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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Oct 19, 21, 24, 26, 28, 31, Nov 1, 2, 4, 7, 8, 9, 10, 14, 15, 16, 22, 23, 30, Dec 2, 23, 2011; Jan 13, 16, 18, 2012	2011_025168_0007	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

ANSON PLACE CARE CENTRE
85 Main Street North, Hagersville, ON, N0A-1H0

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

LISA VINK (168), MARILYN TONE (167), MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Health Consultant, Resident Assessment Instrument (RAI) Co-ordinator, Programs Supervisor, Food Services Supervisor (FSS), Registered Dietitian (RD), Business Co-ordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), personal support workers (PSW), physiotherapy aide (PTA), dietary and support services staff, residents and family members.
Regarding inspection H-002094-11

During the course of the inspection, the inspector(s) reviewed clinical records, observed care and services provided, toured the home and reviewed relevant policies and procedures and other relevant documents as requested/provided.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The written plan of care, set out for residents, did not provide clear directions to staff and others who provide direct care to the resident. [s. 6(1)(c)]
a) The plan of care, including a specialized menu plan, for an identified resident, did not provide clear direction on the number of grain servings that staff are to provide daily. The specialized menu plan did not include grains/bread with the dinner meal or at the lunch meal when the resident receives foods other than a sandwich. Minimum servings of grains would not be met by following directions on the specialized menu. The Registered Dietitian stated the resident was to be offered bread with meals as it was part of the meal, however, the plan does not direct staff to provide bread. Staff serving the lunch meal October 21, 2011, stated the resident routinely did not receive bread with meals.
b) The plan of care for a resident identified that the resident was to have a weekly oral assessment. There is no record of a weekly oral assessment in the the resident's record. During an interview with the RPN, it was confirmed that the resident did not require a weekly oral assessment and that the home did not have a system to complete this assessment weekly. The intervention statement on the plan of care had not been individualized to the needs of the resident.
c) The plan of care for a resident identified that the resident required one staff assistance for transfers however the kardex identified the resident required two persons for physical assist.
d) The plan of care for a resident did not give clear direction related to oral hygiene needs. The plan indicated that staff were to brush teeth and that two staff were required to assist. No other direction was provided. It was confirmed by the DOC that staff were not able to perform mouth care for the resident as she refused. The plan of care did not not identify that the resident refused mouth care nor did it indicate that the resident may be at risk for choking due to an identified behaviour of the resident.
e) The plan of care for a resident contained conflicting information related to toileting and hydration. The toileting section of the plan identified the resident was not being toileted, however, the urinary incontinence section identified scheduled toileting program with toileting every morning, before meals, evening and as needed. The Dietary section of the plan identified a fluid goal of 9 x 125ml per day however the risk for fluid output exceeding intake plan identified a fluid goal of 5-10 x 125 ml per day. Staff interviewed acknowledged that the sections were conflicting and did not provide clear direction.
f) The kardex for a resident, which was available for staff on November 4, 2011, identified the resident to require assistance by two staff for transfers. The hard copy of the resident's plan identified the resident to require extensive assistance by one staff for transfers, however identified extensive assistance by two staff for transfers under psychotropic drug use. During an interview with a PSW it was confirmed that only one staff was required to assist the resident with transfers.
g) The plan of care for an identified resident indicated that the physician ordered a treatment to be administered to open areas in 2011. A few days later the progress notes indicated that the wound care nurse recommended the use of another treatment. This change in direction was not recorded on the resident's Treatment Administration Record to provide clear direction to the staff providing care.
h) The plan of care for an identified resident did not provide clear direction regarding the diet order. The resident was placed on a pureed diet by the RD. The plan of care, identified under high nutritional risk that the resident was on a pureed textured diet, however under oral/dental care noted that the resident was on a minced textured diet. During an interview with the RD on November 1, 2011, it was identified that the RD makes changes only to the plan of care specifically related to nutritional status, all and others are to be completed by the appropriate department.
2. Care set out in the plan of care was not provided to the residents, as specified in their plans. [s. 6(7)]
a) Two identified residents had plans of care that required thickened fluids to be provided at meals related to a risk for choking. The residents were given thin pureed soup at the lunch meals October 21 and November 2, 2011. Nursing staff assisting residents stated the soup was provided by the dietary department and came that way - staff did not attempt to thicken the soup on either day observed. Dietary staff interviewed stated that the soup was to be thickened to the correct consistency at point of service by nursing staff in the dining room.
b) An identified resident did not receive treatment to open areas as specified in his plan of care. In 2011, the Physician ordered treatment to the open areas twice daily. It was noted on the Treatment Administration Record (TAR) for one month that the treatment was administered 26 out of the prescribed 53 times. Progress notes indicated that the wound care nurse instructed staff to hold the physician ordered treatment and suggested another treatment instead. There was no evidence on the TAR that the resident was to receive the suggested treatment although there was documentation in the resident's progress notes to indicate the treatment was completed at least 18 times that month. The TAR, identified that physicians ordered treatment was held 21 times one month. There was no physician's order to discontinue the treatment until the end of the month.
c) The plan of care for an identified resident included the addition of a supplement to the resident's smoothie at the

breakfast meal. The supplement was not provided to the resident as required. Staff were using another supplement instead of the prescribed supplement and the error was not recognized until identified by the Inspector.
d) The plan of care for a resident identified the resident is to have dentures cleaned after meals and soaked each evening. During an interview with a PSW it was identified that at bedtime the resident's dentures are removed/cleaned and oral care provided, followed by oral care again in the morning prior to the dentures being returned to the resident. The resident at times is resistive to having dentures removed. The resident did not have their dentures cleaned after each meal as identified in the plan of care.
3. The licensee did not ensure that the outcome of the care set out in the plan of care and the effectiveness of the plan were documented. [S. 6(9)2,3]
a) The Recreation Resident Assessment Protocol Review Summary for an identified resident dated September 29, 2011, did not include an evaluation the effectiveness of the interventions identified in the plan or the outcome of care provided.
b) Staff administering medications to a resident did not accurately document the outcome of of the care set out in her plan. The resident refused noon medication on November 2, 2011, however the medication administration record indicated that the medication was received.
4. The plan of care for residents was not reviewed and revised when there were changes to the resident needs. [s. 6(10)(b)]
a) A resident had a change in diet in 2011, from a minced meat diet (prior to hospitalization) to a pureed menu (upon re-admission), however, the plan of care was not revised to reflect this change.
5. Residents were not reassessed and their plans of care reviewed and revised when the care set out in their plans was not effective. [s. 6(10)(c)]
a) An identified resident had a goal for weight to be within a specified goal weight range. The resident had been below this weight since April 2011. A nutritional supplement was initiated by the RD in July 2011, resulting in weight stabilization (below goal weight range), however, the plan of care had not been revised and evaluated in relation to the goal to reach the goal weight range. Interventions were not revised to allow for weight gain.
b) The care set out in the plan of care for an identified resident related to bowel management was not effective. Documentation on the PSW flow sheets identified the resident was not routinely having regular bowel movements (every 4-6 days during a two month period of time). The assessment by the RD July 26, 2011, did not identify constipation as a problem and interventions were not initiated by the RD to address the constipation. The resident was at risk for constipation related to a diagnosis and the RAI-MDS (minimum data set) coding completed July 20, 2011, identified constipation as a problem. As needed interventions administered for the management of constipation were not evaluated for effectiveness by the interdisciplinary team and the resident's plan of care related to constipation management was not changed until concerns were voiced by the resident's family.
c) The plan of care for an identified resident was not reviewed and revised when it was not effective in relation to bowel management. The resident had at least 14 occasions of constipation (3-10 days without a bowel movement) during four months in 2011. The plan of care related to constipation was not reviewed nor revised with action taken to address the constipation.
The Resident Assessment Instrument (RAI)-MDS coding on June 29, 2011, identified a change in the resident's bowel continence (March 30, 2011 - occasionally incontinent of bowels, June 29, 2011 - totally incontinent of bowels), however there was no assessment of these identified changes.
d) The plan of care for an identified resident was not revised when ineffective in relation to weight loss. The goal on the resident's plan of care identified the resident's weight would be within target weight range. The resident fell below the goal weight range, and had significant weight loss the next two months, however, the plan of care was not revised to include strategies to allow for weight gain.
e) The plan of care for an identified resident was not reviewed and revised when the care set out was not effective. The plan of care identifies a goal statement for weight gain within the resident's target weight range. The resident's weight has been stable for four months, however, below the target weight range. The plan of care has not been revised to include strategies to allow for weight gain to the target range.
f) The plan of care for a resident was not reviewed and revised when the care was not effective. The plan of care identifies a goal for weight gain, however, the resident had a significant weight loss for three months in 2011. The plan was not revised with strategies to allow for weight gain. During interview, the RD stated that nutritional strategies were being discussed, however, were not currently in place.
g) The plan of care for a resident identified a need related to responsive behaviours. The resident had three occurrences of non-consensual touching of another resident before the plan of care was reviewed and revised when the

care set out was not effective.

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 compliance with sections 6 (1), 6(7), 6(9) and 6(10) of the Long-Term Care Homes Act, 2007, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (2) The licensee shall ensure that each menu,
(a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. 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 did not ensure that all residents were offered a snack during the afternoon November 8, 2011. Residents requiring pureed textured foods, receiving supplements and requiring thickened beverages were not offered a snack. Five identified residents were served or provided a beverage however no snack offered
Staff interviewed could not identify a reason for snacks not being offered to some residents.

During the afternoon nourishment pass on November 1, 2011, an identified resident was served and provided assistance with consuming her nutritional supplement. The PSW did not provide the resident with a snack. The PSW confirmed that the resident was not provided a snack, citing the reason as the supplement is very filling. A review of the November 2011, Residential Nutritional and Intake Record, for the resident has a "0" documented for food at the 1400 nourishment pass.

The Home's policy and procedure "FNSMS020 Meals and Nourishments" states that all residents are to be offered snacks at mid-afternoon and at bed time.
2. Not all residents were offered the planned menu items at meals and snacks.
a) Portion size of some items was very small and did not reflect the portion on the planned menu. Some examples: cheese dreams made with a dinner roll versus a hamburger bun; meat sandwich served with a dinner roll instead of a bun.
b) Residents receiving the pureed menu were not offered all foods according to the planned menu, resulting in reduced variety in comparison to the regular textured menu. The menu was planned to provide pureed sweet potato fries, however, mashed potatoes were served.
3. Not all residents were offered the planned menu items at the lunch meal November 2, 2011. Two residents were not offered a vegetable with their pureed entrees. The vegetable side dish was prepared and available during meal service, however, during interview the dietary staff stated they forgot to provide the vegetable choice.
At the October 21, 2011, noon meal, a resident was not offered a complete meal. The planned menu included soup, an entree (pureed hot dog), vegetable (pureed mixed vegetables) and milk. The resident was offered the soup and entree only, without a side dish and was not offered milk.
4. The licensee did not ensure that the menu for an identified resident provided foods from all food groups in keeping with Canada's Food Guide. The individualized menu is planned to provide 3 to 4 servings of grains per day. Canada's Food Guide requires 6-7 servings of grains per day.
During interview with the RD it was stated that the resident would meet requirement for grains through the snack service, however, the resident does not consume snacks. The resident had abnormal nutritionally relevant laboratory values that would be impacted by inadequate servings of grains (e.g. iron status).

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 menu provides food from all food groups in keeping with Canada's Food Guild, residents are offered snacks twice a day, and planned menu items are offered at each meal and snack, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

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
(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. [O.Reg. 79/10, s. 26(3)8]
The plan of care for an identified resident was not based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination. The RAI-MDS assessment completed July 20, 2011, indicated the resident had a change in bowel continence from incontinent to mostly continent, however, the plan of care initiated July 21, 2011, stated the resident was incontinent of bowels. The plan of care was not consistent with and based on the RAI-MDS assessment data.
2. [O.Reg. 79/10, s. 26(3)14]
The plan of care for an identified resident was not based on an interdisciplinary assessment of hydration status and any risks related to hydration after the July 20, 2011 RAI-MDS assessment. Poor hydration was not coded as a problem on the assessment and dehydration was not triggered. Food and fluid intake records from July 2011 demonstrate a significant decline in hydration from the month prior (e.g. June 2011 - 5 days consuming less than target beverage intake; July 2011 15 days consuming less than target beverage intake). An interdisciplinary assessment of hydration status did not occur and the plan of care was not revised to include strategies to address the poor hydration.
3. [O.Reg. 79/10, s. 26(4)]
a) The RD, who is a member of the staff of the home, did not assess an identified resident's nutritional status in relation to poor skin integrity. The resident developed an open area, however, a referral to the RD related to altered skin was not initiated. The RD assessed the resident's hydration status one month later, but did not assess the resident in relation to skin integrity at that time.
b) The RD did not complete a nutritional assessment of an identified resident after a significant change in health condition related to choking and hydration. The resident choked on minced vegetables. Two days later began to exhibit respiratory symptoms and was medically treated. Progress notes dated one month later identified ongoing concerns swallowing minced vegetables and a referral was made to the RD. The resident was provided a pureed textured diet with thickened fluids on two occasions that month. The resident was assessed during this month for change in diet texture, issues with coughing/choking, delayed healing of skin issues and documented decline in intake. The resident had received thickened fluids on at least 2 occasions due to swallowing problems. The RD did not assess the resident related to this risk relating to hydration, in a timely fashion. During an interview with the RD on November 1, 2011, it was confirmed that the initial choking episode was not communicated to the RD nor was the use of thickened fluids.
c) The RD did not complete a nutritional assessment of an identified resident after a change to the resident's plan of care for bowel management. Following concerns related to constipation identified by the resident's family, interventions were initiated by the physician, however there was no referral to the RD for re-assessment of the resident's hydration status and risks related to nutrition. The resident did not have a reassessment of their fluid intake, total daily fibre intake and goals in relation to the bowel management strategies. The RD did not re-assess the resident until the following month.

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 RD, who is a member of the staff completes an assessment for all residents whenever there is a significant change in health condition and assesses nutrition and hydration status, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Every resident has the right to be protected from abuse.[s. 3(1)2]
An identified resident was touched inappropriately, by another resident on three occasions in 2011. During a discussion with the RN and the DOC on November 9, 2011, it was confirmed that the resident would not be able to consent to this touching and that the three incidents identified were occasions of non-consensual sexual touching. Safeguards, in addition to monitoring were not put in place to protect the resident until the third incident. The resident was not protected from abuse.
2. The Licensee did not ensure that every resident was afforded privacy in receiving treatment. [s. 3(1)8]
a) On October 21, 2011, at the noon meal, a resident had their capillary blood glucose levels checked, via glucometer, by the RPN, while in the dining room with food being served and his table mate seated at the table. The resident was not afforded privacy in the provision of care.
b) During an observation of the medication pass at the noon meal on November 8, 2011, it was noted that an RPN gave a resident an insulin injection while seated at the dining room table with other residents awaiting the noon meal. During the same medication pass, a second RPN conducted a capillary blood glucose level and administered an injection of insulin to another resident while seated at a table in the dining room with other residents awaiting their noon meal.

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 protected from abuse and afforded privacy in receiving treatment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services
Specifically failed to comply with the following subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 home, furnishings and equipment were not maintained in a safe condition or good state of repair.
a) The bathroom in room 201 was noted on October 21, 2011 and November 8, 2011, to have puddling of water and discolouration of the floor tiles around the toilet. The Administrator observed the bathroom on November 8, 2011, confirmed the need for repair and indicated that this bathroom requires ongoing maintenance.
b) The ceiling in the West End hallway was noted to be leaking on October 21, 2011, with water evident on the floor. Visitors reported that areas of the roof have been leaking on and off for an extended period of time. A service provider was onsite making repairs during the last week of October 2011. The Administrator, on November 8, 2011, confirmed that the roof has had major repairs in recent years and that this area is a "new" leak.
2. The following situations of poor repair were observed in the home. These situations prevent staff from effectively cleaning the areas, specifically:
a) The seat on the tub lift in the West End tub room was worn and as a result the surface was no longer smooth to touch, making it difficult to disinfect between resident use. The Administrator observed the chair on November 8, 2011, and confirmed that the surface was worn from usage.
b) Wall damage, specifically holes and scrapes in drywall, was evident in the Sun room Dining Room near the windows and in resident room 215. The Administrator confirmed that these areas had been repaired in the past however due to large chairs and/or resident action the damage is reoccurring.
c) Floor tiles in rooms 227 and 229 had evidence of damage from the bed frames, and had two areas which were completely worn through to the surface below.

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are to be documented.
a) An identified resident was involved in two situations of non-consensual touching in 2011. The assessments, interventions implemented and/or resident's response to the interventions were not documented. There was no documentation in the resident's record of the initial incident. Documentation of the second situation only identified the incident and immediate actions the stop the behaviour, not the response of the resident. A discussion with the DOC on November 10, 2011, identified that there were no reports completed for these incidents and the only documentation available was in the resident's record.
b) Actions taken with respect to an identified resident under the nutrition and hydration program were not documented. The resident's nutritional intake was to be recorded. Documentation of the resident's intake was incomplete for the months reviewed, specifically; September 2011 - 24 omissions; August 2011 - 19 omissions; July 2011 - 11 omissions and June 2011 - 12 omissions. In reviewing the information available on the records for July 2011 it was identified that the resident had a significant decline in intake since the previous month.
c) Actions taken with respect to an identified resident under the nutrition and hydration program were not documented. The plan of care identified that staff were to monitor the resident's nutritional intake, however, documentation was incomplete for the months reviewed, specifically; September 2011 - 17 omissions; August 2011 - 18 omissions; July 2011 - 13 omissions; and June 2011 - 11 omissions.
d) Actions taken with respect to an identified resident under the nutrition and hydration program by the RD were not documented. The RD stated during interview that a nutritional assessment was completed October 14, 2011 in relation to significant weight loss and confirmed this assessment was not documented.
e) Actions taken with respect to an identified resident were not documented. During the RD quarterly assessment of the resident it was identified that the resident's intake was reduced over the past month and during the observation period she was not drinking enough to meet her minimum fluid target, a deficit of, on average 300mls/day. The RD did not revise the resident's plan of care despite this change in needs and recorded a plan to continue to monitor and follow up on a quarterly, at minimum basis. During an interview with the RD on November 1, 2011, it was identified that the RD assessed the resident and reviewed the resident's intake records one week later, however did not record her reassessment.

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 actions with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the Continence Management Program Bowel Protocol was complied with. The protocol directed staff to provide the following: on the third day without a bowel movement, the registered staff administer 30ml of milk of magnesia (as per order) in the evening; on the fourth day without a bowel movement administer a suppository (as ordered) by the day registered staff; on the fifth day without a bowel movement, administer a fleet enema (as ordered) by the day registered staff. If the above protocol is not effective, ask the physician to discontinue the oral stimulants, and start the resident on Lactulose daily or every other day.
Staff interviewed acknowledged that the bowel protocol was not followed and identified that direction related to bowel medications was not clear. Staff were instructed to initiate as needed bowel medications starting on day 2 without a bowel movement which was not consistent with the Home's bowel protocol to start on day three without a bowel movement.
a) Staff providing care to an identified resident did not follow the protocol on several occasions during a three month period in 2011. According to the documentation during this time the resident experienced 13 occasions of four days or greater without a bowel movement before staff provided intervention to promote bowel functioning. On one occasion the resident had only one recorded bowel movement during 18 days. According to the documentation, staff provided interventions to promote bowel functioning on only 3 occasions during this period of time. During an interview with the nursing staff it was identified that the resident's condition was poor during this time and not eating well, therefore staff were not aggressive with bowel management. It was also confirmed, during this interview, that action should have been taken during this time, despite the resident's intake.
b) The bowel protocol was not followed by staff providing care to an identified resident during three months in 2011. The administration of medications for the treatment of constipation did not comply with the home's bowel protocol consistently. The resident was identified at risk of constipation and he did not have regular bowel movements. During the three month period the resident went six days without a bowel movement on six separate occasions and went three days or more without a bowel movement on 20 occasions. On one occasion the resident went seven days without a recorded bowel movement or bowel intervention. On another occasion the resident was provided a laxative on day two of no bowel movement, however no other interventions were provided and the resident did not have a bowel movement for five days. On one occasion the resident was disimpacted for a moderate amount of formed stool, which was upsetting to the resident.
c) The bowel protocol was not followed by staff providing care to an identified resident. The resident did not have a bowel movement for five days in 2011, however, bowel medications were not used as per the protocol.
d) The Continence Management Program refered to the use of Point of Care, however, the home does not use the Point of Care computer system.
2. The staff at the home did not comply with the policy related to Skin and Wound Management, revised April 2010. A resident was readmitted to the home post hospitalization. The home's policy directed staff to complete a head to toe assessment within 24 hours of a resident's return from hospital. Staff did not complete the head to toe assessment within the timelines specified in the home's policy.
3. Staff at the home did not comply with the policy and procedure related to medication administration, 04-02-20 Pharmacy Manual from Medisystem Pharmacy, titled "Medication Pass". This policy directed staff to administer medications to the resident ensuring that oral medications have been swallowed. Do not leave medications at bedside (unless there is a written order to do so). Do not ask someone else to administer the medication. On November 2, 2011, during the noon medication pass, it was noted that the registered staff administering medications placed an identified resident's crushed medications in coleslaw and left another staff member, who was assisting the resident, to ensure that the medication was consumed. It was observed that the resident had not consumed the coleslaw during the lunch meal. This policy also directed staff to initial the Medication Administration Record (MAR) according to policy. Make appropriate notations for medications which could not be given (i.e. refused by the resident). The documentation on the resident's MAR indicated that the medication that was placed in the coleslaw was administered. The resident in fact refused to eat the coleslaw and thus did not consume her medication.

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 this act or regulation requires the licensee to have a policy, plan, protocol, procedure, strategy or system, that this requirement is implemented and complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following subsections:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. A system was not in place to monitor the food and fluid intake of supplements ordered for and administered to an identified resident, who was at nutrition risk. The supplement ordered by the physician in September 2011, was to be given three times daily. Documentation does not reflect this supplement being provided and the RD indicated that she must rely on staff recall of the resident's consumption of the supplements. This process does not allow for an accurate evaluation of the effectiveness of the interventions.

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 there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee did not ensure that no more than a three month supply of drugs obtained for use in the home were kept in the home at any time. During an observation of the drug storage area, it was noted that there was a surplus of stock medications. There were eight bottles of Senekot (800 pills), nine bottles of antihistamine (900 pills), nine bottles of Gravol (900 pills), eight bottles of Regular Aspirin (4000 pills), eight bottles of Enteric Coated Aspirin (800 pills) and there were 60 ampules of B12. It was confirmed by registered staff that only 7 residents were receiving injectable B12 monthly, at the time of the inspection, and therefore the supply on hand was in excess of three months.

WN #10: 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 did not ensure that when residents were taking as needed medications, that there was monitoring and documentation of the resident's response and the effectiveness of the drugs.
a) An identified resident was provided milk of magnesia as needed for constipation. The drug was administered on 16 occasions over a seven month period and the effectiveness of the drug was not recorded.
b) An identified resident was provided milk of magnesia as needed for constipation. The drug was administered on two occasions over a two month period and the effectiveness of the drug was not recorded. Interventions recorded on the electronic Medication Administration Record monthly summary were not consistent with progress notes of medications administered during two months in 2011.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

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 resident did not receive two baths per week as indicated in her plan of care. The plan of care for an identified resident directed staff to provide a bath or a shower twice a week. A review of the resident care flow records for just over a one month period of time revealed that the resident had only six documented baths/showers during that time period despite her plan of care indicating two showers/baths per week.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following subsections:

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;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(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. An identified resident did not receive oral care to maintain the integrity of her oral tissue including mouth care in the morning and in the evening.
Documentation on the Resident Care Flow for the months of September and October 2011 indicated the resident did not have mouth care, which was confirmed by the DOC. Documentation indicated that no oral care was provided as evidenced by a "X" on the areas related to oral care. During a discussion with nursing staff, it was noted that the resident refuses to have mouth care and therefore staff are not able to complete mouth care.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. An assessment that included the identification of causal factors, patterns,and types of incontinence using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence was not completed for an identified resident when she had a decrease in her level of continence noted in 2011. A clinically appropriate assessment instrument was not used and was not available to staff. Staff indicated during interview that they were transitioning to new assessment forms during that time and documentation did not include a specific continence assessment, only revision to the resident's plan of care.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that residents were assessed using an interdisciplinary approach following significant weight loss and that actions were taken and outcomes evaluated.
a) An identified resident had an 8.2% significant weight loss over three months, but action was not taken to address the significant weight loss. Interventions to address weight loss and poor nutritional intake were initiated one month prior, however, action was not taken when further weight loss occurred the following month. The plan identified by the RD was to continue to monitor and follow up at next weight review or as required. An evaluation of the effectiveness of the interventions initiated the month prior did not occur. The resident had further weight loss the next month, triggering another significant weight loss notification (10.4% over 6 months). An interdisciplinary assessment of this significant weight loss did not occur and actions were not taken to address the significant weight loss. The plan of care remained the same as initially initiated, despite further significant weight loss. The resident has recently been referred to the RD related to poor fluid intake and an open area.
b) An identified resident had a 9.5% significant weight loss over three months, however, this was not identified, as it was not flagged by the computer system. The significant weight loss was not assessed using an interdisciplinary approach and actions were not taken to address the significant weight loss. The nutritional assessment completed by the RD did not assess the significant weight loss and noted minimal weight loss over the last quarter.

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 changes to residents weights are assessed using an interdisciplinary approach and that actions are taken and outcomes evaluated, 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 subsections:

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

s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,
(a) purchases relating to the food production system, including food delivery receipts;
(b) the approved menu cycle; and
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).

Findings/Faits saillants :

1. Not all foods were prepared and served using methods which preserved taste, nutritive value, and appearance at the lunch meal October 21, 2011. The pureed foods (hot dog and cheese dreams) prepared and served were runny and not cohesive. The items were running into other items on the plate and nutritive value and appearance was not preserved (too much fluid dilutes the nutritive value). Staff interviewed were aware that the pureed foods served were not of the correct texture.
The "Resident's Choice" menu at the lunch meal on October 21, 2011, was not prepared and served using methods which preserved nutritive value, taste and food quality. Direction related to recipes and portion size was not provided to staff preparing and serving the meal, resulting in potential for variations in flavour, texture and nutritional content.

Not all foods and fluids were served using methods which prevented adulteration and contamination during the afternoon snack service on November 8, 2011. Staff did not sanitize their hands between assisting different residents with eating and drinking and cookies were being portioned with their hands.

The licensee did not maintain and keep for at least one year, a record of menu substitutions. Menu substitutions were recorded on a home specific form, however, the FSS confirmed that these records were discarded and not maintained for at least one year.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The new quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents, had not been fully implemented at the home.
The home had a new Quality Improvement Manual, "Responsive Management Inc. 2011". The managers had received initial training and had implemented some sections of the new program. During an interview with the Administrator it was confirmed that the new Quality Improvement Program had not been fully implemented to date.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.TABLEHomes to which the 2009 design manual appliesLocation - LuxEnclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 322.92 lux continuous consistent lighting throughoutIn all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 luxAll other homesLocation - LuxStairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 215.28 lux continuous consistent lighting throughoutIn all other areas of the home - Minimum levels of 215.84 luxEach drug cabinet - Minimum levels of 1,076.39 luxAt the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 luxO. Reg. 79/10, r. 18, Table.

Findings/Faits saillants :

1. Lighting requirements were not maintained at the bed of each resident, when the bed was at the reading position to a minimum level of 376.73 lux.
During a tour of the home the lighting levels were observed to be low at the bedsides in room 201. On November 9, 2011, the Environmental Consultant evaluated the lighting levels, using a light meter, at the bedside in two areas in room 201. The lighting levels were noted to be approximately 340 lux which is below the requirement of 376.73 lux. The home had replaced one light bulb in a fixture at the bedside in room 201 on November 9, 2011, which then registered a lux reading of greater than 376.73 lux. The Administrator and Environmental Consultant have verbalized a plan to replace the lower bulb in bedside fixtures and consideration to replace diffusers to ensure lighting levels are maintained.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

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 resident's substitute decision-maker (SDM) was not notified within 12 hours of the licensee becoming aware of an incident of resident abuse.
An identified resident was abused by a resident on two occasions in 2011. There were no incident reports available or documentation in the progress notes to indicate notification of the resident's SDM of this abuse. During a discussion with the DOC on November 9, 2011, it was noted that the she had no knowledge of the SDM being notified of the incidents in 2011.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Incidents of lingering offensive odours were not addressed. Offensive odours were identified in two shared resident washrooms on October 21, 2011 and November 8, 2011. Interview with the Administrator confirmed the odours in those identified rooms.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Residents have not been assessed using a clinically appropriate assessment instrument that is specifically designed for falls.
a) An identified resident had a history of falls and had been identified at risk. The resident fell and did not have a post fall assessment conducted using a clinically appropriate assessment instrument, specifically designed for falls following this incident.
b) An identified resident had a history of falls and had been identified at risk. The resident sustained multiple falls. The resident fell and did not have a post fall assessment conducted using a clinically appropriate assessment instrument, specifically designated for falls.
During an interview with the DOC it was confirmed that during a time of transition, between paper and electronic assessments, a few post fall assessments were not completed.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. Improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were not communicated to the Residents Council. During a review of the Resident Council Meeting Minutes there was no indication of the council being informed of improvements made through the quality improvement and utilization review system. This was confirmed during an interview with the Program Supervisor on November 2, 2011.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Residents' Council was not sought for advice in developing and carrying out the satisfaction survey. A review of the Residents' Council Meeting Minutes did not include any information regarding the homes satisfaction survey. During an interview with the Program Supervisor on November 2, 2011, it was confirmed that the home had recently completed their survey, however Residents' Council was not consulted prior to the implementation. At this time the home was compiling the survey results and had communicated plans to share the results with the council.

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee had not responded in writing, within 10 days of receiving recommendations or concerns identified by Resident Council. A review of the Resident Council Meeting Minutes for August 19, 2011, identified that two residents voiced concerns of missing clothing. These concerns were not responded to until September 19, 2011. During an interview with the Program Supervisor on November 2, 2011, it was confirmed that the concerns were not responded to within 10 days.

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 subsections:

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.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Residents were not consistently offered immunizations against tetanus and diphtheria in accordance with publicly funded immunization schedules. During an interview with the DOC on November 1, 2011, it was confirmed that home would administer tetanus and diphtheria vaccinations to new residents on admission, if the need was identified, however the home did not have a program in place to offer these immunizations to residents in accordance with the publicly funded schedules.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. At the lunch meal on October 21, 2011, meal service was not served course by course for an identified resident. An ice cream sandwich was placed on the table, however, the resident was not finished her entree. The dessert sat on the table for over 20 minutes and was melted by the time the resident was able to eat it.
2. Appropriate furnishings, including tables at an appropriate height to meet the needs of all residents, were not available in the dining areas. Several residents were seated at tables that were too high for the residents to socialize and required a table top for their wheelchair as they could not reach the table.
3. Residents' Council had not reviewed the meal and snack times.
A review of the Resident Council Meeting Minutes for the past year did not include any documentation of a review of the meal and snack times. An interview with the Program Supervisor on November 2, 2011, confirmed that council had not reviewed the meal and snack times since July 2010.
4. At the lunch meal on October 21, 2011, proper positioning was not used for for an identified resident while being assisted with eating. The resident was tilted back in the chair while being fed, which created a risk for choking. The resident was at risk for choking and required thickened fluids. Staff stated it was difficult to position the resident during meals.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The resident did not receive drugs in accordance with the directions for use specified by the prescriber.
In 2011, an identified resident did not receive one dose of medication as ordered by the physician. This omission was identified and action was taken to monitor the resident, notify the physician and communicate to the Substitute Decision Maker. During a discussion with the DOC the medication omission was confirmed, the staff member involved was re-educated regarding the electronic medication administration record (EMAR), narcotic record, and College of Nurses of Ontario (CNO) standards for medication administration.

Issued on this 20th day of January, 2012

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