Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 23, 2016	2016_215123_0009	015288-16	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

ORCHARD TERRACE CARE CENTRE
199 GLOVER ROAD STONEY CREEK ON L8E 5J2

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

MELODY GRAY (123), CAROL POLCZ (156), CATHIE ROBITAILLE (536), LESLEY EDWARDS (506)

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): May 25, 26, 27, 30, 31, June 1, 2, 3, 7, 8, 9, 10, 13, 14, 15, 16, 20, 21, 22, 23 and 24, 2016

The following inspections were completed concurrently with the RQI:

Complaints
028471-15 related to alleged abuse

013016-16 related to personal care and assistance, dietary, alleged abuse, safe and secure home
003165-16 related to personal care
004675-16 related personal care, dietary, safe and secure home, alleged abuse, staffing and laundry services
014596-16 related to personal care, safe and secure home, alleged abuse and alleged retaliation
013385-16 related to transfers, safe and secure home, housekeeping, staffing and alleged abuse
015991-16 related to alleged abuse, transferring and positioning
018321-16 related to alleged abuse
005941-16 related to dining and snack service

Critical Incidents
026338-15 related to fall
032338-15 related to staffing, personal care and assistance and alleged neglect
034341-15 related to alleged abuse
016041-16 related to personal care and assistance, staffing and alleged abuse
013076-16 related to alleged resident-to-resident abuse
002591-16 related to improper transfer
018932-16 related to alleged abuse
018822-16 related to alleged abuse
017763-16 related to lifts and transfers and alleged abuse and neglect
017937-16 related to alleged abuse

Follow-up
033395-15 related to bed rails
033400-15 related to abuse
033401-15 related to staffing
033406-15 related to transferring and positioning
033417-15 related to bathing

During the course of the inspection, the inspector(s) spoke with : residents, family members, Personal Support Workers (PSWs), Director of Care (DOC), Administrator, Environmental Services Manager (ESM), program staff, Registered Dietitian (RD); Food Services Manager (FSM), the cook, the Quality Manager, dietary staff and housekeepers

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **15 VPC(s)**
- **5 CO(s)**
- **0 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. 15. (1)	CO #001	2015_210169_0014	536
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2015_210169_0014	123
O.Reg 79/10 s. 31. (3)	CO #003	2015_210169_0014	123
O.Reg 79/10 s. 33.	CO #005	2015_210169_0014	156
O.Reg 79/10 s. 36.	CO #004	2015_210169_0014	536

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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, (e) was available in every area accessible by residents as evidenced by:

A) It was identified that the home did not have a resident-staff communication and response system located in the secured outdoor area used by residents. Interview with the Administrator confirmed that a resident-staff communication and response system was not available in the identified area, which was accessible by residents. (506)

B) Residents were observed sitting and participating in program activities in the front lounge area of the home throughout the inspection. Families were also observed using the area while visiting with residents. No resident-staff communication and response system was observed in the area. The Administrator was interviewed and confirmed that the front lounge area was used by residents for programming activities and that families also used the space while visiting the residents. The Administrator confirmed that the home was not equipped with a resident-staff communication and response system in the front lounge area that, was accessible to residents. [s. 17. (1) (e)]

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status as evidenced by:

A) Resident #001 was noted to have an assessed goal weight range of an identified number of kilograms (kg). The resident's weight was recorded between December 2015 and May 2016.

i) The documented weight in April 2016 represented a weight change of more than seven point five per cent over three months when compared with February 2016. The April 2016 weight also represented a weight change of over five per cent over one month when compared to March 2016.
ii) The May 2016 weight represented a weight change of over ten per cent weight change over six months when compared to December 2015.
The resident was assessed by the Registered Dietitian (RD) as part of the nutritional

quarterly review in April 2016; however, three days later the weight was noted to have decreased by greater than five percent in one month. The RD and the Director of Care (DOC) were interviewed and confirmed that the significant weight change was not referred to the RD by the interdisciplinary team. The weight changes as noted above were not assessed using an interdisciplinary approach, actions were not taken and outcomes were not evaluated as confirmed by the RD and DOC.

B) Resident #003 was noted to have an identified assessed goal weight range. The resident's weight was recorded in April 2016 and in May 2016 which represented a weight change of over five per cent in one month. The DOC confirmed that it was the expectation of the home that the residents with significant weight change were to be assessed by the RD on the next visit; however, the weight change had not been assessed by the RD. The significant weight change was not referred to the RD by the interdisciplinary team. The DOC and the RD confirmed that the weight change was not assessed using an interdisciplinary approach, actions were not taken and outcomes were not evaluated.

C) Resident #004 was noted to have an identified assessed goal weight range. The resident's weight was recorded in March 2016 and in April 2016, which represented a weight change of over ten per cent in one month. The DOC confirmed that it was the expectation of the home that the resident with significant weight change be assessed by the RD on the next visit. In this case, the RD was in the home in April 2016; however, did not assess the weight change until May 2016, when it was noticed during the completion of the nutritional quarterly review. The significant weight change was not referred to the RD by the interdisciplinary team. The weight change was not assessed using an interdisciplinary approach, actions were not taken and outcomes were not evaluated as confirmed with the RD and DOC.

D) Resident #051 was noted to have weights recorded between October 2015 and June 2016. The February 2016 weight represented a significant weight change of over seven point five per cent over three months when compared to the November 2015 weight. The RD saw the resident twice in February 2016 related to diet texture; however, the resident's significant weight change was not addressed until the next RD visit in May 2016. The weight change was not assessed using an interdisciplinary approach, actions were taken and outcomes were not evaluated as confirmed with the DOC. [s. 69.]

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. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

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

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system must, at a minimum, provide for, standardized recipes and production sheets for all menus as evidenced by:

A) The Food Services Manager (FSM) was interviewed and confirmed that there were no current production sheets in the home to effectively guide food production. The FSM reported that any production sheets they had in the home were from November 2015 and did not accurately reflect food production or current production numbers for the home.

B) During the kitchen tour, the cook was interviewed and confirmed that there were no production sheets to guide food production. There were no production numbers and the census board in the kitchen was blank except for a total of 45. There were no numbers outlining the numbers of minced or pureed textured items that needed to be prepared for each dining room.

C) During the inspection, there were several menu substitutions including:
i) During the lunch meal observation on May 25, 2015, it was noted that mixed fruit was substituted for mixed berries.
ii) On May 30, 2016, in the patio dining room, the second choice was different than the activity dining room. It was reported by the FSM that they only had enough of the pizza and salad for the activity dining room and had to substitute the pizza and salad with chicken caesar salad and garlic bread for the patio dining room. The FSM confirmed that during meal service in the activity dining room, the home ran short of pureed salad and had to substitute it with puree beets.

D) On June 2, 2016, in the activity dining room, the sliced chicken sandwich was substituted with sliced ham sandwich as the chicken was not pulled in time to thaw. The FSM and staff #103 were interviewed and they confirmed that the minced broccoli was mixed with carrots in the patio dining room as there was not enough broccoli by itself.

E) Food items were not prepared according to standardized recipes.
i) On June 8, 2016, the minced and puree textured creamy cucumber salad, appeared to be of the same consistency and this was confirmed during interview with the cook.
ii) On June 14, 2016, the minced and pureed oranges appeared to be of the same consistency.
It was reported by the FSM that the home had now purchased a new computerized food production system and planned to have all new menus with therapeutics, production sheets and recipes by July 11, 2016. [s. 72. (2) (c)]

2. The licensee failed to ensure that all food and fluids in the production system were prepared, stored and served using methods which preserved taste, nutritive value, appearance and food quality as evidenced by:

A) During the kitchen walk-through on June 9, 2016, the dry storage area, walk-in fridge and freezer areas were observed and it was noted that several food items were past their best before date or were stored unsafely.
In the main kitchen, bakery goods including breads, rolls and buns were found to be past their best before dates. A package of buns was dated best before June 4, 2016; a package of rolls was dated May 23, 2016 and a package of hamburger buns was dated May 25, 2016. The above packages were found on the bread racks. There were many half used bags of bread goods that were hand tied and without best before tags and therefore the dates were unknown. It was confirmed with the DOC on this date that

these goods should not be used and were disposed of.

B) In the dry storage room, a box of oatmeal raisin cookies was dated best before February 16, 2016. Five full boxes of eight sleeves each of assorted crackers were dated best before May 16, 2014.

C) In the walk-in fridge, a container of diced cantaloupe was dated best before June 1, 2016; a tub of sour cream was dated best before May 14, 2016 and a large piece of cooked ham was loosely wrapped in saran wrap and was not dated.

On June 9, 2016, the DOC confirmed that these items should not be in the home and would be disposed of. These items were not prepared, stored and served using methods which preserved taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

3. The licensee failed to ensure that the home had and that the staff of the home complied with, a cleaning schedule for the food production, servery and dishwashing areas as evidenced by:

During the kitchen walk-through on June 9, 2016, it was noted that the kitchen was in need of deep cleaning. The stove was found to be dirty with caked on food debris between the stove and skillet. Old, dried food splashes were observed on the walls, floors, shelving and food carts. The knife board, garbage cans, shelving in the kitchen fridges and items in the fridge including the milk pitcher and containers were found to be dirty. The walk-in freezer located in the basement had an area on the floor with a large spill that appeared to have been there for some time. The walk-in fridge had spills and or stains on the floor and milk was spilled under the shelving. The walls and area outside of the walk-in freezer and fridge appeared to have a black substance above the walk-in freezer. It was uncertain whether this black substance was mold. The walls and outside of the walk-in fridge and freezer were dirty. The back wall of hallway beside walk-in freezer had a white substance that appeared to be seeping through the walls. The Environmental Services Manager (ESM) was interviewed and reported that it was salt coming through the concrete as it was an outside wall, and it was in need of cleaning. The DOC was shown all of the areas and confirmed that although the home had cleaning schedules posted, they had not been completed and all of the areas required a deep clean. [s. 72. (7) (c)]

Additional Required Actions:

CO # - 003 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 the food production system in the home must, at a minimum provide for, standardized recipes and production sheets for all menus and that all food and fluids in the food production system are prepared, stored and served using methods to, preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented as evidenced by:

A) The DOC was interviewed and confirmed that the home's practice for their "Fall Prevention Program" was, when a fall occurred the expectation was that the staff completed post fall documentation for 72 hours after the fall.
i) Resident #006 was noted to have had a witnessed fall on an identified date in May 2016. A post fall progress note was not completed for the night and day shifts the following day.
ii) Resident #006 was noted to have had another unwitnessed on an identified date in May 2016. A post fall progress note was not completed by the day and evening shifts on the next day; on the evening shift the second day and the night shift on the third day.
iii) Resident #006 was noted to have an unwitnessed fall on an identified date in

September 2015. A post fall progress note was not completed on the night shift two days later.
iv) Resident #006 was noted to have an unwitnessed fall on another identified date in September 2015. A post fall progress note was not completed on the day and night shifts two days later.
v) Resident #006 was noted to have another unwitnessed fall in September 2015. A post fall progress note was not completed on the day or evening shifts the following day.
The DOC confirmed that the post fall documentation and assessments were not completed or documented as required under the program. (506)

B) The record of resident #031 was reviewed including the October 2015 to June 2016 Daily Resident Flow-sheets and Point of Care (POC) documentation. The documentation related to several different care areas was not completed as per the resident's plan of care. The progress notes were reviewed and contained some documentation related to some care areas but not all. The resident's plan of care was reviewed which indicated that they refused personal care at times.
The resident was observed throughout the inspection during the day and evening shifts and no signs of lack of personal care were observed. Care was observed being provided to resident #031 as per their plan of care.
Staff members were also observed asking and taking the resident to provide personal care on several occasions.
The DOC was interviewed and confirmed that the care provided to the resident related to their personal care was not documented as above. They reported that the home identified issues with the documentation of personal care provided through their internal audits. The home implemented electronic documentation and continued to re-educate, support and take action with the front-line staff.
The home failed to ensure that the interventions related to personal care provided to resident #031 were documented. (123)

C) The record of resident #030 was reviewed including the care plan, Daily Resident Flow-sheets and POC documentation from January 2016 to June 2016. The documentation was not completed in relation to several different care areas. The progress notes were reviewed and contained some documentation related to some care areas. The resident's plan of care indicated that they refused personal care at times.
The resident was observed on multiple occasions throughout the inspection during the day and evening shifts and they were clean, neatly groomed with no signs of lack of personal care. Staff were observed providing personal care assistance to the resident.
The DOC was interviewed and confirmed that the care provided to the resident related to

personal care was not documented. They reported that the home identified issues with documentation of personal care provided through their internal audits and took action as above.
The home failed to ensure that the interventions related to personal care provided to resident #030 were documented. [s. 30. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead for housekeeping and laundry had: a post-secondary degree or diploma; knowledge of evidence-based practices and/or prevailing practices as applicable; and a minimum of two years experience in a managerial capacity as evidenced by:

The home's ESM, the designated lead for housekeeping services and laundry services was interviewed and reported that they did not have training in evidence-based practices and or prevailing practices related to housekeeping and or laundry. They took over the position of ESM approximately three years ago and had not worked in that position prior. They confirmed that they did not have a minimum of two years experience in a managerial capacity prior to assuming the role of ESM.
The Administrator was interviewed and confirmed that the home's designated lead for housekeeping and laundry did not have knowledge of evidence-based practices and or prevailing practices and did not have a minimum of two years experience in a managerial or supervisory capacity before taking over the ESM position. The Administrator immediately assumed the role and the ESM was enrolled in the education course in June 2016. [s. 92. (2)]

Additional Required Actions:

CO # - 005 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents as evidenced by:

A) During the initial tour of the home, one bottle of One Step Disinfectant Cleaner was observed on the grab bar in the shower area of the spa. The Material Safety Data Sheet (MSDS) for the product was reviewed and it indicated that the product could cause skin and eye burs and was harmful if swallowed. PSW #100 and the ESM confirmed that the product should be kept in the locked cupboard to ensure the safety of the residents. They immediately placed the bottle into the locked cupboard.

B) During the initial tour of the home, a toaster was observed plugged into the electrical outlet above the counter in the patio dining area. When turned on, the elements became hot. The dining area was left unattended by the staff, the door was unlocked and residents were in the vicinity. Dietary staff #101 and the Administrator confirmed that the toaster was accessible to residents as the patio dining room door was left open for residents to use the area.

C) During the initial tour of the home, the steam table was observed to be plugged in and turned to the "HI" setting in the patio dining area. The staff left the dining room unattended and residents were in the vicinity. Dietary staff #101 confirmed that they left the dining room unlocked and unattended while the steam table was on. The Administrator was interviewed and confirmed that it is the home's expectation that staff are to remain the dining room when the steam table is turned on for resident safety.

D) The family member of resident #030 reported to the Long-Term Care (LTC) Inspector that they found pills on the floor and were concerned for the safety of resident #030 and other residents with cognitive impairments who may ingest the pills. The home's record were reviewed and it was noted that the family member of resident #030 reported to the home that they found pills on the floor.
LTC Inspector #123 found one white pill on the floor of the activity dining room after lunch. The DOC was interviewed and reported that the pill was from the home's medication cart and that all medications were to be kept in the locked medication cart inaccessible to residents. [s. 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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker was given the opportunity to participate fully in the development and implementation of the resident's plan of care as evidenced by:

The family member of resident #030 reported to the LTC Inspector that the resident's diet texture was changed and they were not informed. The home's records were reviewed including the 2016 Client Service Response record and it was noted that in May 2016,

the family member of resident #030 reported that the resident's diet texture was changed and they were not notified. The Administrator was interviewed and confirmed that the resident's diet texture was changed and that the family member was not informed.
The family member of resident #030 was not given the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan as evidenced by:

A) Resident #006's plan of care indicated that the resident was to have two bed rails up for bed mobility. An observation of the resident confirmed that the resident only had one bed rail up. Interview conducted with PSW #102 confirmed the resident was to have two bed rails up for bed mobility; that the resident was observed with one bed rail down and that staff were not following the resident's plan of care. (506)

B) The record of resident #032 was reviewed and the plan of care included: Ensure towel is available in the resident's room. The resident's room was inspected with the ESM and there was no towel available in the resident's room. The resident confirmed that there were no towels in their room and reported that the staff bring in the towel when they called for assistance. The DOC and the Administrator were interviewed and confirmed there was no towel available in the resident's room as per the plan of care. (123)

C) The DOC provided the LTC Inspector with the plan of care for resident #051's personal care device that was posted in the resident's closet. The plan of care identified that once the personal care device was removed it was to be cleaned with soap and water; rinsed out and placed in a clean towel in the resident's bottom drawer. It also identified that the personal care device was to be labelled with the resident's name and dated. The LTC Inspector observed that resident #051's personal care device had been left hanging on the towel bar in the bathroom to dry following cleaning. Staff #113 was asked what the expectation of the home was in regards to cleaning and storing of the personal care device. Staff #113 stated the expectation was to clean out the personal care device with hot water and hang to dry. The LTC Inspector asked the staff if they were aware of the instructions inside resident #051's closet regarding cleaning and storage of the personal care device. The staff identified they were not aware.
The licensee failed to ensure that care set out in the plan of care for resident #051 was provided as specified in the plan. (536)

D) The plan of care and serving notes for resident #001 indicated that the resident was to receive: protein powder at lunch; additional portions at meals and an identified juice daily at lunch.
During the observed lunch meal on an identified date in May 2016, the resident did not receive the protein powder or the extra half portions of entree or vegetables as confirmed with the FSM. The resident also did not receive the identified juice as confirmed with PSW #115.
During another observed lunch meal on an identified date in June 2016, the resident did not receive the protein powder until it was brought to the attention of the dietary staff. The extra portions were not observed being provided and the resident did not receive the identified juice as confirmed with observation and dietary staff #103.
Care in the plan of care for resident #001 was not provided to the resident as specified in the plan.

E) The plan of care for resident #003 indicated that the resident was to receive protein powder at lunch. During the observed lunch meal service on an identified date in June 2016, the resident did not receive the protein powder as confirmed with dietary staff #103. Care set out in the plan of care for resident #003 was not provided to the resident as specified in the plan.

F) The plan of care for resident #004 indicated that the resident was to receive whole milk at lunch. During the observed lunch meal service on an identified date in June 2016, the resident did not receive whole milk as staff #104 reported that the home did not have whole milk. The care set out in the plan of care for resident #004 was not provided to the resident as specified in the plan.

G) The dietary serving notes and plan of care for resident #040 indicated that the resident was to receive nectar thickened fluids. During the observed lunch meal service on an identified date in June 2016, the resident received regular consistency fluids. Staff #107 was feeding the resident and when questioned whether the resident was to receive thickened fluids, the staff replied that they did not know, checked with other staff and then replaced the fluids with nectar thickened fluids. The resident had consumed all of the regular consistency juice by the time the thickened fluids arrived. The resident was observed coughing. The care set out in the plan of care for resident #040 was not provided as specified in the plan as confirmed by staff #105, #106 and #107. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the

resident's care needs change or care set out in the plan was no longer necessary as evidenced by:

A) Resident #001 was noted to have had their goal weight range reassessed by the RD in November 2015, based on weight history and consistently being below the range during the past year. The current plan of care indicated an identified goal weight range which was not revised to reflect the reassessed goal weight range. The RD was interviewed and confirmed that the plan of care was not revised when the resident's care needs changed or care set out in the plan was no longer necessary.

B) Resident #002 was noted to have identified responsive behaviours. The plan of care initiated in November 2015, for resident #002 indicated that staff were to assess and or monitor and or document and report to the physician as needed the risk for harming others, or any other identified responsive behaviours. Interview with the DOC and Administrator, confirmed that the resident's care needs had changed or care set out in the plan of care was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that: the residents, the residents' substitute decision-makers, if any, and any other persons designated by the residents or substitute decision-makers are given an opportunity to participate fully in the development and implementation of the residents' plans of care; the care set out in the plan of care is provided to the residents as specified in the plan and that all residents are assessed and the plan of care reviewed and revised at least every six months and at any other time when, the care needs changed or the care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy for an identified personal care device was complied with as evidenced by:

The home's policy related to an identified personal care device was reviewed and it included: All drainage bags should be labelled with resident's name and date the device was changed. It further stated: The personal care devices are only to be used once then discarded. The LTC Inspector observed resident #051 and #052's personal care devices and they were not labelled or dated as per the home's policy. This was confirmed by staff #114 and staff #113. The DOC was interviewed and stated that the home's expectation was that the personal care devices were re-used for a period of one week and were to be labelled with resident's name and dated the day they were changed. The LTC Inspector confirmed with the DOC that resident #052's personal care device was not labelled or dated. At that time resident #051 was not in the home. The home did not ensure that the policy for an identified personal care device was complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with as evidenced by:

The home's abuse policy and procedures Abuse and Neglect policy number: RCS P-10 was reviewed and it included: "A person who has reasonable grounds to suspect that abuse has occurred must immediately report that suspicion and the information upon which it is based to the Director."
A) The home's records including the Critical Incident reports were reviewed and it was noted that in March 2016, the home received a written letter from the family member of resident #031 which included an allegation of physical abuse. It was reported to the Director in June 2016. The Administrator was interviewed and confirmed the home did not comply with it's written policy that promoted zero tolerance of abuse and neglect as the home did not immediately report the alleged abuse to the Director.

B) The home's records were reviewed including the Critical Incident report and email from the family member of resident #031 and it was noted that the family member informed the home of the alleged financial abuse in March 2016. The home informed the Director in June 2016. The Administrator was interviewed and they confirmed that the home was informed of the alleged financial abuse of the resident in March 2016, and informed the Director in June 2016. The Administrator confirmed that the home did not comply with its written policy that promoted zero tolerance of abuse and neglect of residents.

C) The Administrator was interviewed and reported that the family member of resident #030 informed the home of alleged abuse of the resident in March 2016. The home's records were reviewed including the Client Services report. The home reported the alleged abuse to the Director in June 2016. The Critical Incident report was reviewed and confirmed that the date of the home being aware of the alleged abuse was in March 2016, and that it was reported to the Director in June 2016. [s. 20. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Registered Dietitian completed a nutritional assessment for the resident whenever there was a significant change in the resident's health condition; and assessed the resident's hydration status, and any risks related to hydration as evidenced by:

A) The record of resident #003 was reviewed and it was noted that in February 2016, the resident was found not responding. The resident was transferred to hospital. Upon return from hospital, the resident was noted to have had a change in condition and was pocketing food the following day at lunch. The Administrator was interviewed and confirmed that it was the home's expectation that the resident would be assessed by the RD based on this change in condition. A nutritional assessment completed by the RD regarding the resident's change in health condition was not found in the resident's record. This was confirmed with the Administrator.

B) The record of resident #003 was reviewed and their plan of care indicated that their hydration needs were an identified number of millilitres (ml) per day. A review of the "look back" report for the month of May 2016 indicated that the resident did not meet their assessed hydration needs on all days for the month except for five. There was no evidence found in the resident's record that the RD had assessed the resident's hydration status or risks related to hydration. The DOC and the Administrator were interviewed and they confirmed that the resident was not assessed related to their hydration status or the risks related to hydration. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents on admission and whenever there is a significant change in the resident's condition; and assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition as evidenced by:

A review of the home's records including audits on bathing in February 2016 revealed that baths were not always being completed. Some documentation indicated that when they were short staffed the baths were not done.
A bathing audit of all residents in the home was completed for April, May and up to June 20, 2016. The plans of care, progress notes and bathing reports on POC documentation were reviewed. The DOC and the Administrator were interviewed and they confirmed that if the bath was not documented as being done, they were not done.
Resident #001 was not documented as receiving a bath as scheduled on three occasions in April 2016.
Resident #025 was not documented as receiving a bath as scheduled on one occasion in April 2016 and one occasion in June 2016.
Resident #048 was not documented as receiving a bath as scheduled on two occasions April 2016.
Resident #004 was not documented as receiving a bath as scheduled on two occasions in May 2016.
Resident #049 was not documented as receiving a bath as scheduled in May 2016.
Resident #005 was not documented as receiving a bath as scheduled on two occasions in May 2016.
The licensee did not ensure that each resident was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from the hospital as evidenced by:

The record of resident #006 was reviewed and it indicated that the resident was sent to the hospital and discharged back to the home in May 2016. The resident was noted to have a history of skin breakdown and was identified as being at a high risk of altered skin integrity. A review of the clinical record did not include a skin assessment on readmission to the home. The DOC was interviewed and confirmed the need to conduct and document a head to toe skin assessment of the resident. The DOC confirmed that the assessment was not completed and documented as required. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment as evidenced by:

The record of resident #005 was reviewed. It was noted that in February 2016, the resident had an identified area of altered skin integrity. The Minimum Data Set- Resident Assessment Instrument (MDS-RAI) Coordinator was interviewed and documentation confirmed that the resident's skin was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the altered skin integrity was identified. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose as evidenced by:

The record of resident #006 was reviewed and it was noted that they made verbal expressions of pain on five days in September 2015, related to an injury sustained after falling in September 2015. The resident was also noted to have a new physician's order for pain medication which was initiated on the day of the fall. There were no pain assessments in the clinical record. The DOC was interviewed and confirmed the resident's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that residents demonstrating responsive behaviours the behavioural triggers are identified and strategies are developed and implemented to respond to these behaviours as evidenced by:

A) The record of resident #006 was reviewed and it was noted that they had several incidents of verbal and physical responsive behaviours with residents and staff at the home. These behaviours were documented on the RAI-MDS assessment and Resident Assessment Protocol (RAP) dated March 2016. These responsive behaviours were not included in the document that the home refers to as the care plan nor were any triggers identified or any goals or interventions developed to respond to these responsive behaviours. The DOC was interviewed and confirmed that these responsive behaviours

were not included in the resident's plan of care to respond to the resident's behaviours.

B) The record of resident #023 was reviewed and it was noted that the resident had several incidents of responsive behaviours. These behaviours were documented on the RAI-MDS assessment and RAP dated April 2016. These responsive behaviours were not included in the document that the home refers to as the care plan nor were any triggers identified or any goals or interventions developed to respond to these responsive behaviours. The DOC confirmed that these responsive behaviours were not included in the resident's plan of care to respond to the resident's responsive behaviours. [s. 53. (4) (b)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented as evidenced by:

A) The record of resident #002 was reviewed including the progress notes. The documentation indicated that the resident had episodes of responsive behaviours. Registered staff #108, PSWs #104 and #105 were interviewed and they reported that there were several identified interventions to manage the resident's behaviours. These interventions and responses to these interventions were not documented in the resident's plan of care. The DOC was interviewed and indicated that the resident exhibited behaviours due to three identified triggers. The identified triggers and interventions reported were not included in the plan of care for the resident. The DOC and Administrator were interviewed and they confirmed that actions were not taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

B) The record of resident #002 was reviewed and it was noted that they had episodes of responsive behaviours. The resident was prescribed an identified medication every six hours as needed (PRN), to assist in the management of these behaviours. The Medication Administration Record (MAR), was reviewed and it was noted that the resident received the PRN dosage of the identified medication almost on a daily basis over the two month period. In May 2016, the resident received the PRN medication a total of 32 times and sometimes as often as three times daily. During a nineteen day period in June 2016, the resident received the PRN order a total of 24 times; also sometimes as often as three times daily. The Administrator and the DOC were interviewed and they confirmed that the home did not reassess the resident to ensure

that medications were provided to prevent or manage behaviours before they occurred. They also confirmed that the resident was not reassessed with respect the PRN medication order.

C) The record of resident #002 was reviewed and they were noted to have been exhibiting responsive behaviours and were administered an identified PRN medication twice in May 2016 and twice in June 2016, without effect. There was no documentation found in the resident's record to indicate what actions were taken to respond to the needs of the resident following the ineffective administration of the medication. The DOC was interviewed and confirmed that the resident was not reassessed with respect to the ineffective PRN medication. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible; and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

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

The home's policy and procedures Responsive Behaviour Philosophy: Behavioural Management and Responsive Behaviour Philosophy and Assessment procedure was reviewed and indicated that if strategies to manage behaviours were unsuccessful, the resident would be assessed by the physician. The physician would make a referral to Psychiatric Consultant/University Health Network, the Psycho-geriatric Resource Consultant could be accessed without a referral from the physician.

The record of resident #002 was reviewed and it was noted that the resident exhibited responsive behaviours almost daily and required medication intervention. The behaviours were not managed by the home as the resident was reported by registered staff #108 and PSW staff #104 and #105 exhibit behaviours on a daily basis that was disruptive to other residents in the dining room and to the resident's roommate. It was documented that the medications were not always effective. A review of the resident's record did not indicate that the resident was referred to psycho-geriatric resource consultant or Behavioural Supports Ontario (BSO) to assist with the management of their behaviours. The DOC was interviewed and confirmed that the procedures and interventions developed in the home were not implemented to assist residents and staff. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

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 the home's menu cycle, included alternative choices of entrees, vegetables and desserts at lunch and dinner as evidenced by:

A) During the observed lunch meal service on June 2, 2016, the home did not have an alternate choice for dessert for residents on thickened fluids. The menu indicated ice cream or banana was to be provided for residents on a regular and textured diet; however, ice cream was not suitable for those on thickened fluids. The therapeutic menu did not include an alternate choice of dessert for residents on thickened fluids. The Food Services Manager (FSM) was interviewed and confirmed that the therapeutic menu did not include an alternate choice on June 2, 2016, and the menu did not indicate that an alternate choice was to be provided and those on thickened fluids received banana as the only choice.

B) A review of the three week menu cycle provided to the LTC Inspector by the FSM, revealed that there was no alternate choice of entree or vegetable for Week one Friday lunch. For Week two Friday dinner, no second choice of entree, vegetable or dessert was indicated. The menu did not indicate a second choice of entree or vegetable for Week three Thursday lunch. [s. 71. (1) (c)]

2. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack as evidenced by:

A) During the lunch meal observation in May 2016:
i) The therapeutic menu indicated that minced fruit was to be available; however, it was not available in the activity dining room as confirmed with staff #101.
In the patio dining room, there was no minced or puree fruit available as confirmed by staff #115.
ii) The therapeutic menu indicated that minced corn was to be available; however, it was not available in the patio dining room as confirmed by staff #115.

B) During the lunch meal observation in the activity dining room on May 30, 2016, the therapeutic menu indicated that minced salad was to be available; however, it was not available during meal service. After the meal was completed, the FSM showed the LTC Inspector the minced salad and stated that it had accidentally been left in the kitchen.

C) During the lunch meal observation on June 2, 2016, in the activity dining room, the therapeutic menu indicated minced steamed broccoli; however, it was noted that the minced broccoli was also mixed with carrots as confirmed with the FSM on this date.

D) During the lunch meal observation on June 8, 2016:
i) The therapeutic menu indicated that regular texture corn chowder was to be available; however, only puree textured corn chowder was available in the activity dining room and there was no puree textured corn chowder available in the patio dining room; staff were observed getting three bowls from the activity dining room down the hall.
ii) The menu indicated that a corn muffin was to be served; however, the home served cheese biscuits instead. There was not puree textured cheese biscuit available in either dining room.
iii) The therapeutic menu indicated that minced and puree mandarin oranges were to be available; however, there were no minced textured mandarin oranges available in either dining room.

Food portion sizes were not always found to be followed according to the therapeutic menu as evidenced by:

A) During the lunch meal observation on June 2, 2016, in the activity dining room, there was just enough puree Italian wedding soup for the residents. Staff # 103 reported that they were supposed to use a 125 ml ladle for puree soup but that size ladle was not available as there were not enough in the home so a larger one was used. It was reported that there were only two small ladles for the home and one was being used in the patio dining room and one was being used in the retirement home. The FSM who was present, was not aware of this and indicated that more ladles would be purchased.

B) During the lunch meal observation on June 14, 2016, the therapeutic menu indicated that a #10 scoop was to be used for minced green peas; however, a #12 scoop was observed being used instead. The therapeutic menu indicated that a #12 scoop was to be used for puree green peas; however, a #8 scoop was observed being used instead. The therapeutic menu indicated that minced potato frittata was to be prepared; however, the home used regular texture frittata for residents on a minced textured diet.

C) During the lunch meal observation on June 16, 2016, the menu indicated egg salad on a croissant. The croissants that the home used during this meal were very small and therefore, were provided alongside a scoop of egg salad. The therapeutic menu for this date indicated that a #10 scoop was to be used for minced mixed vegetables; however, a #8 scoop was observed being used instead. The therapeutic menu indicated that a #10 scoop was to be used for puree turkey pot pie; however, a #12 scoop was observed being used instead. [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 the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was sufficient food service workers for the home to meet the minimum staffing hours as calculated below for:
(a) the preparation of resident meals and snacks,
(b) the distribution and service of resident meals,
(c) the receiving, storing and managing of the inventory of resident food and food service supplies, and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service

The minimum staffing hours shall be calculated as follows:
M = A × 7 × 0.45
Where,
"M" is the minimum number of staffing hours per week, and
"A" is,
a) if the occupancy of the home was 97 per cent or more, the licensed bed capacity in the home for the week, or
b) if the occupancy of the home was less than 97 per cent, the number of residents residing in the home for the week, including absent residents as evidenced by:

Interview with the FSM on June 16, 2016 confirmed that the home was at full capacity at 45 residents (A), staffing hours included one cook 0930 hours to1730 hours (eight hours per day) plus dietary aide staff 0600 hours to1400 hours (eight hours per day) plus dietary aide staff 1600 hours to 2000 hours (four hours per day) equating to 20 hours per day. The weekly dietary staffing hours were calculated to be 140 hours per week.
M = A x 7 x 0.45
M = 45 x 7 x 0.45
M = 141.75 hours per week required

Based on the above calculation, the home was short 1.75 dietary staffing hours per week as confirmed with the FSM on June 16, 2016. [s. 77. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was sufficient food service workers for the home to meet the minimum staffing hours as calculated below for:
(a) the preparation of resident meals and snacks,
(b) the distribution and service of resident meals,
(c) the receiving, storing and managing of the inventory of resident food and food service supplies, and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service

The minimum staffing hours shall be calculated as follows:
M = A × 7 × 0.45
Where,
"M" is the minimum number of staffing hours per week, and
"A" is,
a) if the occupancy of the home was 97 per cent or more, the licensed bed capacity in the home for the week, or
b) if the occupancy of the home was less than 97 per cent, the number of residents residing in the home for the week, including absent residents, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for, (a) cleaning of the home, including, (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces as evidenced by:

During the initial tour of the home three areas of dried feces were observed on the floor at the entrance inside the spa room. This was confirmed with PSW #100, the ESM and the Administrator. [s. 87. (2) (a) (ii)]

2. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures were developed and implemented for, (b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and (iii) contact surfaces; as evidenced by:

The wheelchairs of residents #001 and #010 were observed to be dirty on the right handle, seat cushion and right inside of their wheelchairs. PSW # 102 interviewed and reported that the home has a weekly schedule for cleaning of residents' personal assistance services devices, assistive aids and positioning aids. Also, that there is a make-up day each week for any wheelchairs that are missed. All wheelchairs that are cleaned and documented each week. PSW #102 observed and confirmed that the wheelchairs were dirty as above. The schedule was reviewed and the wheelchairs of resident #001 and #010 were not cleaned. [s. 87. (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 cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: supplies and devices, including personal assistance devices, assistive aids and positioning aids, to be implemented voluntarily.

WN #19: 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. (1) Every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section. O. Reg. 79/10, s. 229 (1).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program required under subsection 86(1) of the Act complied with the requirements of this section catheter care policy complied with the requirements of this section as evidenced by:

The home's policy "Male and Female Catheterization Indwelling", policy number: SPC B-05, original date: January 18, 2006, revised date: October 3, 2014 stated: "If urinary drainage bag is to be changed to a leg bag during the day, the overnight drainage bag is to be capped and placed in wash basin inside resident's bedside table or designated space." The instructions did not have any protocol for cleaning of catheter bags that are re-used over a period of seven days before they are discarded and replaced. The Administrator confirmed that there was no other policy for cleaning of urinary drainage bags. (536) [s. 229. (1)]

2. The licensee has failed to ensure that to ensure that the following immunization and screening measures were in place: Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website as evidenced by:

A) A review of the immunization documentation for residents #020, and #021 identified that these residents were not offered immunization against tetanus and diphtheria. The DOC was interviewed and confirmed that the home is to offer the tetanus and diphtheria vaccine as required to new residents or existing residents. The DOC also confirmed, that these residents were not offered their tetanus and diphtheria vaccinations, in accordance with the publicly funded immunization schedules posted on the Ministry website.

B) A review of the immunization documentation for residents #020, #021 and #022 identified that these residents were not offered their immunization against pneumoccocus. The DOC was interviewed and confirmed that these residents have not been offered their pneumoccoccal vaccination, in accordance with publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 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 all residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website and that the home has a protocol for cleaning of catheter bags that are re-used over a period of seven days, to be implemented voluntarily.

Issued on this 4th day of October, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELODY GRAY (123), CAROL POLCZ (156), CATHIE ROBITAILLE (536), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2016_215123_0009
Log No. / Registre no:	015288-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 23, 2016
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	ORCHARD TERRACE CARE CENTRE 199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Agnes Jankowski

To RYKKA CARE CENTRES LP, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall ensure that ensure that the home is equipped with a resident-staff communication and response system in the secured outdoor area and in the front lounge that, is accessible by residents.

Grounds / Motifs :

1. The order is being issued based on the application of factors of severity (2), scope (2), and compliance history of (2), in keeping with s. 299. (1) of the Regulation. This is in respect to the severity of harm or risk of harm to residents, the scope of the harm or risk of harm to residents and the home's history of non-compliance.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, (e) was available in every area accessible by residents as evidenced by:

A) It was identified that the home did not have a resident-staff communication and response system located in the secured outdoor area used by residents. Interview with the Administrator confirmed that a communication and response system was not available in the identified area, which was accessible by residents. (506)

B) Residents were observed sitting and participating in program activities in the front lounge area of the home throughout the inspection. Families were also observed using the area and while visiting with residents. No resident-staff communication and response system was observed in the area. The Administrator was interviewed and confirmed that the front lounge area was used by residents for programing activities and that families also used the space while visiting the residents. The Administrator confirmed that the home was not equipped with a resident-staff communication and response system in the front lounge area that, was accessible to residents . (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 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. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall ensure that all residents including residents #001, #003, #004 and #051 with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises their health status.

Grounds / Motifs :

1. The order is being issued based on the application of the factors of severity (2), scope (2), and compliance history of (4), with a VPC issued for r. 69.1 in February 2014, during the Resident Quality Inspection in keeping with s. 299. (1) of the Regulation. This is in respect to the severity of the harm or risk of harm to residents, the scope of the harm or risk of harm to residents and the home's history of non-compliance.

The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month

2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status as evidenced by:

A) Resident #001 was noted to have an assessed goal weight range of an identified number of kilograms (kg). The resident's weight was recorded between December 2015 and May 2016.

i) The documented weight in April 2016 represented a weight change of more than seven point five per cent over three months when compared with February 2016. The April 2016 weight also represented a weight change also represented a weight change of over five per cent over one month when compared to March 2016.
ii) The May 2016 weight represented a weight change of over ten per cent over six months when compared to December 2015.
The resident was assessed by the Registered Dietitian (RD) as part of the nutritional quarterly review in April 2016; however, three days later the weight was noted to have decreased by greater than five per cent in one month. The RD and the Director of Care (DOC) were interviewed and confirmed that the significant weight change was not referred to the RD by the interdisciplinary team. The weight changes as noted above were not assessed using an interdisciplinary approach and actions were not taken and outcomes were not evaluated as confirmed by the RD and DOC.

B) Resident #003 was noted to have an identified assessed goal weight range. The resident's weight was recorded in April 2016 and in May 2016, which represented a weight change over ten per cent in one month. The DOC confirmed that it was the expectation of the home that the residents with significant weight change were to be assessed by the RD on the next visit; however, the weight change had not been assessed by the RD. The significant weight change was not referred to the RD by the interdisciplinary team. The DOC and RD confirmed that the weight change was not assessed using an interdisciplinary approach and that actions were not taken and outcomes were not evaluated.

C) Resident #004 was noted to have an identified assessed goal weight range. The resident's weight was recorded in March 2016 and in April 2016, which represented a weight change of over ten per cent in one month. The DOC

confirmed that it was the expectation of the home that the resident with significant weight change be assessed by the RD on the next visit. In this case, the RD was in the home in April 2016; however, did not assess the weight change until May 2016, when it was noticed during the completion of the nutritional quarterly review. The significant weight change was not referred to the RD by the interdisciplinary team. The weight change was not assessed using an interdisciplinary approach and actions were not taken and outcomes were not evaluated as confirmed with the RD and DOC.

D) Resident #051 was noted to have weights recorded between October 2015 and June 2016. The February 2016 weight represented a significant weight change of over seven point five per cent over three months when compared to the November 2015 weight. The RD saw the resident twice in February 2016 related to diet texture; however, the resident's significant weight change was not addressed until the next RD visit in May 2016. The weight change was not assessed using an interdisciplinary approach, actions were not taken and outcomes were not evaluated as confirmed with the DOC. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;
(b) a cleaning schedule for all the equipment; and
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Order / Ordre :

The licensee is to ensure that the home has and that the staff of the home comply with, a cleaning schedule for the food production, servery and dishwashing areas.

Grounds / Motifs :

1. The order is being issued based on the application of the factors of severity (2), and scope (2), and compliance history (3), with a WN issued in August 2015, during the Resident Quality Inspection in keeping with the s. 299. (1) of the Regulation. This is in respect to the severity of harm or risk of harm to residents, the scope of the harm or risk of harm to residents and the home's history of non-compliance.

The licensee failed to ensure that the home had and that the staff of the home complied with, a cleaning schedule for the food production, servery and dishwashing areas as evidenced by:

During the kitchen walk-through on June 9, 2016, it was noted that the kitchen was in need of deep cleaning. The stove was found to be dirty with caked on food debris between the stove and skillet. Old, dried food splashes were observed on the walls, floors, shelving and food carts. The knife board, garbage cans, shelving in the kitchen fridges and items in the fridge including the milk pitcher and containers were found to be dirty. The walk-in freezer located in the basement had an area on the floor with a large spill that appeared to have been there for some time. The walk-in fridge had spills and or stains on the floor and milk was spilled under the shelving. The walls and area outside of the walk-in freezer and fridge appeared to have a black substance above the walk-in freezer. It was uncertain whether this black substance was mold. The walls and area outside of the walk-in fridge and freezer were dirty. The back wall of the hallway beside the walk-in freezer had a white substance that appeared to be seeping through the walls. The Environmental Supervisor (ESM) was interviewed and reported that it was salt coming through the concrete as it was an outside wall, and it was in need of cleaning. The DOC was shown all of the areas and confirmed that although the home had cleaning schedules posted, they had not been completed and all of the areas required a deep clean.

(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

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. The licensee shall ensure that Post fall assessments of resident #006 and personal care interventions provided to residents #030 and #031 are documented.

Grounds / Motifs :

1. The order is being issued based on the application of the factors of severity of (2), scope (2) and compliance history (4), with VPC issued for r. 30 (2) in February 2014, during the Resident Quality Inspection in keeping with s. 299. (1) of the Regulation. This is in respect to the severity of harm or risk of harm to residents, the scope of harm or risk of harm to the residents and the home's history of non-compliance.

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 as evidenced by:

A) The DOC was interviewed and confirmed that the home's practice for their "Fall Prevention Program" was, when a fall occurred the expectation was that the staff completed post fall documentation for 72 hours after the fall.
i) Resident #006 was noted to have had a witnessed fall on an identified date in May 2016. A post fall progress note was not completed for the night and day shifts the following day.
ii) Resident #006 was noted to have had another unwitnessed fall on an

identified date in May 2016. A post fall progress note was not completed by the day and evening shifts on the next day; on the evening shift the second day and the night shift on the third day.
iii) Resident #006 was noted to have an unwitnessed fall on an identified date in September 2015. A post fall progress note was not completed on the night shift two days later.
iv) Resident #006 was noted to have a unwitnessed fall on another identified date in September 2015. A post fall progress note was not completed on the day and night shifts two days later.
v) Resident #006 was noted to have an unwitnessed fall on another identified September 2015. A post fall progress note was not completed on the day or evening shifts the following day.
The DOC confirmed that the post fall documentation and assessments were not completed or documented as required under the program. (506)

B) The record of resident #031 was reviewed including the October 2015 to June 2016 Daily Resident Flow-sheets and Point of Care (POC) documentation. The documentation related to several different care areas was not completed as per the resident's plan of care. The progress notes were reviewed and contained some documentation related to some care areas but not all . The resident's plan of care was reviewed which indicated that they refused personal care at times.

The resident was observed throughout the inspection during the day and evening shifts and no signs of lack of personal care were observed. Care was observed being provided to resident #031 as per their plan of care.
Staff members were also observed asking and taking the resident to provide personal care on several occasions.
The DOC was interviewed and confirmed that the care provided to the resident related to their personal care including toileting was not documented as above. They reported that the home identified issues with the documentation of personal care provided through their internal audits. The home implemented electronic documentation and continued to re-educate; support and take action with the front-line staff .
The home failed to ensure that the interventions related to interventions related to personal care provided to resident #031 were documented. (123)

C) The record of resident #030 was reviewed including the care plan, Daily Resident Flow-sheets and POC documentation from January 2016 to June 2016. The documentation was not completed in relation to several different

care areas. The progress notes were reviewed and contained some documentation related to some care areas. The resident's plan of care indicated that they refused personal care at times. The resident was observed on multiple occasions throughout the inspection during the day and evening shifts and they were clean, neatly groomed with no signs of lack of personal care. Staff were observed providing personal care assistance to the resident.
The DOC was interviewed and confirmed that the care provided to the resident related to personal care including toileting was not documented. They reported that the home identified issues with the documentation of personal care provided through their internal audits and took action as above.
The home failed to ensure that the interventions related to personal care provided to resident #030 were documented.

(123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2016

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. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma;
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and
(c) a minimum of two years experience in a managerial or supervisory capacity.
O. Reg. 79/10, s. 92 (2).

Order / Ordre :

The licensee shall ensure that the designated lead for housekeeping and laundry services have, (b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, and laundry, as applicable; and (c) a minimum of two years experience in a managerial or supervisory capacity.

Grounds / Motifs :

1. The order is being issued based on the application of the factors of severity (2), scope (2), and compliance history (2), in keeping with s. 299. (1) of the Regulation. This is in respect to the severity of harm or risk of harm to residents, the scope of the harm or risk of harm to residents and the home's history of non-compliance.

The licensee has failed to ensure that the designated lead for housekeeping and laundry had: knowledge of evidence-based practices and or prevailing practices as applicable; and a minimum of two years experience in a managerial capacity as evidenced by:

The home's ESM, the designated lead for housekeeping and laundry services was interviewed and reported that they did not have training in evidence-based practices and or prevailing practices related to housekeeping and or laundry. They took over the position of ESM in 2013 and had not worked in that position prior. They confirmed that they did not have a minimum of two years experience in a managerial capacity prior to assuming the role of ESM.
The Administrator was interviewed and confirmed that the home's designated lead for housekeeping and laundry did not have knowledge of evidence-based practices and or prevailing practices and did not have a minimum of two years experience in a managerial or supervisory capacity before taking over the ESM position. The administrator immediately assumed the role and the ESM was enrolled in the education course in June 2016. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2017

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 soins 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.

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 soins 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 23rd day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELODY GRAY

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