Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Mar 17, 2016	2016_448155_0002	000864-16	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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

SHARON PERRY (155), DEBORA SAVILLE (192), DOROTHY GINTHER (568), MARIAN MACDONALD (137)

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): January 19, 20, 21, 22, 25, 26, 27, 28, 29, February 1, 2 and 3, 2016.

The following inspections were conducted concurrently during this inspection:
Log # 000446-16 / CI 2915-000004-16 regarding staff to resident abuse;
Log # 002161-16 / CI 2915-000008-16 regarding enteric outbreak;
Log # 029626-15 / Follow up inspection of compliance orders #001 and #002;and
Log # 035312-15 / Complaint inspection regarding the provision of resident care.

Please note: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6.(1)(c) identified in concurrent inspection 2016_235614_0002 (Log # 032589-15) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the General Manager, Assistant General Manager, Director of Nursing, Assistant Director of Nursing Care, Director of Environmental Services, Environmental Services Aides, Scheduling Coordinators, Administrative Assistant, Director of Food Service, Assistant Director of Food Service, Registered Dietitians, Chef, Food Service Aides, Kinesiologist, Volunteer Coordinator, Activation Aide, Recreation Aides, Registered Nurse, RAI/QI Registered Practical Nurses, Registered Practical Nurses, Neighbourhood Coordinators, Personal Care Aides, Resident Council representative, Family Council representative, residents and families.

The inspector(s) also toured the home; observed meal service, medication administration, medication storage areas; reviewed relevant clinical records, reviewed policies and procedures, meeting minutes, schedules, posting of required information; observed the provision of resident care, resident-staff interactions and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **17 WN(s)**
- **9 VPC(s)**
- **7 CO(s)**
- **2 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 228.	CO #001	2015_217137_0041	137

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy titled "Head Injury Routine", Tab 04-30, dated January 2013, indicated that for any known or possible head injury,the Team Leader in the Neighbourhood was responsible for starting the Head Injury Routine immediately, using the Neurological/Head Injury Vital Signs Record form, with all sections being completed for the following time periods; every fifteen minutes, once; every thirty minutes for two hours; every hour, twice; every four hours for twenty-four hours and every shift for two days.

Review of the Head Injury Vital Signs Record for resident #002 for an identified dated, identified that one of two required hourly checks and two of six required four hourly checks had not been documented. Review of the Head Injury Vital Signs Record for an identified date, indicated that one of two required hourly checks, one of four required four hourly checks and one of six required shift checks were not completed. Review of the Head Injury Vital Signs Record for an identified dated, indicated that one of four required four hourly checks and one of six required shift checks were not completed.

Review of the Head Injury Vital Signs Record for resident #005 for an identified date, indicated that three of four required thirty minute checks, one of two required hourly checks and one of six required shift checks were not completed. Review of the Head Injury Vital Signs Report for another identified date, indicated that two of six required four hourly checks and one of six required shift checks were not completed.

Review of four Head Injury Vital Signs Records for resident #029, for identified dates, revealed that the checks were not completed as per the policy.

Interview with Director of Nursing #101 confirmed that the Neurological/Head Injury Vital Signs Record should be completed for each of the time frames and especially during the initial resident checks.

The licensee failed to ensure that the Head Injury Routine policy was complied with when not all sections were completed for the required time periods.

2. The licensee's policy titled "Weight and Height Monitoring", Tab 07-32, dated August 2015, indicated that when a monthly weight identified a weight loss or gain of two kilograms (kg) from the previous month, a reweigh would be completed and when unplanned weight change was identified, the Team Leader would be notified and complete a Request for Nutrition Consultation to be given to the Director of Food Services and Registered Dietitian.

Record review for resident #002 identified that they had experienced a weight change of greater than two kilograms during an identified period of time. A nutritional note completed by the Assistant Director of Food Services #129, confirmed the weight change and the need to complete a referral to the Registered Dietitian.

Interview with the Assistant Director of Food Services #129 and the Registered Dietitian #130 confirmed that a referral had not been forwarded to the Registered Dietitian with regard to resident #002's weight change of greater than two kg.

Interview with the Registered Practical Nurse #114 confirmed that no referral to the Registered Dietitian had been completed, in relation to weight change greater than two kg during an identified period.

The licensee failed to ensure that the Weight and Height policy was complied with, when resident #002 demonstrated a weight change of greater than two kilograms during two identified periods of time.

3. The home's policy titled "Nutrition and Hydration", Tab 04-46, dated April 2014, indicated that each evening, the Nutrition and Hydration Flow Sheets would be tallied by the night Personal Care Aide (PCA) team, which would include the Daily Additional Fluids Chart. The night Registered Practical Nurse/Registered Nurse (RPN/RN) would review and initial the total daily fluid intake. Any resident who had a fluid intake, less

than their estimated fluid requirements, would be reported to the oncoming RPN/RN so that interventions could be initiated. The RPN/RN would assess for signs and symptoms of dehydration (Dehydration Risk Assessment Tool). If a resident exhibited signs and symptoms of dehydration (as documented in the Dehydration Risk Assessment Tool), ensure the request for Nutrition consultation (Tab 07-41) had been initiated for the Registered Dietitian to assess. The Request for Nutrition Consultation would be completed when a resident had a fluid intake of less than 1000 millilitres per individual fluid requirement, as per the plan of care, for three consecutive days and there was at least one sign or symptom of dehydration present.

A review of resident #027's Nutrition and Hydration Flow Sheet revealed that there were no total daily fluid intakes done for 10 of 26 days and there were no RPN/RN initials for 26 of 26 days. Resident #027's nutritional plan of care identified their daily fluid requirement. During an identified period of time, the fluid totals for resident #027 were under the requirement. Record review also revealed that there were no Dehydration Risk Assessments completed for resident #027.

The RAI/QI Coordinator #122 confirmed that there was to be a Dehydration Risk Assessment completed if a resident had a fluid consumption of less than their requirement for three consecutive days. They also confirmed that resident #027 had not had a Dehydration Risk Assessment completed at anytime during the identified period when their fluid consumption was less then their requirement. They also confirmed that there was no request for nutrition consultation made to the registered dietitian.

The home failed to ensure that the Nutrition and Hydration policy was complied with.

4. The home's policy titled "Fall Prevention and Management", Tab 04-33, dated February 2013, indicated:
-the resident would be assessed each shift for 24 hours after the fall by the registered team member who was on the Neighbourhood and a progress note would be completed for three shifts; and,
-a post-fall analysis would be completed by the registered team member 24 hours after the fall occurred.

Record review of resident #029's clinical record revealed that the resident had fallen on identified dates.
There were no progress notes completed for three shifts for a fall on a identified date.
There were no post falls analysis completed at any time for the falls on two identified

dates.

The Director of Nursing #101 confirmed that the progress notes were not completed for three shifts for an identified fall. They also confirmed that there were no post falls analysis completed for two identified falls.

The home failed to ensure that the Falls Prevention and Management policy was complied with.

5. The home's policy, "Catheter (Urethral / Supra Pubic)" dated August 2014, identified under the procedure that the PSW staff would empty the catheter bag at the end of every shift, or more frequently if required. The amount would be entered on the PSW Flow Sheets/Output Record. If output was less than 400 millilitres per shift, the PSW would report immediately to the Team Leader.

Review of the plan of care for resident #036 indicated that the resident had a catheter. The Personal Care Observation and Monitoring Forms for an identified period of time, indicated that outputs were not documented on all shifts, on fourteen of the twenty one days (67 percent).

Interview with a Registered Practical Nurse (RPN) #117 revealed that for residents with a catheter, the expectation was that care staff were to empty the catheter drainage bag at least once a shift and record the output on the PCA flow sheets. The RPN confirmed that care staff had not documented the outputs for resident #036 on each shift during the twenty one day period.

The licensee failed to ensure that the Catheter Care policy was complied with.

6. The home's policy entitled "Nutrition and Hydration" dated April 2014, indicated that the Nutrition and Hydration binders would be placed on the Teacart at the time of each nourishment service by the Food Services Team. The intake of food and fluid would be documented on the flow sheets in the Nutrition and Hydration binder, at the time of service.

a) On an identified date, Recreation Aide #127 was observed serving beverages from the Teacart on a Neighbourhood between 1050 and 1130 hours. The Recreation Aide #127 was also observed to assist some residents with feeding in the lounge and in their

individual rooms on the Neighbourhood. Documentation with regard to intake was not observed and the Nutrition and Hydration binder was not evident on the Teacart.

During an interview with Recreation Aide #127, they indicated that documentation, with respect to intake, would be done by the Personal Care Aide (PCA) on the Nutrition and Hydration flow sheets. The staff member reported that they would sit down with the PCA to assist them with completing the flow sheets. When asked how they could recall the individual intakes, the staff member indicated that they had a very good memory.

b) During observations on an identified date, of the afternoon Teacart on another Neighbourhood PCA #153 was observed serving beverages and snacks to residents in the lounge and in their rooms. The Nutrition and Hydration binder was not observed on the Teacart and PCA #153 was not observed documenting individual intakes.

During an interview with PCA #153, they shared that they document the intakes after they have completed the Teacart service. When asked how they would remember what each resident had consumed, the staff member reported that they had a good memory.

c) On an identified date, PCA #134 was documenting food and fluid intakes for breakfast, morning Teacart, and lunch for resident #027 and all other residents residing on an identified Neighbourhood. PCA's #131, #132 and #133 were present with PCA #134. They indicated that they usually tried to document at the time of the meal or snack but most often they did not have time. When asked how they could recall what each resident ate and drank, they indicated they did it from memory.

The Director of Nursing #101 confirmed that documentation of flood and fluids was to be done at the time of the meal or Teacart.

Staff interview with the Director of Food Services #128 confirmed that it was the home's expectation that staff document resident food and fluid intakes at the time of service. The Nutrition and Hydration binders were to be kept in the dining room during meals and on the Teacart during snack service to facilitate documentation.

The licensee failed to ensure that the Nutrition and Hydration policy was complied with.

7. A review of the "Food Temperature Control" policy, Tab 09-28, dated February 5, 2015, revealed "food temperature checks must be conducted daily, just prior to food leaving the kitchen, at point of service and at end of service. Any food item found to be

below the optimum temperature should be reheated to an acceptable temperature".

During stage one of the this inspection, four residents expressed concerns that their food was cold.

During this inspection on identified dates, a review of the food temperature records on an identified Neighbourhood revealed food temperatures were not recorded for two of four (50 percent) lunch meals.

During an interview, with the Director of Food Services # 128, it was confirmed that food temperatures had not been recorded, the expectation was that food temperature checks must be conducted daily, just prior to food leaving the kitchen, at point of service and at end of service and the home's policy was not complied with.

8. The home's policy titled "Personal Care Ware", Tab 06-02, dated as reviewed January 2015, stated that staff were to ensure that personal ware, including basins and bedpans, were not placed on the floor.

During observation on an identified date, it was noted that two blue basins and a k-basin were placed on the floor beside the toilet in the bathroom in a resident room. The personal ware was again observed on the floor on subsequent identified date. Interview with Registered Practical Nurse #114 confirmed that blue ware should not be on the floor.

During observation on an identified date, Inspector #155 noted that a bedpan was on the floor in the bathroom in another resident room. The personal ware was again observed on the floor on a subsequent date. Interview with Registered Practical Nurse #157 confirmed that personal ware were to be cleaned weekly and should be stored on available shelves, not on the floor.

The licensee failed to ensure that the "Personal Care Ware" policy was complied with.

9. The home's policy titled "Spa (Shower, Tub Bath, Sponge Bath)", tab 04-06, dated February 2014, indicated to document the type of spa provided and the level of assistance provided on the PSW Flow Sheet, including nail and skin care. It also indicated that when a resident declined their spa, after multiple attempts and negotiation, it must be documented on the Personal Support Worker (PSW) Flow sheet under

'bathing' as well as in the 'behaviour' section.

Review of resident's #027 Personal Care Observation and Monitoring Form (PSW Flow Sheets) for a one week period, revealed that resident #027 refused their shower on an identified date, however there was nothing documented under the behaviour section. Review of resident's #027 Personal Care Observation and Monitoring Form for two subsequent weeks revealed no documentation under the bathing or behaviour sections.

Interview with the Director of Nursing #101 identified that bathing was to be documented on the Personal Care Observation and Monitoring Form (PSW Flow Sheets).

The licensee failed to ensure that the Spa policy was complied with.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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. O. Reg. 79/10, s. 30 (1).
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. The licensee has failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that included its goals and objectives, relevant protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required.

Record review and staff interview with the Director of Care #101 and Assistant General Manager #100 revealed that the home did not have a written description of the continence care and bowel management program that included goals and objectives, relevant protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required. The Assistant General Manager #100 indicated that continence care had been identified as an area of quality improvement and they were in the process of developing a more comprehensive program. [s. 30. (1) 1.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #045 was identified on the Daily Infection Control Surveillance record to be exhibiting respiratory symptoms.

Review of the progress notes for resident #045, confirmed by the Director of Resident Care #101, failed to identify that the presence of symptoms of infection, as identified under the Infection Prevention and Control Program, were documented in resident #045's medical record. [s. 30. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

1. Resident interviews and call bell response times for the month of December 2015 revealed:

A) Resident #026 shared that they were often left waiting when they call for assistance. On average they wait 15 minutes but sometimes it was 45 minutes and they didn't make it to the bathroom in time.

Review of the call bell response records indicated that on four occasions the time, between when resident #026 activated the call bell and when it was cancelled, exceeded 15 minutes. The response time on one of these four occasions exceeded 30 minutes.

B) Resident #024 reported that they go to bed. The resident stated that they ring for help but are often left for more than an hour. Staff would come in and shut off the call bell and then leave without providing care.

Review of the call bell response records indicated that on an identified date, the call bell was activated at 21:04 hours and cancelled in 19:23 minutes.

C) Resident #025 shared that they called for assistance to go to the washroom and sometimes had to wait more than 15 minutes.

Review of the call bell response records indicated that on an identified date, the call bell was activated at 06:13 hours and cancelled in 24:23 minutes; on another identified date, the call bell was activated at 08:18 hours and cancelled in 15:00 minutes; and on another date, the call bell was activated at 07:50 hours and cancelled in 16:50 minutes.

D) Resident #032 shared that they sometimes had to wait more than 15 minutes when they call for assistance to use the bathroom.

Review of the call bell response records indicated that on eight occasions the time, between when resident #032 activated their call bell and when it was cancelled, exceeded 15 minutes.

Resident #032's plan of care indicated that the resident was able to verbalize when they wanted to go to the washroom. The resident required two staff to provide extensive assistance for some aspects of toileting. The Minimum Data Set (MDS) most recent assessment, identified that the resident's urinary continence had declined.

Staff interview with Personal Care Aide (PCA) # 141 revealed that resident #032 was usually continent of bladder, the PCA indicated that sometimes the resident was incontinent because they wait too long before calling and staff were not able to reach them in time.

E) Resident #036 reported that sometimes they pushed their button and staff respond, and other times they waited a very long time when they needed help.

Review of the call bell response records indicated that on 15 occasions the time, between when resident #036 activated their call bell and when it was cancelled exceeded 15 minutes. On three of these fifteen occasions the response time exceeded 30 minutes.

F) Resident #001 shared that sometimes staff said they would be back in a minute and it was between 10 to 20 minutes before they returned. The resident stated that because of

this delay, they were not able to get to the bathroom in time.

Review of the call bell response records indicated that on six occasions the time, between when resident #001 activated their call bell and when it was cancelled, exceeded 15 minutes.

2. Recreation Aide #127 shared with Inspector #568 that they had been approached by a Personal Care Aide on a Neighbourhood and asked if they would manage the nourishment cart because they were behind with resident care. The Recreation Aide commenced the morning nourishment cart service at 1050 hours and completed it at 1130.

On January 28, 2015 on a Neighbourhood the nourishment cart was available on the unit at 1900 hours. At 2025 hours residents down one of the halls had not been offered a snack or beverage from the cart. Registered Practical Nurse #146 confirmed that staff had been too busy with resident care to complete the nourishment cart service.

3. Interview with Staffing Coordinator #144 revealed that when they were unable to fill a shift, staff that were cross trained within the Neighbourhood would attempt to carry out as many non-direct care activities as possible. If the vacant shift was on evenings then they would pull their "Tower Support" person to cover.

Review of the "Shifts Not Covered" report for December 2015 revealed that there were 15 day shifts (0600 to 1400/0700to 1500); 30 evening shifts (1400 to 2200/1500to 2300); five 1000 to 1800 shifts, and four night shifts (2200 to 0600/2300 to 0700) not covered.

4. Concerns were raised at the Resident's Council meeting June 25, 2015 about staff not being available during peak times, like bed time, when they were most needed. A second concern was raised at the August 20, 2015 meeting, with regards to insufficient staff in the dining rooms on two identified Neighbourhoods, because they were on their breaks.

5. A review of the call bell response records for an identified Neighbourhood, for December 2015, revealed that there were 79 documented entries where the call bell response time was over 15 minutes. On one identified Neighbourhood there were 98 documented entries where the call bell response time was over 15 minutes. On another identified Neighbourhood, there were 40 documented entries where the call bell response time was over 15 minutes.

Interview with the Assistant General Manager #100 and Neighbourhood Coordinators #108 and #123 revealed that they do a monthly audit of call bell response times on each Neighbourhood. The staff indicated that they look at the average response times, as well as some of the individual response times. When asked what the expectation was in terms of an acceptable response time, the staff indicated that the expectation was that response times would be at or below the average on the Neighbourhood. The average call bell response time in December 2015 on one identified Neighbourhood was 4:09 minutes, on another identified Neighbourhood 3:41 minutes, and on another Neighbourhood 3:34 minutes. [s. 31. (3)]

2. The licensee failed to ensure that there was a written staffing plan that included a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage cannot come to work.

Review of the home's staffing plan and interview with the Assistant General Manager #100 confirmed that the home did not have a written back-up plan that addressed situations when staff, including staff that must provide the nursing coverage, cannot come to work. [s. 31. (3) (d)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: 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: 4. Monitoring of all residents during meals. 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 the home has a dining and snack service that included, at a minimum, monitoring of all residents during meals.

During observation on an identified date, at 1100 hours it was observed that resident #041 was sitting with breakfast on the table in front of them. No staff were present in the dining room or in the vicinity of the dining room. The plan of care for resident #041 under Nutrition identified that the resident required intermittent cueing and the resident was to be watched closely. Observation of the breakfast and lunch meals, for resident #041, identified that staff fed the resident. Interview with Personal Care Aide #143 confirmed that resident #041 required total assistance with eating and staff had been feeding the resident.

During observation on an identified date, resident #042 was observed attempting to eat their breakfast meal in the Dining Room. The resident was observed to be positioned in a reclined chair with a table in front of them. Review of the plan of care identified that the resident had been flagged as being at risk of choking and specific interventions were identified. No staff were noted in the servery or dining room. During observation over a twenty minute period, no staff came to check on the resident or approached the resident. Staff passed by in the corridor but were preoccupied with other activities.

The licensee failed to ensure that the dining and snack service included, at a minimum, monitoring of all residents during meals. [s. 73. (1) 4.]

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.

Record review revealed that resident # 052 was at risk for choking. The resident was to be provided with a specific diet. Staff were to encourage the resident to self feed but if they refused, staff were to provide total feeding assistance.

On an identified date, Personal Care Aide (PCA) #158 was observed standing beside resident #052 who was seated in a wheelchair, tilted approximately 30 degrees. The staff member was noted to be feeding the resident their afternoon snack. As the inspector approached, resident #052 was heard coughing repeatedly, while PCA #158 continued to feed the resident.

During an interview with the Neighbourhood Coordinator #123, it was acknowledged that resident #052 was at risk for choking. The Neighbourhood Coordinator #123 confirmed that it was their expectation that residents would be seated as upright as possible and staff would be either seated or at eye level when providing assistance with feeding.

The licensee failed to ensure that proper techniques were used to assist resident #052 with eating, including safe positioning. [s. 73. (1) 10.]

3. The licensee failed to ensure that proper techniques to assist residents with eating, including safe position of resident who require assistance.

A written notification of non-compliance and a Compliance Order # 005 were previously issued on June 8, 2015, under Log # 008689-15 and Inspection # 2015_217137_0021, with a compliance due date of July 17, 2015, as well as a written notification of non-compliance and a Compliance Order # 002 were previously issued on October 27, 2015, under Log # 013760-15 and Inspection # 2015_217137_0041, with a compliance due date of November 27, 2015, related to not ensuring all direct care staff, volunteers and students received education related to using proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

Interviews, with the Director of Care # 101, Recreation Aide # 140 and Volunteer Coordinator # 139, revealed a total of approximately 125 Personal Care Aides (PCA), 50 Registered Nursing staff, six recreation aides and five volunteers provided dining assistance to residents.

A review of in-service records, between October 21-23, 2015, revealed approximately 59/186 (31.72 percent) of direct care staff and volunteers, (excluding students as records

were not available), received education related to proper techniques used to assist residents with eating, including safe positioning of residents who require assistance.

During an interview, with the Assistant Director of Food Services (ADFS) # 129, it was confirmed that education had not been provided to all direct care staff, volunteers and students, related to proper techniques used to assist residents with eating, including safe positioning of residents who require assistance.

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

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

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control interdisciplinary team met at least quarterly.

Interview with the Infection Prevention and Control Nurse #107 and the Director of Nursing #101 confirmed that the interdisciplinary Infection Prevention and Control Team had failed to meet at least quarterly.

Minutes were available for meetings held in March, June and December 2015.

The licensee failed to ensure that the Infection Prevention and Control interdisciplinary team met at least quarterly. [s. 229. (2) (b)]

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Resident #071 was identified to have symptoms and signage was noted to be posted on the resident's door indicating precautions were in place.

On an identified date, resident #071 was observed to exit their room and approached the medication cart. No personal protective equipment was applied to ensure the safety of other residents and staff the resident encountered. After receiving their medications, resident #071 returned to their room and a few minutes later returned to the dining room, approaching the open servery window. Food Service Aide #124 was observed to take a water bottle and fill it at the sink, returned the filled bottle to resident #071, along with two sandwiches. No hand hygiene was observed. No staff intervened when resident #071 was observed in the full dining room and within three feet of the open food containers ready for the noon service to begin.

Interview with the Registered Practical Nurse #114 and the Director of Nursing #101 confirmed that resident #071 remained on isolation as they had not achieved five days symptom free.

Interview with the Director of Nursing #101 identified that resident #071 was impacted by strict isolation but confirmed that the home could have better managed the needs of resident #071 while protecting the population on the home area.

The licensee failed to ensure that staff participated in the implementation of the infection and control program when residents on the Neighbourhood were not protected from resident #071 who demonstrated signs and symptoms of infection on an identified date.

3. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices.

The home identified one outbreak on January 18, 2016 and another type of outbreak on January 21, 2016.

A) Record review for resident #049 identified that the resident was documented to have a symptom and refused intake one day prior to being added to the Daily Infection Control Surveillance form.

Interview with the Director of Nursing #101 confirmed that when a resident exhibited symptoms of potential infection, they were to be added to the Daily Infection Control Surveillance form, for ongoing monitoring each shift.

Resident #049 was documented to have symptoms of infection. Four days later, resident #049 was documented to have more symptoms of infection and was added to the Daily Infection Control Surveillance. Interview with the Director of Nursing #101 confirmed that resident #049 should have been included on the Daily Infection Control Surveillance when first exhibiting symptoms of infection.

B) Record review identified that resident #048 exhibited signs and symptoms of infection and was diagnosed with an infection by the physician two days later.

Record review identified that resident #048 continued to exhibit signs and symptoms of infection nine days later. Thirteen days later when resident was still having signs and symptoms of infection, resident #048 was then added to the Daily Infection Control Surveillance record.

Interview with the Director of Nursing #101 confirmed that resident #048 had not been included on the Daily Infection Control Surveillance record when they exhibited signs and symptoms of infection.

C) Review of the medical record for resident #043, confirmed by the Director of Nursing #101, identified that one day prior to being included on the Daily Infection Control Surveillance record, resident #043 exhibited signs and symptoms of infection.

D) Review of the medical record for resident #046, confirmed by the Director of Nursing #101, identified that one day prior to being included on the Daily Infection Control

Surveillance record, resident #046 exhibited signs and symptoms of infection.

The home's definition of respiratory outbreak, identified in "Managing a Respiratory Outbreak" policy, tab 04-05, dated September 2013, indicated that whenever there are two cases of acute respiratory illness within 48 hours on one Neighbourhood, an outbreak should be considered.

Residents #048 and #049 from an identified Neighbourhood who exhibited two or more symptoms of respiratory illness over the same period, were not included on the Daily Infection Control Surveillance record. Addition of these residents to the Daily Infection Control Surveillance record may have potentially resulted in an identified outbreak three days prior to when the home confirmed the outbreak.

The licensee failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices when residents #043, #046, #048, #049 were not included on the homes Daily Infection Control Surveillance record when they first exhibited signs and symptoms of infection. [s. 229. (5) (a)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 there was a written plan of care for each resident that set out, clear directions to staff and others who provided direct care to the resident.

The plan of care for resident #042 identified the resident as being at risk and indicated under Nutrition and Choking that the resident was to be supervised during meal and snack times.

Resident #042 was observed on an identified date, seated in their reclined chair with a table in front of them, eating their meal. No staff were in the Dining Room or immediate

area to supervise the resident .

Interview with the Director of Nursing #101 confirmed that the plan of care did not provide clear direction in that "supervision" of the resident could be subjective and did not provide staff with clear direction to staff who provide direct care to the resident. [s. 6. (1) (c)]

2. This finding is being added to this report from a complaint inspection that was done concurrently with this RQI inspection. (Log 032589-15 inspection number 2016_253614_0002).

An interview with RPN #114 revealed that resident #060 required specialized therapy regularly and had a physician's order for the same. The therapy was noted in the resident's treatment administration record (TAR) that was accessed by registered staff only.

On an identified date, resident #060 was observed, in their room. Resident #060 did not have therapy in place at that time. When brought to the attention of the registered staff, the registered staff approached resident #060 and, after a short conversation with the resident #060, they agreed to receive the identified therapy.

A review of resident #060's clinical record indicated that the resident would refuse the identified therapy at times.

Observation of resident #060 on another day, revealed the resident was sitting in their room, receiving therapy.

PCA #159 confirmed that they provided care for the resident this morning and that they had provided resident #060 with identified therapy.

A review of resident #060's care plan, as provided by the Assistant Director of Nursing Care #109, did not include specialized therapy. A review of resident #060's Personal Care Profile, used by the PCA staff, did not include specialized therapy or directions for use.

During an interview, the Assistant General Manager #100 confirmed that the resident received the identified therapy and that the plan of care did not provide clear direction to the staff assisting the resident with the therapy.(614) [s. 6. (1) (c)]

3. The licensee has 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 complement each other.

The Minimum Data Set (MDS) assessment completed on an identified date, identified that resident #007 was continent of bowel and frequently incontinent of bladder.

Interview with Registered Practical Nurse #114 identified that when the MDS assessment was completed, registered staff from the home area were to complete a series of assessments under Quarterly Assessments that included a Bowel and Bladder Assessment form.

Review of the quarterly Bowel and Bladder Assessment form completed five days after the MDS assessment, identified that the resident had no history of urinary or bowel incontinence, in contrast to the MDS assessment which indicated that the resident was frequently incontinent of bladder. The remainder of the Bowel and Bladder Assessment form was left blank.

Review of the quarterly Bowel and Bladder Assessment form completed on an identified date, identified that resident #007 had no history of urinary or bowel incontinence in contrast to the MDS assessment completed the same day, which indicated that the resident was frequently incontinent of bladder.

Interview with the Resident Assessment Instrument (RAI) Coordinator #107 confirmed that the MDS assessment and Quarterly Bowel and Bladder Assessment form completed for resident #007 on two separate identified dates, were inconsistent.

The licensee failed to ensure that staff and other involved in different aspects of care collaborated with each other in the assessment of resident #007, so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (a)]

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

A review of the plan of care for resident #012 indicated total assistance was required for mouth care to maintain teeth in good condition. The resident required total assistance for mouth care, and staff were to provide mouth care twice daily.

During interviews, with resident #012, it was revealed the resident had received mouth care in the evenings only and, at no time, had the resident been offered mouth care twice daily.

A review of the personal care observation and monitoring forms, for a one month period, revealed inconsistent documentation related to mouth care.
Mouth care was documented once daily for eleven days and no documentation recorded for three days.

During an interview with the Director of Nursing #101, the resident confirmed oral care had never been offered in the morning, except for the past three days, as a result of the Ministry of Health inspection.

During an interview, the Director of Nursing #101 confirmed the care set out in the plan of care was not provided to the resident as specified in the plan and the expectation was that the resident would be offered mouth care twice daily. [s. 6. (7)]

5. The licensee has failed to ensure that resident #002 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.

Resident #002 sustained a fall on an identified date. Post fall, the resident complained of pain.

Record review identified that on the day following the fall, resident #002 had problems breathing and had pain. Medications were added and the resident was started on specialized therapy. The resident complained of ongoing discomfort three days after the fall. Fourteen days after the fall, the resident continued to have problems breathing and had pain.

Thirteen days after the fall, resident #002 was observed in their lounge chair with slacks around their thighs, they were short of breath and the therapy was observed to be not in place.

On an identified date, the resident sustained a subsequent fall that resulted in a change in skin integrity. The Kinesiologist #121 confirmed that the post fall assessment did not identify that a Skin Assessment had been completed or that the plan of care had been revised.

Interview with the Director of Nursing #101 and Kinesiologist #121 confirmed that there had been a change in the resident's condition.

Interview with the Kinesiologist #121 confirmed that post fall assessments failed to identify new interventions for resident #002 in relation to the prevention of falls or minimizing injury related to falls. The Kinesiologist #121 also indicated it would be expected that a huddle would be held post fall and that suggested new interventions for the resident would be recorded by the team for consideration and/or implementation. The Kinesiologist #121 confirmed that there was no record of a post fall huddle or recommended intervention for resident #002 in relation to the second fall and that with recent changes in condition it would be expected that additional interventions would be put into place for resident #002 in relation to fall prevention and required assistance with care.

The licensee failed to ensure that the plan of care for resident #002 was reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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

Record review revealed that on an identified date, resident #055 had a fall while unattended. When assessed, the resident was noted to have injuries. The Post Fall Huddle form and the Falls Report for the identified month, on the Neighbourhood, identified as a new intervention that resident #055 must be supervised.

During a staff interview with Personal Care Aide #136, they acknowledged that resident #055 was at risk to fall. The PCA indicated that resident #055 was to be supervised. When asked how staff were updated about changes to the plan of care, the PCA indicated that this was done through verbal communication with other staff, at shift report, and by reading the communication book. There was also a reference sheet in the flow sheet binder for each resident which was derived from the care plan.

A review of the plan on care for resident #055, done fifty-five days after the fall, identified there was no documentation within the plan of care to identify that the resident must be supervised.

Director of Nursing #101 shared that following resident #055's fall, the resident was reassessed and it was determined that they must be supervised. The Director of Nursing #101 confirmed that the plan of care was not revised to reflect this change. [s. 6. (10) (b)]

7. The licensee has 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 care set out in the plan has not been effective.

The Minimum Data Set Resident Assessment Instrument (MDS RAI) done on an identified date for resident #032 identified bladder continence as a "4 - Incontinent - had inadequate control, multiple daily episodes". The previous MDS RAI identified bladder continence as "3 - frequently incontinent - tended to be incontinent daily, but some control present".

Review of resident #032's plan of care for urinary elimination indicated that the resident was incontinent three or more times per week and used pads/briefs. The resident was identified as being able to verbalize when they needed to be toileted and that staff would toilet them when requested.

Staff interview with a Personal Care Aide (PCA) # 141 revealed that resident #032 required a lift for toileting. In terms of the frequency of toileting, the staff member shared that the resident was aware of when they need to go and would ring for staff assistance. When asked if the resident was usually continent of bladder, the PCA indicated that sometimes the resident was incontinent because they wait too long before calling and staff were not able to reach them in time.

During an interview with the RAI/QI Coordinator #122 they acknowledged that resident #032's bladder continence had worsened. The resident went from being frequently incontinent to incontinent of bladder. The RAI /QI Coordinator #122 indicated that when there was a change in continence they would consult with care staff to determine if the interventions in place were effective. The RAI/QI Coordinator #122 and Neighbourhood Coordinator #123 confirmed that resident #032's plan of care for urinary continence had not been effective as the resident's bladder continence had worsened. The plan of care was not revised to include interventions to address these changes.

The licensee failed to ensure that resident #032 was reassessed and the plan of care with respect to urinary continence was revised when the care set out in the plan was not

effective. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius.

During stage one of this inspection eight residents expressed concerns that the home was too cold.

On an identified date, during stage one of the inspection, resident #023 was observed in their room with a sweater and pair of gloves on. The room's thermostat read 69 degrees Fahrenheit (20.5 degrees Celsius). The Environmental Services Aide #154 confirmed that resident #023's room was cold and indicated the room was often cold.

On an identified date, resident #035 revealed that they were cold in their room.
On an identified date, the temperature in resident #035's room, at 1422 hours, was 21 degrees Celsius and this was confirmed by Personal Care Aide #155.

Interview with the Director of Environmental Services #110, revealed that the home used the IView building automation system to monitor temperatures throughout the home including resident rooms. A review of the temperature of resident #035 room, according to the IView building automation system, revealed that the room should be 72.6 degrees Fahrenheit (22.5 degrees Celsius).

On February 2, 2016, the temperature in the Cafe, at 1300 hours, was 20 degrees Celsius. This was confirmed by the Administrative Assistant #142.

On February 2, 2016, at 1450 hours the temperature of the second floor sitting area before the entrance to Arthur Neighbourhood was 21 degrees Celsius and the second floor sitting area, above the town hall (outside of the flower room) was 20 degrees Celsius. This was confirmed by the Director of Environmental Services #110 and by the Assistant Director of Nursing Care #109.

Review of the policy entitled "Water and Air Temperature", tab 07-13, dated October 2011, indicated air temperatures would be checked and recorded daily on the Air Temperature Recording Sheet. The Director of Environmental Services #110 confirmed that air temperatures were not checked and recorded daily on the Air Temperature Recording Sheet. It was also confirmed that there was no auditing of the temperatures that are displayed on the IView program to ensure they are correct.
The Director of Environmental Services also had no temperatures for the one Neighbourhood as the IView system was not functioning for that Neighbourhood since this inspection began on January 19, 2016.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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. The licensee has failed to ensure that when the resident had fallen, that the resident had been assessed and, if required, a post fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Record review of resident #029's clinical record revealed that they had fallen on a number of identified dates.
There was no post falls assessment completed for two falls on identified dates.

An interview with the Director of Nursing #101 confirmed that there was no post falls assessment completed for these two falls and it was the homes expectation that there was a post falls assessment done when a resident had fallen. [s. 49. (2)]

Additional Required Actions:

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

WN #9: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff.

During a review of the home's quality improvement plans and audits there was no evidence that a satisfaction evaluation of continence care products had been completed.

The Director of Nursing #101 and Assistant General Manager #100, confirmed that an annual resident satisfaction evaluation had not been completed with respect to continence care products in consultation with residents, substitute decision-makers, and direct care staff. [s. 51. (1) 5.]

2. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The Minimum Data Set (MDS) assessment completed for resident #007, identified the resident as continent of bowel and bladder. The MDS assessments completed for the next two quarterlies, identified resident #007 to be continent of bowel and frequently incontinent of bladder.

Interview with Registered Practical Nurse (RPN) #114 confirmed that the resident was incontinent of bladder. Documentation reviewed for two identified dates, indicated that the resident had incontinence during the evening and night for each of the two days reviewed with the RPN.

Interview with the Resident Assessment Instrument (RAI) Coordinator #107, for the Neighbourhood confirmed that when resident #007 changed from continent to frequently incontinent, a Continence Assessment should have been completed in relation to the resident's bladder incontinence. The RAI Coordinator #107 confirmed that no Continence Assessment was completed for resident #007.

The licensee failed to ensure resident #007 who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential

to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

3. The licensee had failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Resident #007 was assessed in the Minimum Data Set (MDS) assessments, for two quarterlies, to be frequently incontinent of bladder.

The plan of care, indicated that the resident was continent of bowel and bladder. Intervention in place stated to encourage/remind resident to use the toilet regularly every two hours and as necessary. Offer physical assistance especially during periods of increased fatigue and unsteadiness.

Review of documentation on the flow sheet confirmed that the resident was incontinent on evening and night shifts.

Interview with the Resident Assessment Instrument (RAI) Coordinator #107 confirmed that the plan of care to promote and manage bowel and bladder continence was not based on the assessments completed, that identified the resident to be incontinent of bladder and that interventions in the plan of care were not updated to address the needs of the resident.

Observations of resident #007 between 0935 hours and 1330 hours on an identified date were made. The resident was not observed to have been reminded or encouraged to use the bathroom during this time frame.

Interview with the Personal Care Aide (PCA) #136 identified that the resident was able to tell staff when they needed to use the bathroom or, if they noticed the resident to be wandering, staff would direct them to the bathroom. PCA #136 provided the Personal Care Profile as the source of information related to resident #007's care needs. The Personal Care Profile identified resident #007 to be usually continent with limited, non-weight bearing assistance required for toileting. No other assistance was identified to be required.

The licensee failed to ensure that resident #007, who was identified to be incontinent of

bladder in assessments, had an individualized plan of care to promote and manage bladder incontinence, based on the assessment and that the plan was implemented. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the continence care and bowel management program provides for and annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated; that each resident who is incontinent receives an assessment that includes identification of casual 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; and 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (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 failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening.

During stage 1 of the inspection, resident #026 shared that they were offered a beverage in the morning and afternoon but they don't see a snack or beverage in the evening. Resident #021 indicated that in the evening they were not offered a snack or beverage. Resident #024, also reported that it was hit or miss as to whether they were offered a snack or beverage in the evening.

On an identified dated, the nourishment cart was observed sitting in front of the servery on a Neighbourhood at 1900 hours. At 1940 hours the cart had been moved to the front of the nursing station and residents in the lounge were being offered a snack and beverage. A Personal Care Aide was then observed in the hallway beside the lounge, offering beverages and snacks to residents in their rooms. The nourishment cart was then brought back to the nursing station. The PCA did not continue with nourishment service to residents that resided down the other hallway.

During an interview with Registered Practical Nurse (RPN) #146 at 2015 hours, they indicated that the Personal Care Aides usually take the nourishment cart to residents in the lounge and in their rooms between 1900 and 2000 hours. RPN #146 confirmed that it had not been taken down the other hallway beside staff were busy assisting residents with toileting and evening care.

During interviews with resident #053, #054 and #024 they confirmed that a beverage and snack were not offered to them on the identified evening.

The home's policy entitled "Nourishments" dated May 2014, indicated that the nursing team would serve snacks with consideration to information on the nourishment list. Snacks would be served in the morning between 1000-1100, in the afternoon between 1400 – 1500, and in the evening between 1900 – 2000.

The licensee failed to ensure that each resident on the Neighbourhood was offered a between-meal beverage and snack in the evening after dinner. [s. 71. (3) (b)]

2. The licensee has failed to ensure that planned menu items were offered and available

at each meal and snack.

During observation of the noon meal on an identified date, residents at the table with resident #002 were shown plates containing a croissant sandwich and mushroom bake. Two of three residents at the table chose the croissant sandwich.

When the meal was served to the residents, the sandwich provided was on white bread. The staff member serving the meal, apologized to the residents and indicated that there were no croissant sandwiches left. The residents voiced concern that their table frequently was served last and their preferences were no longer available.

The staff member was observed to offer the residents alternative choices and both refused.

Interview with Food Service Aide #124 confirmed that they had run out of croissant sandwiches and had called the kitchen, receiving three additional croissants. Food Service Aide #124 stated that staff serving the meal should have told them that the residents had requested the croissant.

Interview with Food Service Aide #125 confirmed that three croissant sandwiches had been requested and sent to the Neighbourhood from the kitchen and indicated that no additional croissant sandwiches had been requested.

The licensee failed to ensure that planned menu items offered were available at the noon meal, when croissant sandwiches were not available for all residents making this choice. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and a snack in the afternoon and evening; and the licensee shall ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Registered Dietitian (or dietitians) who were members of the staff of the home were on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The licensee had 192 Long-term Care residents requiring 96 Registered Dietitian hours per month.

In November 2015, a new Registered Dietitian started with the home, working with the current Registered Dietitian. Hours were split between the two RD's.

Interview with the Director of Food Services #128 identified that during November and December 2015, the Registered Dietitians had worked a total of 90 hours in each month, six hours short of the required 96 hours.

Contracts for each Registered Dietitian (RD) were reviewed and confirmed with the Director of Food Services #128 and identified that the total number of RD hours contracted for the home were 90 hours, six hours short of the required 96 hours.

Review of invoices provided by the Registered Dietitians for November and December 2015, confirmed the RD's hours to be a total of 90 hours for each of the two months.

The licensee failed to ensure that the Registered Dietitians who were members of the staff of the home were on site a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. [s. 74. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #12: 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:

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. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

During an interview, the Resident Council President #071 revealed that the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

During an interview, the Assistant General Manager #100 confirmed that the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey and the expectation was that the licensee would seek the advice of the Residents' Council. [s. 85. (3)]

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 licensee seeks 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, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, followed by the report required under subsection (4).

On an identified date, three resident's on a Neighbourhood were identified to have enteric signs and symptoms. An enteric outbreak was declared on the Neighbourhood the next day.

Review of the Critical Incident System and interview with the Infection Prevention and Control Nurse #107 and the Director of Resident Care #101 confirmed that the Director was not immediately notified of the outbreak and a critical incident report was not completed until seven days after the outbreak was declared.

The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an enteric outbreak, followed by the report required under subsection (4). [s. 107. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, and in accordance with any conditions that were imposed by the physician, the registered nurse in the extended class or other prescriber.

Interview with the Registered Practical Nurse #114 identified that resident #071 used medication and was allowed to self-administer the medication.

Interview with resident #071, by Inspector #137 confirmed that resident #071 continued to carry a medication on them and self administered the medication.

Review of the Physician Orders for resident #071 failed to identify an order for the resident to keep the drug on his or her person or to self administer the medication. It was noted that the Medication Administration Record (MAR) contained a statement MAR note - resident may carry medication with them.

Interview with the Director of Nursing #101 confirmed that there was no physician order for the resident to self administer or to keep the medication on them.

Record review identified that resident #071 had no physician's order to self administer or to keep the medication on them.

The licensee failed to ensure that resident #071 self administered and kept the medication on them self, with authorization of the physician and in accordance with any conditions that were imposed by the physician. [s. 131. (7)]

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 no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, and in accordance with any conditions that were imposed by the physician, the registered nurse in the extended class or other prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were clean and sanitary.

During observation on a Neighbourhood on an identified date, it was noted that the base of the tub chair was heavily soiled with a white substance on the lift and spills and debris noted on the base.

Interview with the Environmental Services Aide #148 identified that housekeeping were responsible for cleaning the tub room once the bathing has finished for the day but do not clean the equipment in the room.

Interview and observation with Neighbourhood Coordinator #108, in the tub room the Neighbourhood, confirmed that the tub lift was heavily soiled with white substance. It was identified by the Neighbourhood Coordinator #108 as hard water staining running down the lift from the controls to the base; droplets of a spilled substance on the legs of the lift; heavy soiling with a rust coloured substance at the joints in the base of the lift; and a gray substance containing hair and other debris covering the base of the lift; believed by Neighbourhood Coordinator #108 to be soap residue.

The Neighbourhood Coordinator #108 identified that the seat of the lift, where residents would have contact with the lift, would be cleaned by the Personal Care Aide responsible for bathing. The staff member did not identify who would be responsible for cleaning the base of the lift.

The licensee failed to ensure the home, furnishings and equipment were kept clean and sanitary. [s. 15. (2) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive individualized personal

care, including hygiene care and grooming on a daily basis.

Resident #008 was observed on two identified dates, to have long facial hair on their chin and upper lip.

Review of resident #008's plan of care identified that the plan was silent on care of the resident's facial hair.

Interview with the Director of Nursing #101 identified that the plan of care would include specific requirements for the individual care of residents in relation to the removal of facial hair.

Review of the policy titled Spa (Shower, Tub Bath, Sponge Bath), Tab 04-06 dated as revised February 2014 indicated that female residents will have facial hair shaved or plucked as per their personal choice and care plan.

Interview with Personal Care Aide #119 identified that resident #008 would be able to indicate to staff if they wished facial hair to be removed.

Interview with resident #008 confirmed that it would be their preference to have facial hair removed on a regular basis.

The licensee failed to ensure that resident #008 received individualized personal care, including hygiene care and grooming when facial hair was not removed as the resident preferred. [s. 32.]

2. Resident #005 was observed on two identified dates, to have long facial hair on their chin.

Review of resident #005's plan of care identified that the plan was silent on care of the resident's facial hair.

Interview with the Director of Nursing #101 identified that the plan of care would include specific requirements for the individual care of residents in relation to the removal of facial hair.

Review of the policy titled Spa (Shower, Tub Bath, Sponge Bath), Tab 04-06 dated as revised February 2014 indicated that female residents will have facial hair shaved or

plucked as per their personal choice and care plan.

Interview with Personal Care Aide #119 identified that resident #005 would be able to indicate to staff if they wished facial hair to be removed.

Interview with resident #005 confirmed that it would be their preference to have facial hair removed by shaving, on a regular basis.

The licensee failed to ensure that resident #005 received individualized personal care, including hygiene care and grooming when facial hair was not removed as the resident preferred. [s. 32.]

3. Resident #027 was observed on four identified dates, to have long facial hair on their chin.

Review of resident #027's plan of care identified that the plan under the personal hygiene section that resident #027 required limited to extensive assistance of 1-2 care team members to help wash, apply deodorant, brush hair, and shave.

Interviews with Personal Care Aides #131, #132 and #135 revealed that resident #027 had their facial hair shaved on their shower days unless they refused. Review of the spa schedule for indicated that resident #027 had their shower on an identified date. Personal Care Aide #131 confirmed that resident #017 had long facial hair on their chin, one day after the resident #027 was identified to having had a shower.

The licensee failed to ensure that resident #027 received individualized personal care, including hygiene care and grooming when facial hair was not removed as per the residents preference identified in the plan of care. [s. 32.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

Resident #005 was identified to have long finger nails. The finger nails on the resident's left hand were observed to be long and rough, a black substance was observed under the nails.

Review of the flow sheet identified that the resident had been showered and that nail care had been provided on the same day and on two days prior.

Review of the residents progress notes failed to identify that the resident had refused nail care during bathing.

Review of the residents plan of care indicated that nail care and skin assessment was to be completed by staff on bath day.

Interview with the resident #005 confirmed that their nails were too long, rough, dirty and required attention.

The home's policy, confirmed by the Director of Nursing #101, titled "Spa (Shower, Tub Bath, Sponge Bath)", Tab 04-06 dated as revised February 2014, indicted that after bathing is completed, nail care to feet and hands was to be provided. [s. 35. (2)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 27th day of April, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHARON PERRY (155), DEBORA SAVILLE (192), DOROTHY GINTHER (568), MARIAN MACDONALD (137)
Inspection No. / No de l'inspection :	2016_448155_0002
Log No. / Registre no:	000864-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 17, 2016
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bryce McBain

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The home shall prepare, submit and implement a plan to ensure that the following plans, policies, protocols, procedures, strategies or systems instituted or otherwise put in place are complied with specifically related to:

a) Fall Prevention and Management policy in regards to assessment of resident each shift for 24 hours after the fall by the registered team member and a progress note completed for three shifts; and a post -falls analysis being completed by the registered team member 24 hours after the fall.
b)Nutrition and Hydration policy in regards to documentation of the food and fluid intake of residents on the flow sheets at the time of meal and snack service; nutrition and hydration flow sheets being tallied and reviewed and initialled by the Registered Nurse/Registered Practical Nurse; dehydration risk assessment tools being completed as per policy ; and requests for nutrition consultation being completed as per policy.
c)Weight and Height Monitory policy in regards to completion of requests for nutritional consultations being completed for weight loss or gain of two kilograms from the previous month.
d) Head Injury Routine policy in regards to the neurological/head injury vital signs being completed as set out in the policy.
e) Spa (Shower, tub Bath, Sponge Bath) policy in regards to the documentation of the type of spa provided and the level of assistance provide on the PSW flow sheet, including nail and skin care. If resident declined their spa it is to be documented as per policy.
f) Personal Care Ware policy in regards to staff ensuring that personal ware, including basins and bedpans, are stored as per policy and not placed on the floor.
g) Food temperature Control policy in regards to food temperature checks being conducted as per policy.
h) Catheter (Urethral / Supra Pubic) policy in regards to recording output on the PSW flow sheets/output records.

The plan must include what immediate and long-term actions will be undertaken to ensure there is a process in place to monitor on-going compliance including education, as well as who will be responsible and the dates for completion.

Please submit the plan, in writing, to Sharon Perry, Long-Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance and Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, by email, at Sharon.Perry@Ontario.ca by April 1, 2016.

Grounds / Motifs :

1. This legislation/regulation was previously issued:
-as a written notification and voluntary plan of correction on October 13, 2015, inspection number 2015_355588_0028;
-as a written notification on June 12, 2015, inspection number 2015_325568_0017;
-as a written notification and compliance order on May 11, 2015, inspection number 2015_217137_0021;
-as a written notification and voluntary plan of correction on April 14, 2015, inspection number 2015_226192_0018;
-as a written notification on December 30, 2014, inspection number 2014_303563_0065;
-as a written notification and voluntary plan of correction on November 19, 2014, inspection number 2014_253514_0037;
-as a written notification and voluntary plan of correction on October 16, 2014, inspection number 2014_183135_0086;
-as a written notification and voluntary plan of correction on October 15, 2014, inspection number 2014_183135_0085;
-as a written notification and voluntary plan of correction on August 1, 2014, inspection number 2014_271532_0026;
-as a written notification and voluntary plan of correction on June 4, 2014, inspection number 2014_183135_0040;
-as a written notification and voluntary plan of correction on May 16, 2014, inspection number 2014_228172_0007;
-as a written notification and voluntary plan of correction on April 22, 2014, inspection number 2014_228172_0004;
-as a written notification and voluntary plan of correction on April 14, 2014, inspection number 2014_226192_0012;
-as a written notification and voluntary plan of correction on November 1, 2013, inspection number 2013_202165_0023;
-as a written notification and voluntary plan of correction on October 17, 2013, inspection numbers 2013_202165_0018, 2013_226192_0016 and 2013_226192_0017;
-as a written notification and voluntary plan of correction on August 21, 2013, inspection number 2013_170203_0039; and
-as a written notification and compliance order on June 28, 2013, inspection number 2013_232112_0001.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy titled "Fall Prevention and Management", Tab 04-33, dated February 2013, indicated:
-the resident would be assessed each shift for 24 hours after the fall by the registered team member who was on the Neighbourhood and a progress note would be completed for three shifts; and,
-a post-fall analysis would be completed by the registered team member 24 hours after the fall occurred.

Record review of resident #029's clinical record revealed that the resident had fallen on identified dates.
There were no progress notes completed for three shifts for a fall on a identified date.
There were no post falls analysis completed at any time for the falls on two identified dates.

The Director of Nursing #101 confirmed that the progress notes were not completed for three shifts for an identified fall. They also confirmed that there were no post falls analysis completed for two identified falls.

The home failed to ensure that the Falls Prevention and Management policy was complied with.
(155)

2. The home's policy titled "Nutrition and Hydration", Tab 04-46, dated April 2014, indicated that each evening, the Nutrition and Hydration Flow Sheets would be tallied by the night Personal Care Aide (PCA) team, which would include the Daily Additional Fluids Chart. The night Registered Practical Nurse/Registered Nurse (RPN/RN) would review and initial the total daily fluid intake. Any resident who had a fluid intake, less than their estimated fluid requirements, would be reported to the oncoming RPN/RN so that interventions could be initiated. The RPN/RN would assess for signs and symptoms of dehydration (Dehydration Risk Assessment Tool). If a resident exhibited signs and symptoms of dehydration (as documented in the Dehydration Risk Assessment Tool), ensure the request for Nutrition consultation (Tab 07-41) had been initiated for the Registered Dietitian to assess. The Request for Nutrition Consultation would be completed when a resident had a fluid intake of less than

1000 millilitres per individual fluid requirement, as per the plan of care, for three consecutive days and there was at least one sign or symptom of dehydration present.

A review of resident #027's Nutrition and Hydration Flow Sheet revealed that there were no total daily fluid intakes done for 10 of 26 days and there were no RPN/RN initials for 26 of 26 days. Resident #027's nutritional plan of care identified their daily fluid requirement. During an identified period of time, the fluid totals for resident #027 were under the requirement. Record review also revealed that there were no Dehydration Risk Assessments completed for resident #027.

The RAI/QI Coordinator #122 confirmed that there was to be a Dehydration Risk Assessment completed if a resident had a fluid consumption of less than their requirement for three consecutive days. They also confirmed that resident #027 had not had a Dehydration Risk Assessment completed at anytime during the identified period when their fluid consumption was less then their requirement. They also confirmed that there was no request for nutrition consultation made to the registered dietitian.

The home failed to ensure that the Nutrition and Hydration policy was complied with. (155)

3. The licensee's policy titled "Weight and Height Monitoring", Tab 07-32, dated August 2015, indicated that when a monthly weight identified a weight loss or gain of two kilograms (kg) from the previous month, a reweigh would be completed and when unplanned weight change was identified, the Team Leader would be notified and complete a Request for Nutrition Consultation to be given to the Director of Food Services and Registered Dietitian.

Record review for resident #002 identified that they had experienced a weight change of greater than two kilograms during an identified period of time. A nutritional note completed by the Assistant Director of Food Services #129, confirmed the weight change and the need to complete a referral to the Registered Dietitian.

Interview with the Assistant Director of Food Services #129 and the Registered Dietitian #130 confirmed that a referral had not been forwarded to the Registered Dietitian with regard to resident #002's weight change of greater than

two kg.

Interview with the Registered Practical Nurse #114 confirmed that no referral to the Registered Dietitian had been completed, in relation to weight change greater than two kg during an identified period.

The licensee failed to ensure that the Weight and Height policy was complied with, when resident #002 demonstrated a weight change of greater than two kilograms during two identified periods of time.

(192)

4. The home's policy titled "Head Injury Routine", Tab 04-30, dated January 2013, indicated that for any known or possible head injury,the Team Leader in the Neighbourhood was responsible for starting the Head Injury Routine immediately, using the Neurological/Head Injury Vital Signs Record form, with all sections being completed for the following time periods; every fifteen minutes, once; every thirty minutes for two hours; every hour, twice; every four hours for twenty-four hours and every shift for two days.

Review of the Head Injury Vital Signs Record for resident #002 for an identified dated, identified that one of two required hourly checks and two of six required four hourly checks had not been documented. Review of the Head Injury Vital Signs Record for an identified date, indicated that one of two required hourly checks, one of four required four hourly checks and one of six required shift checks were not completed. Review of the Head Injury Vital Signs Record for an identified dated, indicated that one of four required four hourly checks and one of six required shift checks were not completed.

Review of the Head Injury Vital Signs Record for resident #005 for an identified date, indicated that three of four required thirty minute checks, one of two required hourly checks and one of six required shift checks were not completed. Review of the Head Injury Vital Signs Report for another identified date, indicated that two of six required four hourly checks and one of six required shift checks were not completed.

Review of four Head Injury Vital Signs Records for resident #029, for identified dates, revealed that the checks were not completed as per the policy.

Interview with Director of Nursing #101 confirmed that the Neurological/Head Injury Vital Signs Record should be completed for each of the time frames and especially during the initial resident checks.

The licensee failed to ensure that the Head Injury Routine policy was complied with when not all sections were completed for the required time periods. (192)

5. The home's policy titled "Spa (Shower, Tub Bath, Sponge Bath)", tab 04-06, dated February 2014, indicated to document the type of spa provided and the level of assistance provided on the PSW Flow Sheet, including nail and skin care. It also indicated that when a resident declined their spa, after multiple attempts and negotiation, it must be documented on the Personal Support Worker (PSW) Flow sheet under 'bathing' as well as in the 'behaviour' section.

Review of resident's #027 Personal Care Observation and Monitoring Form (PSW Flow Sheets) for a one week period, revealed that resident #027 refused their shower on an identified date, however there was nothing documented under the behaviour section. Review of resident's #027 Personal Care Observation and Monitoring Form for two subsequent weeks revealed no documentation under the bathing or behaviour sections.

Interview with the Director of Nursing #101 identified that bathing was to be documented on the Personal Care Observation and Monitoring Form (PSW Flow Sheets).

The licensee failed to ensure that the Spa policy was complied with. (155)

6. The home's policy titled "Personal Care Ware", Tab 06-02, dated as reviewed January 2015, stated that staff were to ensure that personal ware, including basins and bedpans, were not placed on the floor.

During observation on an identified date, it was noted that two blue basins and a k-basin were placed on the floor beside the toilet in the bathroom in a resident room. The personal ware was again observed on the floor on subsequent identified date. Interview with Registered Practical Nurse #114 confirmed that blue ware should not be on the floor.

During observation on an identified date, Inspector #155 noted that a bedpan was on the floor in the bathroom in another resident room. The personal ware

was again observed on the floor on a subsequent date. Interview with Registered Practical Nurse #157 confirmed that personal ware were to be cleaned weekly and should be stored on available shelves, not on the floor.

The licensee failed to ensure that the "Personal Care Ware" policy was complied with. (192)

7. A review of the "Food Temperature Control" policy, Tab 09-28, dated February 5, 2015, revealed "food temperature checks must be conducted daily, just prior to food leaving the kitchen, at point of service and at end of service. Any food item found to be below the optimum temperature should be reheated to an acceptable temperature".

During stage one of the this inspection, four residents expressed concerns that their food was cold.

During this inspection on identified dates, a review of the food temperature records on an identified Neighbourhood revealed food temperatures were not recorded for two of four (50 percent) lunch meals.

During an interview, with the Director of Food Services # 128, it was confirmed that food temperatures had not been recorded, the expectation was that food temperature checks must be conducted daily, just prior to food leaving the kitchen, at point of service and at end of service and the home's policy was not complied with.
(137)

8. The home's policy entitled "Nutrition and Hydration" dated April 2014, indicated that the Nutrition and Hydration binders would be placed on the Teacart at the time of each nourishment service by the Food Services Team. The intake of food and fluid would be documented on the flow sheets in the Nutrition and Hydration binder, at the time of service.

a) On an identified date, Recreation Aide #127 was observed serving beverages from the Teacart on a Neighbourhood between 1050 and 1130 hours. The Recreation Aide #127 was also observed to assist some residents with feeding in the lounge and in their individual rooms on the Neighbourhood. Documentation with regard to intake was not observed and the Nutrition and Hydration binder was not evident on the Teacart.

During an interview with Recreation Aide #127, they indicated that documentation, with respect to intake, would be done by the Personal Care Aide (PCA) on the Nutrition and Hydration flow sheets. The staff member reported that they would sit down with the PCA to assist them with completing the flow sheets. When asked how they could recall the individual intakes, the staff member indicated that they had a very good memory.

b) During observations on an identified date, of the afternoon Teacart on another Neighbourhood PCA #153 was observed serving beverages and snacks to residents in the lounge and in their rooms. The Nutrition and Hydration binder was not observed on the Teacart and PCA #153 was not observed documenting individual intakes.

During an interview with PCA #153, they shared that they document the intakes after they have completed the Teacart service. When asked how they would remember what each resident had consumed, the staff member reported that they had a good memory.

c) On an identified date, PCA #134 was documenting food and fluid intakes for breakfast, morning Teacart, and lunch for resident #027 and all other residents residing on an identified Neighbourhood. PCA's #131, #132 and #133 were present with PCA #134. They indicated that they usually tried to document at the time of the meal or snack but most often they did not have time. When asked how they could recall what each resident ate and drank, they indicated they did it from memory.

The Director of Nursing #101 confirmed that documentation of flood and fluids was to be done at the time of the meal or Teacart.

Staff interview with the Director of Food Services #128 confirmed that it was the home's expectation that staff document resident food and fluid intakes at the time of service. The Nutrition and Hydration binders were to be kept in the dining room during meals and on the Teacart during snack service to facilitate documentation.

The licensee failed to ensure that the Nutrition and Hydration policy was complied with. (568)

9. The home's policy, "Catheter (Urethral / Supra Pubic)" dated August 2014, identified under the procedure that the PSW staff would empty the catheter bag at the end of every shift, or more frequently if required. The amount would be entered on the PSW Flow Sheets/Output Record. If output was less than 400 millilitres per shift, the PSW would report immediately to the Team Leader.

Review of the plan of care for resident #036 indicated that the resident had a catheter. The Personal Care Observation and Monitoring Forms for an identified period of time, indicated that outputs were not documented on all shifts, on fourteen of the twenty one days (67 percent).

Interview with a Registered Practical Nurse (RPN) #117 revealed that for residents with a catheter, the expectation was that care staff were to empty the catheter drainage bag at least once a shift and record the output on the PCA flow sheets. The RPN confirmed that care staff had not documented the outputs for resident #036 on each shift during the twenty one day period.

The licensee failed to ensure that the Catheter Care policy was complied with.

The scope of this area of non-compliance is widespread, despite Ministry of Health action (voluntary plans of correction and compliance orders) non-compliance continues with the original area of non-compliance and the severity is determined to be a level 2. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must take action to ensure that the home has a written description of the continence care and bowel management program, that includes but is not limited to, goals and objectives, relevant protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required. The licensee shall also ensure that the continence care and bowel management program is implemented in the home as required under section 48 of this Regulation.

Grounds / Motifs :

1. The licensee has failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that included its goals and objectives, relevant protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required.

Record review and staff interview with the Director of Care #101 and Assistant General Manager #100 revealed that the home did not have a written description of the continence care and bowel management program that included goals and objectives, relevant protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required. The Assistant General Manager #100 indicated that continence care had been identified as an area of quality improvement and they were in the process of developing a more comprehensive program. [s. 30. (1) 1.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #045 was identified on the Daily Infection Control Surveillance record to be exhibiting respiratory symptoms.

Review of the progress notes for resident #045, confirmed by the Director of Resident Care #101, failed to identify that the presence of symptoms of infection, as identified under the Infection Prevention and Control Program, were documented in resident #045's medical record.

The scope of this area of non-compliance is pattern, there is previous related non-compliance and the severity is determined to be a level 2. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The home shall prepare, submit and implement a plan to ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and includes a back up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

The plan must include what immediate and long-term actions will be undertaken to ensure there is a process in place to monitor on-going compliance, as well as who will be responsible, specifically related to call bell response time monitoring and the monitoring of coverage of Personal Care Aide shifts.

Please submit the plan, in writing, to Sharon Perry, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, by email, at Sharon.Perry@ontario.ca by April 1, 2016.

Grounds / Motifs :

1. This legislation/regulation was previously issued:
-as a written notification and compliance order #003 on June 8, 2015, inspection number 2015_217137_0021 and complied on October 27, 2015;
-as a written notification and compliance order #001 on May 26, 2014, inspection number 2014_228172_0004 and complied on November 22, 2014; and
-as a written notification and compliance order #001 on Mach 17, 2014, inspection number 2014_202165_0005.

A) Resident interviews and call bell response times for the month of December 2015 revealed:

a) Resident #026 shared that they were often left waiting when they call for assistance. On average they wait 15 minutes but sometimes it was 45 minutes and they didn't make it to the bathroom in time.

Review of the call bell response records indicated that on four occasions the time, between when resident #026 activated the call bell and when it was cancelled, exceeded 15 minutes. The response time on one of these four occasions exceeded 30 minutes.

b) Resident #024 reported that they go to bed. The resident stated that they ring for help but are often left for more than an hour. Staff would come in and shut off the call bell and then leave without providing care.

Review of the call bell response records indicated that on an identified date, the call bell was activated at 21:04 hours and cancelled in 19:23 minutes.

c) Resident #025 shared that they called for assistance to go to the washroom and sometimes had to wait more than 15 minutes.

Review of the call bell response records indicated that on an identified date, the call bell was activated at 06:13 hours and cancelled in 24:23 minutes; on another identified date, the call bell was activated at 08:18 hours and cancelled in 15:00 minutes; and on another date, the call bell was activated at 07:50 hours and cancelled in 16:50 minutes.

d) Resident #032 shared that they sometimes had to wait more than 15 minutes when they call for assistance to use the bathroom.

Review of the call bell response records indicated that on eight occasions the time, between when resident #032 activated their call bell and when it was cancelled, exceeded 15 minutes.

Resident #032's plan of care indicated that the resident was able to verbalize when they wanted to go to the washroom. The resident required two staff to provide extensive assistance for some aspects of toileting. The Minimum Data Set (MDS) most recent assessment identified that the resident's urinary continence had declined.

Staff interview with Personal Care Aide (PCA) # 141 revealed that resident #032 was usually continent of bladder, the PCA indicated that sometimes the resident was incontinent because they wait too long before calling and staff were not able to reach them in time.

e) Resident #036 reported that sometimes they pushed their button and staff respond, and other times they waited a very long time when they needed help.

Review of the call bell response records indicated that on 15 occasions the time, between when resident #036 activated their call bell and when it was cancelled exceeded 15 minutes. On three of these fifteen occasions the response time exceeded 30 minutes.

f) Resident #001 shared that sometimes staff said they would be back in a minute and it was between 10 to 20 minutes before they returned. The resident stated that because of this delay, they were not able to get to the bathroom in time.

Review of the call bell response records indicated that on six occasions the time, between when resident #001 activated their call bell and when it was cancelled, exceeded 15 minutes.

B) Recreation Aide #127 shared with Inspector #568 that they had been approached by a Personal Care Aide on a Neighbourhood and asked if they would manage the nourishment cart because they were behind with resident care. The Recreation Aide commenced the morning nourishment cart service at

1050 hours and completed it at 1130.

On January 28, 2015 on a Neighbourhood the nourishment cart was available on the unit at 1900 hours. At 2025 hours residents down one of the halls had not been offered a snack or beverage from the cart. Registered Practical Nurse #146 confirmed that staff had been too busy with resident care to complete the nourishment cart service.

Interview with Staffing Coordinator #144 revealed that when they were unable to fill a shift, staff that were cross trained within the Neighbourhood would attempt to carry out as many non-direct care activities as possible. If the vacant shift was on evenings then they would pull their "Tower Support" person to cover.

Review of the "Shifts Not Covered" report for December 2015 revealed that there were 15 day shifts (0600 to 1400/0700to 1500); 30 evening shifts (1400 to 2200/1500to 2300); five 1000 to 1800 shifts, and four night shifts (2200 to 0600/2300 to 0700) not covered.

Concerns were raised at the Resident's Council meeting June 25, 2015 about staff not being available during peak times, like bed time, when they were most needed. A second concern was raised at the August 20, 2015 meeting, with regards to insufficient staff in the dining rooms on two identified Neighbourhoods, because they were on their breaks.

A review of the call bell response records for one identified Neighbourhood, for December 2015, revealed that there were 79 documented entries where the call bell response time was over 15 minutes. On one identified Neighbourhood there were 98 documented entries where the call bell response time was over 15 minutes. On another identified Neighbourhood, there were 40 documented entries where the call bell response time was over 15 minutes.

Interview with the Assistant General Manager #100 and Neighbourhood Coordinators #108 and #123 revealed that they do a monthly audit of call bell response times on each Neighbourhood. The staff indicated that they look at the average response times, as well as some of the individual response times. When asked what the expectation was in terms of an acceptable response time, the staff indicated that the expectation was that response times would be at or below the average on the Neighbourhood. The average call bell response time in December 2015 on one identified Neighbourhood was 4:09 minutes, on

another Neighbourhood 3:41 minutes, and on another Neighbourhood 3:34 minutes.
(568)

2. The licensee failed to ensure that there was a written staffing plan that included a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage cannot come to work.
Review of the home's staffing plan and interview with the Assistant General Manager #100 confirmed that the home did not have a written back-up plan that addressed situations when staff, including staff that must provide the nursing coverage, cannot come to work.

The scope of this area of non-compliance is widespread and despite Ministry of Health Action (voluntary plan of correction, compliance order) non-compliance continues with the original area of non-compliance and the severity is determined to be a level 3.
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2015_217137_0041, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must take action to achieve compliance with O.Reg 79/10, s.73.(1) 10. by:

a) Ensuring staff use proper techniques to assist resident #052 and any other residents with eating, including safe positioning of residents who require assistance.

b) Ensuring all direct care staff, volunteers and students receive education related to proper techniques used to assist residents, with eating, including safe positioning of residents who require assistance.

c) Ensuring there is a process in place to monitor on-going compliance in order that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

Grounds / Motifs :

1. This legislation/regulation was previously issued:
-as a written notification and compliance order #002 on October 27, 2015, inspection number 2015_217137_0041; and
-as a written notification and compliance order #005 on June 8, 2015, inspection number 2015_217137_0021.

The previous orders were related to not ensuring all direct care staff, volunteers and students received education related to using proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

Interviews, with the Director of Care # 101, Recreation Aide # 140 and Volunteer Coordinator # 139, revealed a total of approximately 125 Personal Care Aides (PCA), 50 Registered Nursing staff, six recreation aides and five volunteers provided dining assistance to residents.

A review of in-service records, between October 21-23, 2015, revealed approximately 59/186 (31.72 percent) of direct care staff and volunteers, (excluding students as records were not available), received education related to proper techniques used to assist residents with eating, including safe positioning of residents who require assistance.

During an interview, with the Assistant Director of Food Services (ADFS) #129, it

was confirmed that education had not been provided to all direct care staff, volunteers and students, related to proper techniques used to assist residents with eating, including safe positioning of residents who require assistance.

(137)

2. Record review revealed that resident # 052 was at risk for choking. The resident was to be provided with a specific diet. Staff were to encourage the resident to self feed but if they refused, staff were to provide total feeding assistance.

On an identified date, Personal Care Aide (PCA) #158 was observed standing beside resident #052 who was seated in a wheelchair, tilted approximately 30 degrees. The staff member was noted to be feeding the resident. As the inspector approached, resident #052 was heard coughing repeatedly, while PCA #158 continued to feed the resident.

During an interview with the Neighbourhood Coordinator #123, it was acknowledged that resident #052 was at risk for choking. The Neighbourhood Coordinator #123 confirmed that it was their expectation that residents would be seated as upright as possible and staff would be either seated or at eye level when providing assistance with feeding.

The licensee failed to ensure that proper techniques were used to assist resident #052 with eating, including safe positioning.

The scope of this area of non-compliance is widespread and despite Ministry of Health action (voluntary plan of correction, compliance order) non-compliance continues with original area of non-compliance and the severity is determined to be actual harm/risk.

(568)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must take action to ensure compliance with O.Reg. s.73.(1) 4. by ensuring resident #041, #042 and all other residents are monitored during meals.

Grounds / Motifs :

1. During observation on an identified date, at 1100 hours it was observed that resident #041 was sitting with breakfast on the table in front of them. No staff were present in the dining room or in the vicinity of the dining room. The plan of care for resident #041 under Nutrition identified that the resident required intermittent cueing and under Activities of Daily Living (ADL's) indicated the resident was to be watched closely.
Observation of the breakfast and lunch meals, for resident #041, identified that staff fed the resident. Interview with Personal Care Aide #143 confirmed that resident #041 required total assistance with eating and staff had been feeding the resident.

During observation on an identified date, resident #042 was observed attempting to eat their breakfast meal in the Dining Room. The resident was observed to be positioned in a reclined chair with a table in front of them. Review of the plan of care identified that the resident had been flagged as being at high risk of choking and specific interventions were identified. No staff were noted in the servery or dining room. During observation over a twenty minute period, no staff came to check on the resident or approached the resident. Staff passed by in the corridor but were preoccupied with other activities.

The scope of this area of non-compliance is pattern, there is previous related non-compliance and the severity is determined to be a level 2.
(192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must take action to achieve compliance with O.Reg. 79/10, 229. (5) (a) to ensure that on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices.

Grounds / Motifs :

1. The home identified an outbreak on January 18, 2016 and another type of outbreak on January 21, 2016.

A) Record review for resident #049 identified that the resident was documented to have a symptom and refused intake one day prior to being added to the Daily Infection Control Surveillance form.

Interview with the Director of Nursing #101 confirmed that when a resident exhibited symptoms of potential infection, they were to be added to the Daily Infection Control Surveillance form, for ongoing monitoring each shift.

Resident #049 was documented to have symptoms of infection. Four days later, resident #049 was documented to have more symptoms of infection and was added to the Daily Infection Control Surveillance.

Interview with the Director of Nursing #101 confirmed that resident #049 should have been included on the Daily Infection Control Surveillance when first exhibiting symptoms of respiratory infection.

B) Record review identified that resident #048 exhibited signs and symptoms of infection and was diagnosed with an infection by the physician two days later. Record review identified that resident #048 continued to exhibit signs and symptoms of respiratory infection nine days later. Thirteen days later when resident #048 was still having signs and symptoms of infection, resident #048 was then added to the Daily Infection Control Surveillance record.

Interview with the Director of Nursing #101 confirmed that resident #048 had not been included on the Daily Infection Control Surveillance record when they exhibited signs and symptoms of infection.

C) Review of the medical record for resident #043, confirmed by the Director of Nursing #101, identified that one day prior to being included on the Daily Infection Control Surveillance record, resident #043 exhibited signs and symptoms of infection.

D) Review of the medical record for resident #046, confirmed by the Director of Nursing #101, identified that one day prior to being included on the Daily Infection Control Surveillance record, resident #046 exhibited signs and symptoms of infection.

The home's definition of respiratory outbreak, identified in "Managing a Respiratory Outbreak" policy, tab 04-05, dated September 2013, indicated that whenever there are two cases of acute respiratory illness within 48 hours on one Neighbourhood, an outbreak should be considered.

Residents #048 and #049 from an identified Neighbourhood who exhibited two or more symptoms of respiratory illness over the same period, were not included on the Daily Infection Control Surveillance record. Addition of these residents to the Daily Infection Control Surveillance record may have potentially resulted in an identified outbreak three days prior to when the home confirmed the outbreak.

The licensee failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices when residents #043, #046, #048, #049 were not included on the homes Daily Infection Control Surveillance record when they first exhibited signs and symptoms of infection.

The scope of this area of non-compliance is pattern, there is previous related non-compliance and the severity is determined to be a level 2. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must take action to achieve compliance with LTCHA, 2007 S.O. 2007, c.8, s.6. 10. (b) by:

a) Ensuring that all residents are reassessed and the plan of care is reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

b) Ensure that resident #002's plan of care is reviewed and revised to include additional interventions related to falls prevention and the required assistance with care.

c) Ensure that resident #055's plan of care is reviewed and revised to include interventions related to falls prevention including the type of assistance and supervision required with activities of daily living specifically related to toileting.

Grounds / Motifs :

1. This legislation/regulation was previously issued:
-as a written notification and voluntary plan of correction on August 27, 2014, inspection number 2014_226192_0029;
-as a written notification on April 24, 2014, inspection number 2014_226192_0011;
-as a written notification on April 14, 2014, inspection number

2014_226192_0012;
-as a written notification and voluntary plan of correction on October 17, 2013, inspection number 2013_202165_0018;
-as a written notification and voluntary plan of correction on October 17, 2013, inspection number 2013_226192_0016;
-as a written notification, voluntary plan of correction, and compliance order #001 on December 3, 2013, inspection number 2013_226192_0017; and
-as a written notification and voluntary plan of correction on October 16, 2013, inspection number 2013_183135_0059.

Record review revealed that on an identified date, resident #055 had a fall while unattended. When assessed, the resident was noted to have injuries. The Post Fall Huddle form and the Falls Report for the identified month, on the Neighbourhood, identified as a new intervention that resident #055 must be supervised.

During a staff interview with Personal Care Aide #136 they acknowledged that resident #055 was at risk to fall. The PCA indicated that resident #055 was to be supervised. When asked how staff were updated about changes to the plan of care, the PCA indicated that this was done through verbal communication with other staff, at shift report, and by reading the communication book. There was also a reference sheet in the flow sheet binder for each resident which was derived from the care plan.

A review of the plan on care for resident #055, done fifty-five days after the fall, identified there was no documentation within the plan of care to identify that the resident must be supervised.

Director of Nursing #101 shared that following resident #055's fall, the resident was reassessed and it was determined that they must be supervised. Director of Nursing #101 confirmed that the plan of care was not revised to reflect this change.

(568)

2. Resident #002 sustained a fall on an identified date. Post fall, the resident complained of pain.

Record review identified that on the day following the fall, resident #002 had problems breathing and had pain. Medications were added and the resident was started on specialized therapy. The resident complained of ongoing discomfort three days after the fall. Fourteen days after the fall, the resident continued to have problems breathing and had pain.

Thirteen days after the fall, resident #002 was observed in their lounge chair with slacks around their thighs, they were short of breath and the therapy was observed to be not in place.

On an identified date, the resident sustained a subsequent fall that resulted in a change in skin integrity. The Kinesiologist #121 confirmed that the post fall assessment did not identify that a Skin Assessment had been completed or that the plan of care had been revised.

Interview with the Director of Nursing #101 and Kinesiologist #121 confirmed that there had been a change in the resident's condition.

Interview with the Kinesiologist #121 confirmed that post fall assessments failed to identify new interventions for resident #002 in relation to the prevention of falls or minimizing injury related to falls. The Kinesiologist #121 also indicated it would be expected that a huddle would be held post fall and that suggested new interventions for the resident would be recorded by the team for consideration and/or implementation. The Kinesiologist #121 confirmed that there was no record of a post fall huddle or recommended intervention for resident #002 in relation to the second fall and that with recent changes in condition it would be expected that additional interventions would be put into place for resident #002 in relation to fall prevention and required assistance with care.

The licensee failed to ensure that the plan of care for resident #002 was reviewed and revised when the resident's care needs changed.

The scope of this area of non-compliance is pattern, despite Ministry of Health action (voluntary plans of correction and compliance order) non compliance continues with the original area of non-compliance and the severity is determined to be a level 2. (192)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 17th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHARON PERRY

Service Area Office /
Bureau régional de services : London Service Area Office