD revealed that resident #10's limited intake at breakfast and lunch and the impact on resident's total energy intake was not a component of the nutritional assessment. An estimated nutritional requirement for resident #10's energy needs was not calculated and compared with resident's estimated nutritional intake. As a result, it was unclear to the RD if adequate energy to achieve the goal weight of 40 kilograms as identified in the plan of care was being offered. [s. 26. (4) (a),s. 26. (4) (b)]

3. A review of weights for resident #14 identified significant weight loss of 5 percent body weight over a one month period, in June 2014. The RD's corresponding documentation indicated the resident's food intake varied and averaged no more than 50 percent. An estimation of the resident's energy and protein intake and the resident's energy and protein requirements were not located.

An interview with the RD confirmed that an assessment of the energy and protein requirements and estimated intake for resident #14 was not completed. [s. 26. (4) (a),s. 26. (4) (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 registered dietitian who is a member of the staff of the home assesses the resident's nutritional status, including an estimation of residents' energy and protein needs, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Resident #11's plan of care identified the need for two side rails engaged when in bed resting/sleeping. The resident is not able to get out of bed independently. The last nursing note identifying the resident as having attempted to get out of bed was in February 2014.
An interview with registered staff confirmed the restraint device had not been ordered by a physician. [s. 31. (2) 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 where a resident is being restrained by a physical device under section 31 of the Act that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes: mouth care in the morning and evening, including the cleaning of dentures.

The written plan of care identified that the resident once set up can perform his/her own mouth care and requires supervision. When interviewed resident #13 was unable to confirm whether mouth care was completed.

A record review of resident #13's point of care documentation from August 1 to 17, 2014, revealed that the resident did not receive oral care or supervision of oral care in the morning on the following dates: August 7, 11, 16 and 17, 2014.

Staff interviews with the PSWs confirmed that they did not provide or supervise oral care on the morning of the above mentioned dates and the resident did not receive mouth care in the morning on a daily basis. [s. 34. (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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes: mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A record review revealed resident #07 requires a two person transfer with bed mobility and transferring. In August 2014, resident #07 revealed to inspector #110 an incident that occurred during a transfer into bed with a mechanical lift. The resident asked the PSW to stop the transfer when the resident's back struck the side rail causing discomfort. An interview with another PSW who witnessed the transfer substantiated the resident's description of the incident and indicated the resident stated "you're hurting me".
Interviews with the PSW, CDOC and DOC confirmed that the staff did not use safe transferring techniques when assisting resident #07. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #15: 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, (d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for, (g) documentation on the production sheet of any menu substitutions. 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, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are standardized recipes for all menus.

On August 26, 2014, the menu identified shepherd's pie for dinner. The shepherd's pie was observed to be a mixture of ground meat and diced potatoes. Interviews with residents #03 and #67 confirmed the shepherd's pie did not look like traditional shepherd's pie prepared with mashed potatoes. A review of the recipe revealed there was no standardized recipe for the shepherd's pie and there was a recipe for vegetarian shepherd's pie instead. An interview with the cook revealed the shepherd's pie was prepared as the cook was trained, with hamburger and diced potatoes.

On August 27, 2014, during a breakfast observation, a PSW informed a DA that the pureed bran muffin was too thick. The inspector sampled the pureed bran muffin and identified the muffin to be sticky, required chewing and was difficult to swallow. A review of the recipe binder failed to reveal a recipe for pureed bran muffin.

An interview with the FSS confirmed the recipe for shepherd's pie and the pureed bran muffin were not available in the cook's recipe binder. [s. 72. (2) (c)]

2. The licensee failed to ensure that all menu items are prepared according to the

planned menu.

Observations and staff interviewed identified that the lunch meal on August 13, 2014, the initial day of the unannounced inspection identified the mini submarine sandwich with a slice of cooked ham, not black forest, as confirmed by dietary aide and a slice of mozzarella on a hot dog bun.
Recipe review revealed that the mini submarine sandwich ingredients were to include a slice of turkey breast, black forest ham, shredded lettuce, fresh sliced tomatoes and light mayonnaise.
An interview with the FSS confirmed that the recipe should be followed and they are not using black forest ham but substituting with cooked ham which was confirmed to be $4.92 per kilogram cheaper than black forest. Staff interviews identified that the FSS is making "cut backs" in the kitchen. [s. 72. (2) (d)]

3. The licensee has failed to ensure that menu substitutions are documented on the production sheet.

On Tuesday, August 26, 2014, a lunch observation identified banana pudding was served instead of tapioca pudding. On Wednesday, August 27, 2014, a breakfast observation identified bran muffin was served instead of carrot muffin. An interview with the dietary aide/cook confirmed that the tapioca pudding was substituted with banana pudding and the carrot muffin was substituted with bran muffin. A review of the production sheets did not reveal documentation of the substitution. The FSM confirmed the menu substitutions were not documented on the production sheets. [s. 72. (2) (g)]

4. The licensee has failed to ensure that all foods are stored and served using methods which prevent contamination.

On August 27, 2014, during breakfast service on home area #3, the inspector observed three plastic tubs containing marmalade, jam and peanut butter. There were separate tablespoons in each tub, and the PSW portioned the condiments onto the residents' entree plates. The inspector observed what appeared to be peanut butter in the jam tub. After meal service, the condiments were covered and stored. The inspector asked to see the tub of jam, removed the lid and observed peanut butter in the jam tub. The dietary aide confirmed that the peanut butter in the jam tub was a source of contamination. [s. 72. (3) (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:
- there are standardized recipes for all menus
- all menu items are prepared according to the planned menu.
- menu substitutions are documented on the production sheet
- all foods are stored and served using methods which prevent contamination, to be implemented voluntarily.

WN #16: 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).

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 has failed to ensure that the dining and snack times were reviewed by Residents' Council.

Interviews with the Residents' Council president and the council assistant confirmed the
dining and snack times were not reviewed by the Residents' Council. [s. 73. (1) 2.]

2. The licensee has failed to ensure that all residents who require assistance with eating and drinking are only served a meal when someone is available to provide assistance.

On August 21, 2014, at 9:05a.m. resident #22 was observed to be served cream of wheat with no staff assistance provided. At 9:16a.m. staff approached the resident requesting his/her entrée selection. At 9:19a.m. the resident's uneaten cereal was removed and the resident was served poached eggs and toast. At 9:35a.m. the resident was provided total feeding assistance from staff and the resident ate well. Resident #22's plan of care indicated the resident is at moderate nutritional risk with nutrition interventions to prevent weight loss and required extensive staff feeding assistance.
Staff interview confirmed resident required total assistance with meals and that they were short staffed by one PSW at breakfast.

On August 21, 2014, resident #21 was identified at 8:48 a.m. to be served hot cereal while resident was asleep at the table. At 9:21a.m. a registered staff removed the resident's uneaten bowl of cereal while the resident remained asleep. At 9:25 a.m. the resident was removed from the table, still asleep and the resident's wife stated to staff "he didn't eat his cereal". Staff responded "he does that sometimes and just sleeps". Resident was not approached by staff to be woken up between the start and finish of meal service.
Resident #21's plan of care identifies resident at high nutritional risk related to, in part, low body weight and requires mealtime set up, cueing and encouragement as required. [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 dining and snack times were reviewed by Residents' Council,
- all residents who require assistance with eating and drinking are only served a meal when someone is available to provide assistance, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring the staff member.

A review of the personnel files for five staff was completed.
Two out of the five files failed to reveal a vulnerable sector criminal reference check.
One of the identified staff indicated a copy of the criminal reference check had not been provided to the employer for filing.
The other identified staff is no longer employed by the licensee and there was no criminal reference check on file.
An interview with the DOC confirmed there were no criminal reference checks on file at the time of the inspection for the two identified staff. [s. 75. (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 vulnerable sector criminal reference checks are conducted prior to hiring the staff member, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff receive retraining annually related to whistle-blowing protection.

Through interviews and record reviews of the training documents it was identified that two out of five PSWs interviewed had not received training on whistle-blowing protection.
Through interviews and record review of the training documents it was identified that three out of five PSWs interviewed did not remember having received training on whistle-blowing protection despite the fact the training records indicated otherwise.
The training on whistle-blowing protections was offered in June 2014 and consisted of a fact sheet which included the definition and required staff to sign, date and return to the staff educator.
When interviewed the CDOC confirmed two out of five identified staff had not received training in whistle-blowing protection. [s. 76. (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 all staff receive training annually related to whistle-blowing protection, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in a medication cart that is used exclusively for drugs and drug related supplies.

On August 20, 2014, at 10:20a.m. the following items were observed on the home area 3 medication cart:
- dressing supplies
- flashlight
- nail clipper
- hearing aide batteries
- pens, colored markers
- labels with the words coumadin and antibiotics

An interview with a RPN confirmed the above items were not drugs or drug related supplies and should not be stored on the medication cart. The RPN removed the items from the medication cart immediately. [s. 129. (1) (a)]

2. The licensee failed to ensure that drugs are stored in an area that is secure and locked.

On August 27, 2014, the inspector observed on home area 3, an open container on the linen cart with no staff in attendance, containing prescription creams for residents #78, #79, #80, #81 and #82.

Interviews with PSWs confirmed they had placed the container with the prescriptions on the cart and left it unattended.
Interviews with the RPN and the evening charge nurse confirmed the prescription creams were not stored safely or securely. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area that is secure and locked, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On August 27, 2014, the inspector observed a container with a prescription cream for resident #81 sitting on the linen cart.

The prescription cream was ordered in May 2014, for 14 days. Staff interviews with the PSWs confirmed the prescription cream was still being applied. Registered nursing staff confirmed this medication should have been discontinued in May 2014. The home did not follow the directions for use as specified by the physician. [s. 131. (2)]

2. The licensee failed to ensure when a member of the registered nursing staff permits a staff member, who is not otherwise permitted to administer a drug to a resident, to administer a topical, that the staff member does so only if they have been trained by a member of the registered nursing staff in the administration of topicals and under the supervision of the registered nursing staff.

Interviews with PSW staff revealed that newly ordered topical medications for residents are put in the basket of topicals stored in the clean utility room without any direction from the registered staff as to how and where to apply.
Interviews with registered staff failed to identify a specific procedure to be followed when delegating the application of the topical medications to the PSWs.
An interview with the DOC confirmed the home does not have a policy on the delegation of duties to PSWs and the topical medications are to be stored in the medication room when not being applied. [s. 131. (4)]

3. On August 27, 2014, the inspector observed a container of prescription creams on the linen cart in home area 3.
Interviews with PSWs and registered nursing staff confirmed the PSWs apply the prescription creams in the home.
Interviews with PSWs and registered nursing staff confirmed they were not trained to apply topical medications to residents. [s. 131. (4) (a)]

4. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During an interview resident #17 revealed that zinc sulfate ointment is kept at the resident's bedside and is applied by the spouse and staff. A review of the physician's orders indicated no permission for the drug to be kept at the bed side.
The RPN confirmed the above. [s. 131. (7) (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;
- drugs are administered to residents in accordance with the directions for use specified by the prescriber
- when a member of the registered nursing staff permits a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if the staff member has been trained by a member of the registered nursing staff in the administration of topicals and does so under the supervision of the member of the registered nursing staff
- no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least quarterly there is a documented reassessment of each resident's drug regime.

A review of the quarterly reassessment of resident #17's drug regime revealed the reassessment for the period from July 1 to September 30, 2014, was transcribed July 20, 2014, but there was no date indicated when the physician authorized the reassessment.
The previous quarterly reassessment of resident #17's drug regime was transcribed as of April 12, 2014, but there was no date when the physician authorized the review. There were at least 99 days after the previous drug reassessment which is not within the required quarterly period of 91 days.

A review of the quarterly reassessment of resident #19's drug regime revealed the reassessment for the period from August 1 to October 31, 2014, was transcribed August 7, 2014, but there was no date indicated when the physician authorized the reassessment.
The previous quarterly reassessment of resident #19's drug regime was transcribed as of May 1, 2014, but there was no date when the physician authorized the review. There were at least 99 days after the previous drug reassessment which is not within the required quarterly period of 91 days.
An interview with the DOC confirmed the physician reassessment was not dated and as such there was no way of determining that the reassessment had occurred at least quarterly.

Interviews with registered staff confirmed there was no date recorded when the physician completed the reassessment of the identified residents' drug regimes and as a result were unable to identify when the physician orders had been renewed.
An interview with the DOC confirmed the quarterly reassessments of the residents' drug regimes were not completed at least quarterly. [s. 134. (c)]

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 at least quarterly there is a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record is kept of all medication incidents including analysis and the corrective action taken.

A review of several medication incidents from January to July 2014 failed to reveal a written record of the analysis and corrective action completed for each medication incident.
An interview with the DOC confirmed a written record had not been completed as required. [s. 135. (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 a written record is kept of all medication incidents including analysis and the corrective action taken, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the home's drug destruction and disposal policy includes that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

In August 2014, the inspector observed six vials of injectable pain medication in the controlled medication bin in the home area 1 medication cart for a resident who had died 4 days earlier.
An interview with the RPN revealed the opening of the locked box was not large enough to allow the discontinued controlled medication to be disposed into it until the DOC arrived with the keys.
An interview with the DOC confirmed the home's Drug Disposal policy did not include that drugs that are to be destroyed and disposed shall be stored separate from drugs that are available for administration to a resident, until the destruction and disposal has occurred. [s. 136. (2) 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 the home's drug destruction and disposal policy includes that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs, to be implemented voluntarily.

WN #24: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are screened for tuberculosis within 14 days of admission.

Following review of clinical documentation for three identified residents, clinical documentation revealed that resident #17 did not receive step two for the tuberculosis immunization, this was confirmed by the CDOC. [s. 229. (10) 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 residents are screened for tuberculosis within 14 days of admission., to be implemented voluntarily.

WN #25: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection 8 (3) of the Act.

Record review of the daily staff assignment of August 25, 2014, identified the DOC to be working in the capacity of a RPN during days on home area 2. Interview with the DOC confirmed that he/she was on call, received a sick call and worked from 7-3p.m. administering medications. [s. 8. (4)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

On August 25, 2014, at 10.45a.m., resident #37 was observed in bed and had not been provided individualized personal care. The assigned PSW stated the staff provide the individualized personal care to residents when they can.
Resident #36 was dressed and sitting in a wheelchair. When interviewed the resident's family member revealed it is a "hit and miss" if the resident gets the required personal care.
Resident #36 and #37 were observed not to have received individualized personal care at 10.45a.m. The charge nurse revealed in an interview it is the expectation that the residents will receive specific grooming requirements on their bath days and more often if there are enough staff. Neither resident had been provided the individualized personal care at 11:46a.m. and the home area was fully staffed.
Resident #37 was observed at breakfast on August 26, 2014, not to have been groomed. The home area was fully staffed and this was confirmed by the CDOC. [s. 32.]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

A record review revealed resident #07 requires a two person transfer with bed mobility and transferring. In August 2014, resident #07 revealed to an inspector an incident that occurred during a transfer into bed with a mechanical lift. The resident asked the PSW to stop the transfer when the resident's back struck the side rail causing discomfort. An interview with another PSW who witnessed the transfer substantiated the resident's description of the incident and indicated the resident stated "you're hurting me".
The home completed a Critical Incident when the inspector brought it to the home's attention. The home did not notify the resident's substitute decision-maker upon becoming aware of the incident. The home indicated the SDM was not notified because the incident occurred several months ago. [s. 97. (1) (a)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that a drug record is established and maintained, in which the following information is recorded in respect of every drug that is ordered and received in the home:
- the name, strength and quantity of the drug
- the date the drug is received in the home.

A review of the drug record book on home area 1 with the consulting pharmacist identified several medications either not recorded when ordered or when the drug received in the home.
The pharmacist confirmed previous audits had identified this issue in the past. [s. 133.]

Issued on this 20 day of February 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
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TORONTO, ON, M2M-4K5
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Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DIANE BROWN (110) - (A1)

Inspection No. / No de l'inspection : 2014_369153_0006 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : T-076-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 20, 2015;(A1)

Licensee / Titulaire de permis : HUNTSVILLE LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

LTC Home / Foyer de SLD : MUSKOKA LANDING
65 ROGERS COVE DRIVE, HUNTSVILLE, ON, P1H-2L9

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : ERIN CUNNINGHAM

To HUNTSVILLE LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall develop and implement a contingency plan for staffing shortages with specific strategies and direction to staff to ensure all residents receive care consistent with their assessed personal care and safety needs, specific to bathing twice weekly, assistance with toileting, provision of food to meet nutritional needs at meal and snack times.

The licensee shall ensure all staff receive training/education on the plan and the licensee shall monitor and ensure the plan is implemented on the shifts when staff shortages occur.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs as resident and staff interviews and record review revealed the home is more regularly staffed outside of the home's staffing plan.

a) On August 11, 2014, the posted schedule included two unfilled PSW day shifts and one unfilled RPN day shift. Home area #2, with one of the unfilled PSW shifts, was also affected by a sick call for a PSW day shift on August 11, 2014. The shuffling of shifts resulted in the night PSW from home area 2 staying overtime for 4hrs and a PSW from another unit reassigned to home area 2. The identified PSW that worked on home area 2 revealed that he/she worked short by two PSW's for several hours on Monday August 11, 2014. A resident and a staff interview revealed that resident #15 waited at least 20 minutes on the toilet after ringing the call bell for staff assistance on the morning of August 11, 2014. The identified resident stated "they are always short on the weekends but the 11th was the worst I've seen". Staff interview revealed that he/she was unable to give resident #27 breakfasts on August 11, 2014.

b) On August 16, 2014, the posted schedule included two PSW day shifts unfilled on home area 3 and one PSW day shift on home area 1.
On August 16, 2014, staff interviews confirmed that breakfast was not provided to several residents on home area 3 as a result of staff shortages. Staff interview and record review revealed that residents #22 and #23 were not bathed according to their scheduled bath routine related to insufficient staff. The missed baths were not rescheduled.

c) On August 21, 2014, the posted schedule included one unfilled PSW day shift on home area 3. A staff interview and record review revealed no attempts were made to fill this open shift with no PSW shift replacement record available.
Staff interviews and observations revealed that at breakfast on August 21, 2014, residents #21 and #22 on home area 3 did not receive mealtime assistance according to their plan of care and the morning snack pass was not delivered. Further it was confirmed by staff and resident that resident #25 was not laid down after lunch according to his/her plan of care as there was insufficient staff.

d) Record review and an interview with staffing coordinator revealed that in August 2014, there was a shortfall of 360 PSW hours and 113 RPN hours that were not filled according to the home's staffing plan and not directed into resident care. In July 2014, there was a shortfall of 356.25 PSW hours and 61.5 RPN hours that were not filled according to the home's staffing plan and also not directed into resident care.

e) An interview with the DOC, new to the position as of August 11, 2014, stated that if they are short staffed in the schedule the staffing coordinator and charge nurse/RN will put out the calls to fill the shift otherwise they do extensions. The DOC was not aware that care was not provided August 11, 16 and 21, 2014. (110)

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

Dec 15, 2014

Order # /
Ordre no : 002

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall immediately begin to provide each resident of the home with a bath, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

a) A record review and staff interviews identified that resident #22 did not receive his/her scheduled shower on August 3, 10, 16, 2014. Two baths per week were not provided between August 3, 2014, and August 20, 2014, a 16 day period.

b) A record review and staff interviews identified that resident #23 did not receive his/her scheduled bath on August 1, 12, 19, 2014. Two baths per week were not provided between August 1-19, 2014. An interview with the President of Residents' Council revealed that scheduled showers are not routinely provided as required.

c) An interview with the DOC revealed a lack of awareness that residents #22 and #23 did not receive their baths twice a week and that staff identified a lack of staff as the reason for not providing the scheduled baths.

d) Record review, resident and staff interviews identified that resident #20 did not receive his/her scheduled shower August 10 and 17, 2014. Family expressed

concern to management on August 17, 2014, that for two weeks in a row two baths were not provided to the resident. Resident was bathed August 18, 2014, in response to the family's concern. Two baths per week were not provided the week of August 10, 2014.

e) Resident interview revealed that staff shortages were identified on both August 10 and 17, 2014.

f) Record review and staff interviews identified that resident #04 did not receive his/her scheduled bath between July 30 and August 13, 2014, or for a 13 day period. An interview with the President of Residents' Council revealed that scheduled baths are routinely not provided as required.

g) An interview with DOC confirmed that he/she was unaware that resident #04 was not bathed twice a week and that staff identify unfilled PSW shifts and being short staffed as the issue.
(110)

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

Dec 15, 2014

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

(A1)
The following Order has been rescinded:

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 20 day of February 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN - (A1)

Service Area Office /
Bureau régional de services : Toronto