Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2015	2014_267528_0038	T-000083-14	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

PINE GROVE LODGE
8403 Islington Avenue North Woodbridge ON L4L 1X3

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

CYNTHIA DITOMASSO (528), ASHA SEHGAL (159), DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 16-19, 22-24, 29-31, 2014.

This inspection was completed concurrently with complaint inspection log#: T-4002-14.

During the course of the inspection, the inspector(s) spoke with Acting Administrator/DOC, Resident Assessment Protocol (RAI) Coordinator, Director of Social Services, Dietary Service Manager (DSM), Program and Support Manager, Environmental Service Manager (ESM), corporate consultants, registered dietitian (RD), Nurse Manager, Behavioural Supports Ontario (BSO) nurse, registered nurses (RNs), registered practical nurses (RPNs), personal support workers, dietary aides, housekeeping, laundry staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **7 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 the written plan of care for each resident sets out the planned care for the resident.

Throughout the course of the inspection, resident #14 was noted to be ambulating around the nursing home area without socks and shoes on.
i. Review of the written plan of care indicated that the resident had a variety of responsive beahviours but did not include any mention of the resident's preference related to footwear.
ii. Interview with direct care staff confirmed that the resident never wore socks or shoes

and refused if staff or family tried to assist the resident to put them on. Interview with registered staff confirmed that the plan of care was not updated to include the resident's preference. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

The plan of care for resident #17 revealed that the resident had a history of responsive behaviours. As a result of outpatient psychiatric assessments in 2013 and 2014, recommendations included but were not limited to, performing daily checks of the resident's room to mitigate risk of harm to others.
i. On the mornings of December 23 and 27, 2014, a razor and a knife were found in the resident's room. Direct care staff caring for the resident on both days confirmed that a razor or a knife were not supposed to be in residents' room and were to be removed immediately.
ii. The written plan of care included interventions for staff to remove sharp items and bottles of alcohol and place in medication room, no knives at dining room table, staff to remind family sharp items and bottles of alcohol are not allowed in the facility, and staff to search the resident's room on a weekly basis.
iii. Interview with the Social Worker and activation staff indicated direct care staff were not to remove items from the resident's room or weekly room checks, however, at all times direct care staff were responsible to notify registered staff if any sharp objects or bottles of alcohol were in the reisdent's room. If so, program staff or the Social Worker would remove items.
The written plan of care did not provide clear direction to direct care staff on what to do if an item was found in the resident's room and that direct care staff were to be aware of items at any time when in the resident's room, to ensure there was no risk of harm to residents and staff. [s. 6. (1) (c)]

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

A. In June 2014 , resident #21 was coded on the Admission Minimum Data Set (MDS) Assessment as incontinent of bowels and continent of bladder due to use of an indwelling catheter. The next Quarterly MDS Assessment from September 2014, the resident was coded as incontinent for both bowels and bladder.
i. Although the resident's bladder continence status changed from requiring an indwelling

catheter to incontinent, the Quarterly Assessment from September 2014 did not reflect the change, and the registered staff indicated that the resident had no change in continence level.
ii. Interview with RAI Coordinator confirmed that the MDS assessment from September 2014 was not consistent with the resident's change in urinary continence level.

B. A review of June 2014, dietary MDS supplement assessment documented in the progress notes stated resident #12 had no new issues, tolerating regular texture well and continues to be independent at meals. The documented dietary assessment indicated resident's fluid intake was above 80%, over all adequate, resident remains at moderate nutritional risk. However, the RAP summary for dehydration completed in June 2014 by registered practical nurse stated "resident is at risk for dehydration, resident was hospitalized with an infection and treated with antibiotic. Resident requires extensive assistance with feeding and will become tired and not finish his/her meals." Interviews conducted with registered staff confirmed that the resident was hospitalized and returned with a significant change in health status and the assessments conflicted. [s. 6. (4) (a)]

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

Resident #21 was incontinent of both bowel and bladder and required extensive assistance with toileting. The written plan of care for the resident directed staff to toilet the resident every two hours and as needed.
i. On December 20, 2014, for a three and a half hour period, the resident was not provided assistance with toileting as outlined in the written plan of care.
ii. Interview with direct care staff confirmed that the resident was toileted prior to lunch service but was not assisted to the toilet as outlined in the plan. [s. 6. (7)]

5. The licensee failed to ensure that the resident was 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 changed or care set out in the plan was no longer necessary.

Resident #23 received new upper and lower dentures in September 2014, according to the Social Worker. Review of the plan of care indicated that the resident had natural teeth and partial dentures and did not include any mention of upper and lower dentures. In an interview with registered staff, it was confirmed that the plan of care was not revised when the resident received new dentures. The registered staff updated the written plan of care on December 29, 2014, indicating that the resident has full upper and

lower dentures. [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 the following:
i. there is a written plan of care for each resident that sets out clean directions to staff and others who provide direct care to the resident,
ii. the care set out on the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with 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. 1. The licensee failed to ensure that the following plan, policy, protocol, procedure, strategy or system, put into place was complied with.

A. The home's policy "Resident Abuse-Abuse Prevention Program-Whistle Blowing Protection RRCS-G-05", last revised November 2014, was not complied with for an incident of resident to resident abuse. The policy directed staff if abuse of a resident occurs by anyone resulting in harm or risk of harm, it was to be immediately reported with the information which it was based on to the Ministry of Health and Long Term Care (MOHLTC).

In December 2014, resident #63 and #64 had an altercation which resulted in superficial injuries to resident #63. Review of the plan of care did not identify that a report had not been submitted to the Ministry of Health and Long Term Care (MOHLTC). Interview with RAI Coordinator and DOC confirmed that immediate reporting was not completed and a report was not sent to the MOHLTC until after the Inspector's inquiry in December 2014, seven days after the incident.

B. The home's policy "Continence Care and Management RRCS-C-20", last revised September 2013, was not complied with for one resident. The policy outlined that continence management or incontinence care in the residents care plan was to include the following:
i. frequency of the service - day and time period, type of support, or reminders, toileting routines, toileting routines for day/aft/nights
ii. specific care to be provided - resident personal supplies/products
iii. resident personal supplies/products to be used
iv. safety measures for staff to consider,
v. medical conditions to consider during the completion of care
vi. monitoring and prevention of constipation, level of assistance, documentation care, flow charts or progress notes
vii. resident personal preference
viii. level of assistance
ix. documentation of care completed.

Resident #20 was identified as being frequently incontinent of bladder, requiring the use of continent products and total assistance from staff.
i. Review of the plan of care did not include any specific toileting routines for days/afternoons and nights or specific care/hygiene to be provided to the resident.
ii. Interview with direct care staff confirmed that the resident was mostly incontinent of bladder in bed and in their wheelchair, and sometimes exhibited behaviours. They also indicated that the resident had episodes of continence, and would attempt to self toilet.
ii. Interview with registered staff confirmed that the plan of care did not include an individualized toileting routine for the resident, as identified in the Policy.

C. The home's policy "Hydration Assessment and Program LTCE-FNS-E-07", last revised September 2013, was not complied with for resident #12.

i. The policy defined if a resident's intake is 1000 mililitres (ml) per day or less for three consecutive days the resident will be referred to the RD.

ii. Documented food and fluid intake record indicated resident #12's fluid intake was less than 1000ml per day for four consecutive days in June 2014. The clinical record review and staff interview confirmed a referral to the RD was not initiated when the resident's fluid intake was less than 1000ml per day for four consecutive days.

D. The home's policy "Fluid Intake LTC-CA-WQ-200-02-27", last revised November 2013, was not complied with for resident #12.
i. The policy stated, under procedure #3, that care staff were to monitor and document food and fluid intake of all residents on the Food and Fluid form or electronically in the Point of Care (POC) application. Furthermore, it identified in procedure #6, that registered staff were to review the Daily Food and Fluid intake Record to ensure completion.
ii. Resident #12 did not have food and fluid intake consistently recorded by staff. Review of documented food and fluid intake record was found incomplete/inaccurate. Intake entries were missing in the month of June, September and November 2014. Over a period of four months, resident #12's meal consumption report had 19 meals, snacks, and fluid intake entries not recorded. Interview with registered staff and the Acting Administrator/Director of Care confirmed the documentation of food and fluid intake was not completed as per the home's policy.

E. The home's policy and procedure for "Personal Clothing–Missing NESM-E-01.01", issued February 2011, indicated the person reporting lost clothing will be directed to the lost and found clothing area for initial search of the items reported missing. If the items are not found are recovered in the lost and found area, step 2, 3, and 4 shall commence. The person receiving the report of lost clothing will document all information on the missing clothing report form. Further it identified procedure #4 an immediate search of the laundry area shall commence. If the item's reported missing are not found in the laundry room, the ESM will then post the missing clothing report in the laundry room for three consecutive days. Upon completion of the posting the ESM will contact the person reporting the missing item's and report the results of the search.
i. Residents # 13, #17, #23, and families reported to have had missing clothing and personal items, and stated they reported their missing items to the staff. Resident #13, #17 and #23 clothing and personal items. Residents' interviewed confirmed lost clothing and personal items were still missing.
ii. The acting Administrator/DOC reported that an initial missing clothing report form should have been completed.
iii. The Environmental Services Manager was only able to provide three missing clothing report forms from 2013 and four forms from 2014.

iv. It was noted the missing clothing report forms were incomplete and did not indicate the home had contacted the resident/substitute decision makder (SDM) and reported the results of the missing personal clothing.
v. Residents #13, #17, #23, and families who were interviewed confirmed lost clothing and personal items were still missing and the home had not notified of tracking of lost laundry and personal items or the results of the search.
vi. The procedure for missing clothing and management of personal belonging was not followed and communicated to the Resident, Substitute Decision Maker, or Family. The home's policy missing personal clothing was not complied with when procedure to assist residents to reclaim lost personal clothing items was not followed. The Acting Administrator/Director of Care further confirmed that the current procedures being followed for missing resident clothing did not reflect the home's 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 that any plan, policy, protocol, procedure, strategy or system, put into place is complied with, 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:

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 has failed to ensure that the Registered Dietitian (RD) assessed nutritional statuses, including risk related to nutrition care, for one resident.

A. The clinical record for resident #12 indicated that the resident had a 15 percent (%) weight loss over a six month period. The documented progress notes and staff interviews confirmed that four weight warnings were triggered and the referrals were made to the home RD.
i. A review of the resident's weight record, MDS assessment, and the progress notes confirmed there had been a significant change in resident's health status in relation to a unplanned weight loss, poor food and fluid intake, and abnormal lab values. The nutritional strategies were not reviewed and there was no reassessment of energy, protein and fluid requirements in relation to the concerns identified. Nutritional interventions and strategies were not initiated and implemented despite a 7.8 % weight loss (4.4 kg) over two months. The food and fluid intake record indicated resident was eating less than 50% most meals and in fluid intake 1,100ml to 1,125ml per day.
ii. The documented multidisciplinary progress notes from October 2014, identified a dietary referral was made for further weight loss greater than 10% in four months. The registered dietitian documented in the multidisciplinary progress notes in October 2014, to discontinue specialized diet and to provide resident regular diet and 90ml Resource 2.0 at the end of breakfast meal. A re-assessment of the resident's nutritional risk status in relation to further weight loss and dietary requirements were not completed. Resident's nutritional and hydration requirements i.e. energy, protein and fluid needs were not evaluated since five months prior. The resident continued to be identified at moderate nutritional risk despite the increased risks identified i.e. significant unplanned weight loss, most meals taken less than 50% and the fluid consumption most days less than their estimated fluid requirement.
ii. The review of clinical health records and staff interview confirmed another weight warning was triggered for resident #12. In November 2014, a dietary referral was made to the RD for further weight loss. The RD did not evaluate the existing interventions with regards to effectiveness. Resident's nutritional requirements for energy, protein, and fluids were not estimated and adjusted accordingly. The resident continued to be experiencing weight loss, and had 6.2 kg weight loss, 11.0 % over six months.
iv. Review of resident #12's weight record confirmed further weight loss in December 2014 with referral to RD completed for 15% weight loss over seven months.
v. The RD did not reassess the weight changes using an interdisciplinary approach with action taken, and outcomes evaluated. The progress notes documented by the home RD in December 2014, identified resident at high nutritional risk, however, the assessment did not include an evaluation and effectiveness of strategies in relation to resident's inadequate food and fluid intake and progressive weight loss. The registered staff had documented in the multidisciplinary progress notes that the resident was eating most meals half full and required extensive encouragement with food and fluid intake. Weight

changes were not reassessed using an interdisciplinary approach with action taken and outcomes evaluated for resident #12.
vi. Record review and staff interview confirmed resident #12 was hospitalized due to infections, and had a significant change in food and fluid intake which had resulted in weight loss.

The licensee failed to ensure that a Registered Dietitian (RD) who is a member of the staff of the home assessed resident #12's hydration status and any risk related to hydration.
The RD did not assess resident #12's hydration status and risk related to hydration when there was a significant change in resident's condition after returned from the hospital.
Resident's fluid intake most days was less than his/her assessed fluid requirement.
In June 2014, documented progress notes indicated the resident had a significant change in health status.
Minimum Data Set(MDS) from June 2014, indicated a new Resident Assessment Protocol (RAP) was triggered by coded 12K=1,O4e=7 for Dehydration/Fluid Maintenance. The RAP summary documented by registered practical nurse on June 23, 2014, indicated the resident was at risk for dehydration, hospitalized with an identified infection and was being treated with antibiotics. The registered staff had documented the resident required extensive assistance and encouragement with eating and drinking. A plan would be addressed and goal was to minimize the risk for dehydration.
The plan of care for resident #12 reviewed in December 2014, and interview with registered staff confirmed the plan of care under the nutrition and hydration program did not include hydration assessment and risks relating to hydration. The goals and interventions to minimize the risk for dehydration were not care planned.
Review of home's documented food and fluid intake record for a period of six months confirmed that the resident's fluid intake was most days below last assessed estimated daily fluid requirement. Clinical record review, staff interviews, registered nurse and corporate dietitian confirmed the resident did not meet the assessed fluid requirement most days.
The Dietary MDS Supplement notes documented by the RD in June 2014, did not contain information to demonstrate that the resident's risk for dehydration was assessed when the RD identified that there had been no hydration risk and the daily fluid intake average 1,125ml per day.
A review of the assessment and plan of care records confirmed the last care plan review completed by registered staff was in June 2014, and it did not include nutritional interventions and strategies to minimize the risk for dehydration. The registered nurse

and corporate RD reviewed the clinical records including care plans with the LTC Inspector and confirmed that the plan of care for resident #12 did not address goals and nutritional interventions for dehydration. The corporate RD further confirmed that the home RD had not identified risk for dehydration and therefore hydration assessment was not completed for the resident. The clinical record review and staff interviews further confirmed resident #12 did not receive an interdisciplinary hydration assessment and risks relating to hydration.[s.26(4) (a) [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 completed a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and assesses nutritional status, including height, weight and any risks relating to nutrition care, and hydration status and any riss related to hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

A. Review of the plans of care for residents #60, #61, and #62 confirmed that all three residents used a tilt wheelchair as a personal assistance services device (PASD), and were dependent on staff for repositioning every two hours. Residents #60 and #61 were also noted to have areas of altered skin integrity.
i. On December 20, 2014, the three residents sat in their wheelchairs from 1115 a, to 3 pm, with a slight tilt activated. At no time during the observation by the LTCH Inspector were the residents repositioned.
ii. Interview with two PSW's confirmed that the residents were not repositioned every two hours as required in their plans of care. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(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; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(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; O. Reg. 79/10, s. 51 (2).**

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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.

A. The home's continence program directed registered staff to reassess each resident's continence status at minimum quarterly and when there was a significant change in resident's status using the Ontario Bladder Continence Assessment in Point Click Care (PCC).
i. Review of resident #12's electronic health record indicated that the home had not

completed a reassessment using a reassessment instrument that is specifically designed for assessment of bladder incontinence.
ii. The resident's MDS quarterly assessment for continence completed in 2014, indicated that the resident experienced urinary continence deterioration.
iii. Interview with the registered staff confirmed that the reassessments were conducted using the Ontario Bladder Continence assessment forms in PCC upon significant change in resident status, and that resident #12 was not re-assessed using a reassessment instrument in relation to change in continence care. According to the registered staff resident #12 had varied bladder incontinence. [s. 51. (2) (a)]

2. The licensee of failed to ensure that 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.

A. Throughout the course of the inspection, resident #20 was noted to smell of incontinent odours. Review of the plan of care indicated that the resident was frequently incontinent of bladder, requiring total assistance from staff; however, often resisted care with unpredictable physical aggressive behaviour.
i. The written plan of care for the resident did not identify any toileting routines for day/afternoon and night.
ii. Interview with direct care staff confirmed that the resident was offered assistance to the toilet, which was dependent on the resident's behaviours and not any specific routine.
iii. Interview with registered staff confirmed that although the resident often refused care, an individualized toileting routine should have been identified in the resident's plan of care.

B. The licensee has failed to ensure that resident #12 who was incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder.
i. Resident #12 was identified to be incontinent and did not have individualized care plan addressing all aspects of urinary continence care needs. The plan of care did not include pattern, type of incontinence and potential to restore bladder function, promoting continence and specific interventions.
ii. Resident #12's MDS quarterly review for continence completed in September 2014 indicated that the resident experienced urinary Continence deterioration. Clinical record review, RAI co-ordinator and registered staff interviewed confirmed individualized plan of care with specific interventions was not developed and implemented for resident#12. [s. 51. (2) (b)]

3. The licensee failed to ensure that residents were provided with a range of continence care products that promote resident comfort, ease of use, dignity and good skin integrity.

In a review of the home's Resident Profile Worksheet dated December 2014, which outlined each resident and type of continent care product(s) used, it was identified residents in the home using a pull up type continent product had the products supplied by their families.

i. Each SDM of the residents who used a pull type product were contacted. All of the SDM's indicated that they paid for pull up products out of their pocket because they were advised to do so by the home. They stated that the home would only provide a brief or pad for the residents; however, the residents used a pull up product. All SDMs confirmed that the resident's would be willing to try the pull up from the product line the home carried.
ii. In an interview with the Registered Nurse and observation of the continent care products in the home, it was confirmed that the home had pull ups (from the product line carried within the home) in stock but the product was not available for use by the residents.
iii. Interview with PSWs on the second and third floors revealed that the direct care staff were unaware that the home supplied a pull up type product. Since the product was unavailable to the staff, families were advised that they did not have this type of product available.
iv. All families contacted were paying for a pull up type continent product out of pocket.

The resident's were not provided with a continent care product that promoted the resident's comfort, ease of use, dignity, and good skin integrity. [s. 51. (2) (h) (iii)]

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 following:
i. each resident who is incontinent receives an assessment that includes identification ofcausal 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
ii. 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 andthat the plan is implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A. The plan of care for resident #17 indicated that the resident had resistive/responsive high risk behaviours with potential of harm to self, co-residents and staff.
i. As a result of a history of high risk behaviours, a Psychogeriatric Consults from 2013 and 2014, directed staff to complete daily room checks to ensure safety.
ii. The written plan of care directed staff to check the resident's room on a weekly basis.
iii. On December 17, 2014, resident #17 was observed by the Inspector to exhibit high risk behaviours.
iv. On December 23 and 29, 2014, when asked by the Inspector to search the resident's room, direct care staff found unsafe/prohibited items.
v. Interview with the Social Worker confirmed that staff check the resident's room weekly, however, if direct care staff find any unsafe items they are to report it to the registered staff who will notify Recreation Staff or Social Work and the item will be removed.
Since the Inspector found unsafe items in the resident's rooms on two separate days, the interventions recommended by psychogeratrians, were not implemented. [s. 55. (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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids are prepared, stored and served using methods that preserved taste, nutritive values, appearance and food quality.

A. On December 22, 2014, the pureed food served at the noon meal did not preserve the appearance, taste and quality. The meal served to residents did not appear to be appetizing and nutritious. The texture of the pureed food items served were too runny, resulting in reduced nutritive value as the food was diluted with additional liquid. Lamb stew and vegetables were noted running into each other on the plate and did not hold their form on the plate. Resident #81 was observed to feed themself and was noted to experience difficulty scooping the food off the plate due to runny consistency. The resident had spilt most of the food on their clothes. Staff interviewed confirmed the pureed food consistency was runny and had too much liquid. [s. 72. (3) (a)]

Additional Required Actions:

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

WN #8: 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:

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 has failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

A. The plan of care for resident #19 identified that the resident required extensive assistance with personal care including but not limited to, dressing and hygiene.

i. On December 23 and 31, 2014 around lunch time, the resident was observed to be sitting in a wheelchair wearing unclean clothing. Old stains were noted to the residents sleeves, down the front of their shirt and pants with crumbs in lap.
ii. Interview with PSW's caring for the resident on both days, confirmed that the resident was not cleaned after breakfast and snack, however, the resident required staff to complete this type of care after meals.

Staff did not assist resident #19, as required, on both observed days, and therefore the resident was not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident recieved assistance to insert dentures prior to meals and at any time when requested by the resident or required in the resident's plan of care.

A. The plan of care for resident #10 indicated that the resident was bedfast requiring total assistance with all aspects of care, including but not limited to oral and denture care.
i. On December 19, 2014, at 11:30 am the resident was observed in bed without teeth in their mouth.
ii. In an interview with the PSW, it was confirmed that the resident had not yet received oral care and was fed breakfast without dentures in. The PSW also confirmed that the resident was provided a regular diet with minced meat and usually wore both top and bottom dentures.
The resident was not provided assistance to insert dentures prior to breakfast, as confirmed by direct care staff. [s. 34. (2)]

WN #10: 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:

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 did not respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes from January 2014 until November 2014 identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting Minutes for May 30, 2014, indicated that residents had concerns regarding missing clothing. There were no written responses to these concerns by the licensee.

Meeting Minutes for August 29, 2014, indicated that residents raised concerns in regards to missing clothing again. These concerns were not responded to by the licensee.

Interview with the Acting Administrator and the Program and Support Manager confirmed that written responses to these concerns were not completed. [s. 57. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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 failed to ensure that planned menu items were offered and available at each meal and snack.

A. On December 16, 2014, the therapeutic menu for lunch service was roast chicken with cranberry sauce, rigatoni with marinara sauce, broccoli, apricot, buttered whole wheat bread; the alternate choice was beef and vegetable stew, parsley sprig, seasoned rice, peach slices, buttered whole wheat bread.
i. Observation of lunch service on third floor from 11:45 am to 1 pm, did not include offering of cranberry sauce and buttered whole wheat bread.
ii. Interview with the Dietary Aid indicated that the cranberry sauce was not available. Interview with the DSM indicated that the bread was available at the servery and would be given to those residents who requested it. Interview with the Dietary Consultant confirmed that the bread should have been offered to residents as it was part of the therapeutic menu.

B. On December 22, 2014, the planned menu posted in the dining room for lunch consisted of baked pork chops, bow tie pasta with olive oil, green beans, vanilla caramel swirl cake. The alternate choice of menu was lamb stew, seasoned rice, Moroccan vegetable blend and blueberries. The buttered whole wheat bread, milk, tea and coffee were available for all residents.
During the lunch in Piazza Del L'Amore dining room not all residents were offered/served bread at lunch. Residents #80, #81, and #82 were served pureed menu but pureed bread was not served. The Dietary Consultant and the dietary staff confirmed pureed bread was available but was not offered to all residents. (159) [s. 71. (4)]

WN #12: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids served were at a temperature that was both safe and palatable to the residents.

A. During the observed lunch meal December 22, 2014, hot food temperatures were found to be in the unsafe temperature zone at the point of service.
i. At approximately 12:25 pm the inspector tested the hot food temperature of certain food items held in the hot food steam cart. The pureed lamb stew was probed at 115 degree Farenheight (F), pureed pork 117 degree F and pureed green beans 120 degree F and pasta 125 degree F.
ii. Dietary staff interview confirmed the hot food temperature needs to be at a minimum 140 degreeF. The corporate dietary consultant confirmed hot food temperatures did not meet the standard, and there was not enough water in the steam cart wells to maintain the hot food temperature during the service.
iii. Hot and cold foods not served at safe temperatures compromises palatability, reduces food intake and also increases risk for food contamination. [s. 73. (1) 6.]

2. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

A. Not all residents who required assistance with eating were positioned safely at lunch meal on December 22, 2014. Resident #82 was sliding down in his/her wheel chair and had his/her head tilted back with chin pointed towards the ceiling while being fed, creating a risk for choking. Registered staff confirmed the resident was not safely positioned during the meal. [s. 73. (1) 10.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

A. Throughout the course of the inspection, strong lingering offensive odours were present in the hallway on the third floor. Interview with housekeepers and the ESM revealed that the room was being cleaned more often and staff were using room deodorants to try and combat the odours. Although additional interventions were being implemented, the odour remained. In an interview with the DOC, the home was unable to provide a formalized policy or procedure for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Issued on this 17th day of February, 2015

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

Original report signed by the inspector.