Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 27, 2015	2015_450138_0018	O-002655-15	Resident Quality Inspection

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD SUITE 301 MISSISSAUGA ON L5N 2X4

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

PERTH COMMUNITY CARE CENTRE
101 CHRISTIE LAKE ROAD R. R. #4 PERTH ON K7H 3C6

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

PAULA MACDONALD (138), ANANDRAJ NATARAJAN (573), HEATH HEFFERNAN (622), RUZICA SUBOTIC-HOWELL (548)

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): October 13, 14, 15, 16, 19, 20, 21, 22, and 23, 2015.

Two Critical Incident (CI) Inspections were completed concurrently as part of this RQI:
O-001365-14
O-002825-15

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, the Director of Resident Care, the RAI/Education Coordinator, the Activity Coordinator, the Environmental Supervisor, the Maintenance Supervisor, the Food Service Manager, the President of the Residents' Council, a member of the Family Council, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), laundry aides, the Registered Dietitian, dietary aides, a restorative care aide, the Occupational Therapist (OT), the Physio Assistant, and a technician from a medical equipment company.

As part of the RQI, the inspectors toured residential and non residential areas in the home, reviewed Critical Incident Reports, observed the lunch dining service on Wiseman, observed the medication pass on second floor, reviewed the home's policies related to maintenance, restraints, catheters, and reporting and complaints, reviewed resident health care records, reviewed restraint monitoring documentation, observed resident closets, reviewed maintenance logs and audits, reviewed Residents' Council minutes, reviewed Family Council minutes, reviewed Food Committee minutes, reviewed the home's documentation regarding complaints, and reviewed the home's wheelchair cleaning schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- 12 WN(s)
- 4 VPC(s)
- 0 CO(s)
- 0 DR(s)
- 0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with section 15.(2)(a) of the Act in that the licensee failed to ensure the home, furnishings, and equipment is kept clean and sanitary.

On October 14, 2015, Inspector #573 observed that both Resident #007 and Resident #041's wheelchair frame under the seat and brakes had a heavy accumulation of dust and dirt. Further, Resident #007's wheelchair was soiled with dried food stains on the lower metal frames, wheel guards and wheels.

On October 20, 2015, Inspector #573 also observed that Resident #048's wheelchair frame, wheels and cushion were heavily soiled with food stains and dirt resembling old dried food.

In addition to the wheelchairs, Inspector #573 observed on October 14, 2015, unclean privacy curtains in Resident #002 and Resident #010's rooms.

Inspector #573 spoke with the Environmental Supervisor who stated that the home has a process in place for cleaning wheelchairs as well as resident privacy curtains on a regular basis and when required. The Environmental Supervisor further indicated that there is a weekly wheelchair cleaning schedule in a binder located at the nursing station for staff to follow for the specific day that wheelchairs are to be cleaned. Inspector #573 and the Environmental Supervisor both reviewed the weekly wheelchair cleaning schedule for September 1, 2015 to October 20, 2015. No documentation was found indicating that Resident #041 and Resident #048's wheelchairs had been cleaned.

On October 20, 2015, Inspector #573 observed the two unclean privacy curtains in Resident #002 and Resident #010's rooms and also the three identified wheelchairs for Residents #007, Resident #041, and Resident #048 in the presence of the Environmental Supervisor. The Environmental Supervisor confirmed with the inspector that both the privacy curtains were unclean and also agreed that the wheelchairs were unclean and not sanitary. Further, the Environmental Supervisor indicated to the inspector that there will be follow up to address these issues. [s. 15. (2) (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 resident wheelchairs are cleaned as required, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 60.(2) of the Act in that the licensee failed to ensure that the licensee responds in writing within 10 days to the Family Council after receiving advice related to concerns or recommendations.

On October 22, 2015, Inspector #548 spoke with a current member of the Family Council who reported being a regular member of the Family Council for over a year. This member of the Family Council indicated that concerns and recommendations are recorded at each meeting, however, written responses by the home to these concerns and recommendations were not provided until the following scheduled meeting, normally the following month.

Inspector #548 obtained and reviewed the minutes of the Family Council meetings for May, June, and September 2015 along with the home's corresponding written responses. It was noted by the inspector that the Family Council raised concerns and recommendations on May 13, 2015, however a written response was provided after 10 days, dated May 27, 2015. The Family Council raised several concerns and recommendations on June 10, 2015, and again the written response was dated after 10 days on June 23, 2015. Then, on September 9, 2015, the Family Council raised several concerns and recommendations and, again, the written response was not within 10 days, instead the response was dated October 2, 2015.

Inspector #548 spoke with the Activity Coordinator who indicated that she assists the Family Council and records concerns and recommendations raised at Family Council meetings. The Activity Coordinator stated she will meet with the Administrator the following morning to advise her of the concerns and recommendations brought forward by the Family Council.

Inspector #548 also spoke with the Administrator who indicated that she meets with the Activity Coordinator the morning after the Family Council meetings and is aware of Family Council concerns and recommendations at that time.

It has been noted that non-compliance under this section was found during:
RQI in March 2013, Inspection #2013_179103_0009, log #O-000117-13 and;
RQI in November 2014, Inspection #2014_362138_0015, log #O-001107-14. [s. 60. (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 concerns and recommendations from the Family Council are responded to in writing within 10 days, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with section 85.(3) of the Act in that the licensee failed to seek the advice of the Residents’ Council in developing and carrying out the satisfaction survey.

Inspector #573 spoke with the President of the Residents’ Council who indicated that the licensee did not seek the advice of the Residents’ Council regarding the development of the home’s annual satisfaction survey.

On October 21, 2015, Inspector #573 spoke with home’s Administrator who stated that the home conducted an annual satisfaction survey for 2015 but did not seek the advice of the Residents' Council in developing and carrying out the annual satisfaction survey.

It has been noted that non-compliance under this section was found during:
RQI in March 2013, Inspection #2013_179103_0009, log #O-000117-13 and;
RQI in November 2014, Inspection #2014_362138_0015, log #O-001107-14. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee seeks the advice of the Resident's Council in developing and carrying out the annual satisfaction survey, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to comply with section 110.(7) of the Regulation in that the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.

A) Resident #026 was observed on October 16, 2015, to be wearing a front closure lap belt while seated in a wheelchair. Inspector #548 found that Resident #026 was not physically or cognitively able to undo the lap belt. RN #116 indicated to Inspector #548 that the lap belt is considered a restraint for Resident #026. PSW #117 indicated that the resident is in his/her wheelchair with the lap belt applied from 0830 hours until the resident's bedtime and is released from the lap belt for toileting and repositioning.

On October 16, 2015, during an interview, RN #101 indicated that the resident is monitored hourly by the PSWs who document the application, release and repositioning of the resident on the form titled: Restraint and Personal Safety Device Monitoring Record. RN #101 indicated that the registered nurse records the resident's response and the effectiveness of the restraint every eight hours on the form.

A review of the documentation for the time period of September 1, 2015 to October 20, 2015 for Resident #026 was completed with RN #116 and Inspector #548. The inspector noted that the documentation did not capture the application, release and repositioning as required in section 110.(7)5 and 110.(7)7 of the Regulation for September 19, 25, 26, 2015 and October 1, 14 and 19, 2015 from 0700-1400 hours and September 14, 2015 and October 3, 2015 from 1500-2200 hours. The documentation does not capture all assessment, reassessment and monitoring, including the resident's response as required in section 110.(7)6 of the Regulation on September 4, 8, 11, 12, 13, 16, 22, 23, 24, 26, 27, 28 and 30, 2015 and October 2, 6, 9, 14, 15, 18, 19 and 20, 2015 from 0700-1400 hours and September 9, 18, 23, 25, and 29, 2015 from 1500-2200 hours.

B) Similarly, Resident #023 was observed on October 14, 2015 to be wearing a front closure lap belt while seated in a wheelchair. Inspector #548 found that Resident #026 was not physically or cognitively able to undo the lap belt. RN #116 indicated to Inspector #548 that the lap belt is considered a restraint for Resident #023. PSW #117 indicated that the resident is in his/her wheelchair with the lap belt applied from 0800 hours until the resident's bedtime and is released from the lap belt for toileting and repositioning. It was noted by the inspector that there was a physician's order for the lap belt while in the wheelchair as well as consent by the Substitute Decision Maker (SDM).

A review of the documentation for the time period of October 1-20, 2015 for Resident #023 was completed with the RN #116 and Inspector #548. The documentation does not capture the application, release and repositioning as required in section 110.(7)5 and 110.(7)7 of the Regulation for October 1, and 19, 2015 from 0700-1400 hours and

October 3, 2015 from 1500-2200 hours. The documentation does not capture all assessment, reassessment and monitoring, including the resident’s response, the application, release and repositioning as required in section 110.(7)6 of the Regulation for October 2, 6, 16, 18 and 20, 2015 from 0700-1500 hours and October 20, 2015 from 1500-2200 hours. [s. 110. (7)]

2. The licensee failed to comply with section 110.(7) of the Regulation in that the licensee failed to ensure that the every use of a physical device to restrain a resident under section 31 of the Act is documented and the licensee shall ensure that the following are documented: (6) all assessment, reassessment and monitoring, including the resident’s response.

Resident #007’s most recent assessment conducted in October 2015 identifies the daily use of a trunk restraint. The inspector reviewed Resident #007’s health care records for restraint which includes the SDM's consent and a corresponding physician’s order dated for the use of wheelchair lap belt as a restraint.

Inspector #573 spoke with RN #112 who stated that the monitoring of any restraint is documented on a form titled “Restraint and Personal Safety Device Monitoring Record” and is kept in a binder on each of the units. The inspector reviewed Resident #007`s restraint monitoring records and was unable to find the wheelchair lap belt restraint monitoring record during the period of June 15 to 30, 2015, July 2015, August 2015 and September 1 to 8, 2015.

On October 16, 2015, RN #112 and the Administrator reviewed Resident #007’s health care records in the presence of Inspector #573. Both confirmed that they were unable to find the wheelchair lap belt restraint monitoring record for the period of June 15 to 30, 2015, July 2015, August 2015 and September 1 to 8, 2015.

It has been noted that non-compliance under section 110.(7)6 was found during:
RQI in November 2014, Inspection #2014_362138_0015, log #O-001107-14. [s. 110. (7) 6.]

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 restraints use is documented for each resident including: the person who applied the device and the time of the application; all assessment, reassessment and monitoring, including the resident`s response; and every release of the device and all repositioning, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with section 6.(1)(c) of the Act in that the licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Resident #026 is dependent for care of personal hygiene. On October 15, 2015, Resident #026 was observed to have long facial hair on the chin. Family members indicated that the resident never liked chin hair and they would like it removed on bath days and in between, if necessary.

On October 16, 2015, during an interview, PSW #100 indicated that chin hair is routinely removed on bath days for residents. The PSW indicated that Resident #026 received his/her scheduled bath that morning and had not presented with any behaviours and accepted personal care and grooming. It was noted by the inspector again that day, October 16, 2015, that Resident #026 still had long facial hair to the chin area.

The resident's care plan indicates that the resident will be provided personal hygiene in the morning, afternoon, evening and when necessary with no specific directions related to the removal of chin hair. [s. 6. (1) (c)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with section 29.(1)(b) of the Act, whereby the licensee failed to ensure that the written policy to minimize the restraining of residents is complied with.

The home’s policy, NM-II-R008 dated February 2012 titled “Restraint”, indicates under Procedure - (A) Decision to Restrain, bullet point # 3 to “Consider the most reasonable method by considering other alternative methods to restraints. Document the effectiveness of the alternatives to restraint that have been considered or tried on the form, Methods to Manage Safety Risks (Form 049)”.

A review of Resident #007 and Resident #041’s health care record both demonstrates a physician's order for the use of a lap belt restraint while in a wheelchair. The use of the lap belt restraint is also included in Resident #007 and Resident #041’s plan of care. There was no documentation found in either of the resident health care records regarding any alternatives to restraining that were considered, including a completed Form 049 as per the home’s policy.

On October 20, 2015, the Director of Resident Care stated to Inspector #573 that the multidisciplinary team would discuss restraint alternatives before any type of restraint is used and further stated the registered nursing staff would initiate restraint alternatives by using Form 049. The Director of Resident Care reviewed Resident #007 and Resident #041's health care records with Inspector #573 and she was not able to locate any supporting documents, including a completed Form 049 as per the home's policy, that demonstrated that any alternatives were considered before restraining the residents. [s. 29. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with section 31.(2)4. of the Act in that the licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied; a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Inspector #548 observed that Resident #026 was wearing a front closure lap belt while seated in a wheelchair in the dining room. The resident was cognitively and physically unable to undo the lap belt.

On October 16, 2015, during an interview, RN #101 indicated that the home is to ensure there is a physician's order approving a resident restraint and that consent by the resident or the SDM is obtained. Resident #026's health care record was reviewed and it was noted that SDM consent was obtained for the use of a lap belt restraint upon the resident's admission. The inspector, however, was unable to find the physician's order for the restraint. The inspector further reviewed Resident #026's health care record with RN #101 and confirmed that there was no physician's order approving the lap belt as a restraint.

On October 22, 2015, during an interview, the Director of Resident Care indicated that she was not aware that there was a lack of a physician's order for the lap belt restraint for Resident #026 as the home’s process clearly indicates the expectation of obtaining a physician's order for restraints. [s. 31. (2) 4.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents’ Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to comply with section 67. of the Act in that the licensee has failed to ensure that the licensee consults regularly with the Residents' Council and Family Council, if any, and in any case shall consult with them at least every three months.

On October 22, 2015, Inspector #548 spoke with a current member of the Family Council who reported being a regular member of the Family Council for over a year. This member of the Family Council indicated that the licensee does not meet regularly with the council or consult with them at least every three months.

On October 22, 2015, during an interview, the Administrator indicated that she will attend any Family Council meeting when invited, however, she considered her written response to recommendations and concerns as a means of consultation with Family Council. The Administrator was not able to provide anything else that specifically demonstrated that the licensee consulted with the Family Council on a regular basis, at least every three months. [s. 67.]

2. Inspector #573 spoke with the President of the Residents' Council who indicated that the licensee does not consult regularly with the Residents' Council. The President further indicated to the inspector that Residents' Council wish to consult with someone from the licensee on a regular basis.

Inspector #573 reviewed the minutes of the Residents' Council meeting from January 2015 to October 2015. Upon review of the meeting minutes, the inspector was unable to find any documentation regarding the licensee consulting the Residents' Council since February 2015, eight months ago.

The inspector interviewed the Activity Coordinator who is assigned to assist the Residents' Council. The Activity Coordinator stated that it is the Administrator who consults with the Residents' Council on behalf of the licensee and that this is done at least twice a year. She further stated that the last consultation with the Administrator and the Residents' Council was February 2015. [s. 67.]

WN #9: 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,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed comply with section 71.(1)(f) of the Regulation in that the licensee failed to ensure that the home's menu cycle is reviewed by the Residents' Council.

On October 22, 2015, during an interview, the President of the Residents' Council stated that the home's menu is not reviewed by the Residents' Council.

Inspector #573 determined that the home had a Food Committee which is a sub committee of the Residents' Council and that both the Food Committee and the Residents' Council share the same membership. The inspector obtained and reviewed the minutes of the Residents' Council meetings and the Food Committee meetings from January 2015 to October 2015 and was unable to find any documentation that the home's menu cycle was reviewed by the residents.

On October 22, 2015, during an interview, the Food Service Manager confirmed with the inspector that the current menu cycle, in effect for several months, was not reviewed by the Residents' Council or the Food Committee. [s. 71. (1) (f)]

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 73.(1)2. of the Regulation in that licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, a review, subject to compliance with subsection 71(6), of the meal and snack times by the Residents' Council.

On October 22, 2015, during an interview, the President of the Residents’ Council stated that he/she could not recall the Residents’ Council reviewing the home’s meal and snack times.

Inspector #573 determined that the home had a Food Committee which is a sub committee of the Resident's Council and that both the Food Committee and the Residents' Council share the same membership.

Inspector #573 reviewed the minutes of the Residents’ Council meeting and the Food Committee meeting from October 2014 to October 2015 and was unable to find any documentation to indicate that the meal and snack times were reviewed by either the Residents' Council or the Food Committee.

On October 22, 2015, in two separate interviews, Inspector #573 spoke with the Activity Coordinator and the Food Service Manager. Both confirmed with the inspector that the meal and snack times were not reviewed by either the Residents’ Council or the Food Committee. [s. 73. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents’ linens are changed at least once a week and more often as needed,
(ii) residents’ personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents’ soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents’ lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 89.(1)(a)(ii) of the Regulation in that the licensee failed to ensure, as part of the laundry services, that procedures are developed and implemented to ensure that resident’s personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

Inspector #138 viewed the clothing in the closet of Resident #004 and noted that there were several clothing items not labelled. Specifically, items not labelled included three cream coloured shirts, a red shirt, a black pea coat, a beige coat, a pair of running shoes, and a pair of slip on casual shoes.

The inspector viewed several more resident closets and resident rooms and noted the following unlabelled items in the residents' respective closets and rooms:

Resident #006 had a black jacket, blue Croc shoes, blue slippers, Athletic Works shoes, a suit with accessories, and a leather vest all found in the closet.

Resident #035 had a pair of black boots in the closet. The resident stated that these were brought to the home the past spring. There was also a pair of black shoes with Velcro closure beside the resident's closet. The resident stated that these shoes were his/her everyday shoes and that s/he has had them in the home for some time.

Resident #036 had a green jacket in the closet. The resident stated that this jacket had

come with him/her on admission several months prior.

Resident #042 had one white athletic shoe (right side) under the closet. The inspector also found a yellow and white jacket and a green and white jacket in the closet.

Resident #044 had one brown leather shoe (left foot) and one slipper (right foot). The inspector found a dark gray wool coat, a blue jacket, and a red plaid coat in the closet.

Resident #046 had one white casual shoe by the bed.

Resident #047 had one black shoe (right foot in size 9) and one black shoe (left foot size 8).

The inspector verified again several days later and the items indicated above were still not labelled.

The inspector spoke with the Environmental Supervisor regarding the home's process to label residents clothing. It was discussed that the home lacked adequate processes to ensure resident clothing and shoes brought into the home after a resident's admission were consistently labelled. [s. 89. (1) (a) (ii)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to comply with section 101.(2) of the Regulation in that the licensee failed to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal and or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Resident #026 was admitted to the home late in 2014. On October 15, 2015, Resident #026’s family reported to Inspector #548 that the resident’s wheelchair had gone missing while in the home. Inspector #138 followed up with RPN #108 who stated to the inspector that she recalled the family raising a concern over six months ago that Resident #026’s wheelchair had been missing. The RPN was unable to recall any details related to the actions taken to address the concern or what the outcome was.

Inspector #138 spoke with the Director of Resident Care regarding Resident #026’s missing wheelchair and she stated that she had no knowledge of any concerns with the resident’s wheelchair. The inspector inquired about the process for handling complaints and the Director of Resident Care stated that staff, usually registered nursing staff, are to document the concerns on a Report of Concern form and submit to administration for follow up.

Inspector #138 also spoke with the Administrator regarding the home’s process for handling concerns and complaints. The Administrator stated that complaints and concerns are to be documented on a Report of Concern form and treated as per the home’s policy. The home’s policy, Complaints – Resident/Family ADMMVII-035, was reviewed by the inspector. This policy states the procedure for handling a complaint and further indicates that the home is to maintain documentation of verbal and written complaints, including the date the complaint was received, the response to the complainant, the final resolution, the date the response was made along with a description of the response, and any responses made by the complainant. The inspector requested and obtained from the Administrator the home’s documentation relating to complaints for 2014 and 2015. The inspector reviewed and verified that there was no documentation relating to Resident #026’s missing wheelchair. [s. 101. (2)]

Issued on this 27th day of October, 2015

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

Original report signed by the inspector.