1. [O.Reg. 79/10, s. 53(4)(b)]
The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Resident #265 demonstrated a responsive behaviour by becoming aggressive towards another resident. The resident was sent out for further evaluations and upon return to the home, a referral was made for specialized services and assessment. The resident was seen by specialist and recommendations were made to change several medications and the dosage of medications. The resident's clinical record, electronic medication record (emars), physician's digi-order and progress notes indicated that these medication strategies, that were developed in response to the resident's behaviour, were not implemented by the registered staff until six days later and not administered to the resident until eight days after the recommendations were made. [s. 53. (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 with ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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1. [O.Reg. 79/10, s. 57(2)]
A written response was not provided within 10 days of receiving Residents' Council advice related to concerns or recommendations. Interview with the Administrator confirmed that a written response was provided in the meeting minutes from the previous month meeting, however, not within 10 days. [s. 57. (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 with ensuring that if the Residents' Council has advised the licensee of concerns or recommendations, under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #21: 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. [O.Reg. 79/10, s. 69.1]
Not all residents with significant weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.
A) Resident #194 had a significant weight loss of 16% in one month and a further significant weight loss of 5.6% the next month(32% loss in one year). A referral was completed by nursing staff in relation to weight loss on two occasions. Action was not taken to address the weight loss and poor intake and the resident was not re-assessed by the Dietitian until after the second significant weight loss. Interview with the Dietitian indicated that the referral was missed prior to the Dietitian's vacation.
B) Resident #800 had a 5.1% significant weight loss over one month and a further weight loss of 4.95% the next month (9.8% loss over 2 months), which triggered a significant weight loss warning. At the nutritional review interventions were not revised and action was not taken to address the weight loss. [s. 69.]

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 with ensuring that residents with a change of 5 per cent of body weight, or more, over one month, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(4)]
Not all residents were offered the planned menu items at each meal.
a) At the lunch meal June 4, 2013, three residents (#250,#809, #810) who were the last to finish their meals, were not offered dessert. The dessert cart was removed from the dining room prior to the residents finishing their meals and the residents were not offered dessert until requested by the inspector. After the inspector asked, the residents were given pudding (not what was on the planned menu) and they were not offered a choice of dessert.
b) At the lunch meal June 17, 2013, pureed dessert was not available on the dessert cart (all pureed desserts were taken) for resident #807 and the resident was not offered dessert. The Food Service Manager stated that if a dessert was not available then staff were to get one from another floor.
c) Pureed bread was not offered to residents on an identified floor at the lunch meal June 24, 2013. Staff stated that the residents were offered mashed potatoes instead (different food group), however, the planned menu indicated pureed bread. Staff serving stated residents did not like cold pureed bread and only cold bread was available. The menu indicated a hot pork sandwich and the pureed bread was to be served hot. [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 with ensuring the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #23: 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,
(d) preparation of all menu items according to the planned menu; 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. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. 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,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 72(2)(d)]
Not all menu items were prepared according to the planned menu.
A) Not all recipes were followed by staff preparing meals. At the supper meal June 19, 2013 the recipe for pureed and minced honey mustard chicken stated to use the regular texture and then mince or puree the items. Staff used chicken breasts for the regular texture and diced chicken (white and dark meat) for the minced and pureed. The regular texture recipe called for whole chicken thighs. Staff added only broth to the minced and pureed texture, however, the recipe called for cornstarch, milk, mustard, honey, thyme, pepper, and parsley. The prepared minced and pureed chicken was less flavourful than the item on the planned menu. Interview with the Food Services Manager confirmed that staff were to follow the recipe so the sauces were the same for the regular and texture modified and not to use diced chicken for the texture modified menu unless specified in the recipe.
B) The recipe for Reuben sandwiches was different than the method used by staff preparing the sandwiches. Also, the amount of meat used for the sandwich was 40grams (as per staff), however, the recipe called for 66 grams of turkey, which would result in a reduced amount of protein than required on the planned menu.
C) The recipe for Reuben sandwiches called for staff to use whole regular sandwiches and then texture modify the sandwich. Staff were observed using crusts sliced off the minced sandwiches and adding the toppings separately. Direction was not provided to staff on the quantity of crusts they would have to use and the texture of the pureed sandwich would be different than when using a full sandwich (as per the planned recipe) [s. 72. (2) (d)]

2. [O.Reg. 79/10, s. 72(3)(a)]
Not all foods were prepared and served using methods that preserved taste, nutritive value, appearance and food quality.
A) Food items were prepared too far in advance of meal service, resulting in reduced nutritive value, appearance and food quality. On June 24, 2013, asparagus for the minced and pureed menus was observed being prepared at 1335 hours for the supper meal at 1700. Staff stated that they would cool the item and then reheat it prior to meal service. The Food Services Manager confirmed that staff were to prepare minced and pureed vegetables from the regular items and as close to meal service as possible, without cooling and re-heating the items. On June 17, 2013 the cook placed pans of sweet potatoes with butter into the steamer at 1303 hours. The cook confirmed that vegetables were for the supper meal at 1700. On June 19, 2013 the cook was panning green beans and then placing them back into the refrigerator for

later. The beans were partially thawed, however, cooking directions state that the beans should be cooked from a frozen state for quality. Recipes stated, "For optimal food safety and nutrient retention, texture modifications should be done within one hour of service". The Food Service Manager confirmed that the home was aware that staff were preparing items too far in advance of meal service and have planned for additional staff training.
B) Batch cooking was not provided for the first and second meal sitting. Food was placed in the steam table and sat for both sittings. Recipes stated food was not to be hot held for more than two hours.
C) Some recipes did not enhance the flavour and nutritive value of some items. The pureed tuna sandwich recipe stated to add water to the regular sandwich, vegetable recipes did not include any seasonings (vegetables only) and additional water to be added to the pureed vegetables (not flavourful or nutrient dense).
D) Multiple resident voiced concerns over food quality. [s. 72. (3) (a)]

3. [O.Reg. 79/10, s. 72(3)(b)]
Not all foods were stored using methods that prevented contamination. The scoop for the bin of ground flax was stored inside the container and had the potential to contaminate the entire bin of flax. [s. 72. (3) (b)]

4. [O.Reg. 79/10, s. 72(7)(a)]
The salt and pepper shakers on the second floor dining area were not kept clean. On June 4, 2013, during the lunch meal, the salt and pepper shakers were covered in hardened food debris. [s. 72. (7) (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 with ensuring the preparation of all menu items according to the planned menu 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 #24: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)1]
The weekly menu for two specialized diets were not posted for residents. The Food Services Manager confirmed that the menus were only communicated at point of service for the specific day's menu; the weekly menus were not posted for residents requiring these therapeutic diets. [s. 73. (1) 1.]

2. [O.Reg. 79/10, s. 73(1)4]
Not all residents were monitored during the lunch meal June 24, 2013 in an identified dining area. The dining room was left unattended at 1355 hours while three residents were still eating. Staff were not present in the dining room and the plan of care for one of the residents (#806) eating identified dysphagia with difficulty swallowing and history of choking on food and/or fluids. [s. 73. (1) 4.]

3. [O.Reg. 79/10, s. 73(1)6]
Not all food and fluids were served to residents at a temperatures that was palatable to residents.
A) Several residents voiced concerns about the temperature of the coffee/tea. The inspector tested the temperature of the coffee at the lunch meal service June 17, 2013 in the first floor dining room. The temperature at 1233 hours was 130 degrees Fahrenheit (F) in one carafe and 132 degrees F in another carafe. Residents were still eating and taking coffee with dessert at this time. The home's food temperature policy stated that hot beverages were to be served at 170-190 degrees F. Cold coffee was noted in the Food Council Meeting minutes on January 24, 2013 and March 22, 2013.
B) Several residents also voiced concerns about the food temperatures at meals. Review of temperature monitoring records revealed temperatures that were less than 140 degrees F (minimum temperature indicated on the home's "Serving Temperature policy FNSMS 140" without evidence that corrective action was taken to correct the low food temperatures. Not all staff were taking ending food temperatures, as per the home's Serving Temperature policy. Cold food temperatures were noted in the Food Council Meeting minutes on May 31, 2013.

Second floor:
May 29, 2013 lunch: alternate vegetable first sitting 139 degrees F
June 3, 2013 lunch: main course first sitting 137 degrees F
June 5, 2013 supper: pureed meat second sitting 134 degrees F
June 10, 2013 breakfast: egg first sitting 130 degrees F, second sitting 135 degrees F

June 16, 2013 breakfast: first sitting minced meat 134 degrees F

First floor:
May 29, 2013 lunch: alternate main course started at 160 degrees F, however, ended at 130 degrees F; minced vegetable 130 degrees F at the end of service
June 4, 2013 lunch: minced starch ending temperature 130 degrees F; pureed meat ending temperature 135 degrees F; starch 135 degrees F ending temperature
June 10, 2013 supper - no food temperatures recorded [s. 73. (1) 6.]

4. [O.Reg. 79/10, s. 73(1)10]
Proper techniques were not used to assist residents with eating, including safe positioning of residents who required assistance with eating.
A) At the lunch meal June 4, 2013, resident #802 was reclined in their tilted wheelchair and was being fed in a reclined position. The chair was not positioned in an upright manner and the resident was coughing while being fed by staff. Staff stated the resident's chair was to be in an upright position during meal times.
B) Staff assisting resident #807 with the lunch meal on June 4 and June 17, 2013 were aggressively scraping the residents mouth with a spoon while feeding the resident. [s. 73. (1) 10.]

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 with regulation sections 73(1)4, 73(1)6, and 73(1)10, to be implemented voluntarily.

WN #25: 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,
(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. [O.Reg. 79/10, s. 87(2)(b)]
Written procedures had not been developed and/or implemented for cleaning and disinfecting bath tubs (without a built-in disinfection system), resident personal care equipment such as basins, bed pans and urinals, using hospital grade disinfectant.

A cleaning schedule had been developed so that such items were cleaned weekly, however the expectations as to how and where to clean the equipment could not be found in writing. Policy and procedure IFC B-15 titled "Reusable Equipment" stated that "equipment in direct contact with a resident should be cleaned before use on another resident". There were no instructions on when and how to disinfect the equipment and when and how to store cleaned and disinfected items.

Care staff who were interviewed stated that the basins or bed pans were cleaned in the resident's washroom sink with soap and water and wiped dry with paper towel. Personal care articles were observed to be stored on top of toilet tanks or on grab bars. A stained urinal was noted on the grab bar in an identified washroom on June 25, 2013. Basins were stored on grab bars in six identified rooms. Bed pans were sitting on toilet tanks in two identified rooms on June 6 and June 27, 2013. The Director of Care expects that the personal care articles be stored in the resident's night table or wardrobe and not be left in the bathroom.

No disinfectant was connected to the mechanical tub located in the third floor tub room. It appeared the tub had not been designed with a built-in disinfection line. The home did not have any policies or procedures with respect to how to clean a tub between use manually, without the use of a built-in disinfection system. [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 with regulation s. 87(2)(b), to be implemented voluntarily.

WN #26: 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).

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,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

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,
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 89(1)(a)(iii)]
Procedures had not been developed and/or implemented to ensure that the resident's clothing, once cleaned was delivered to the resident.

Health Care Aides in the home had been assigned the task to deliver clothing to resident closets according to the environmental services supervisor. However, the clothing was not delivered to the appropriate resident. Residents who were interviewed stated that they had often times found clothing in their closet that did not belong to them. Confirmation was made during the inspection when random closets were checked. On June 27, 2013 in an identified room, a ladies night gown was found and returned to a resident residing in a different room. The label was clearly marked with the resident's name. A cotton sweater was found on June 27, 2013 in a resident's closet belonging to another resident who no longer resided in the home. A labeled cotton top was found in the home's lost and found bin in the basement, instead of being returned to the resident. The home's policy and procedure D-20-35 stated that the clothing would be delivered to the residents but did not identify who would deliver it and who would ensure that the process was followed.

Procedures had not been developed and/or implemented to ensure that linen was maintained in a good state of repair. Multiple pillows were in a poor state of repair (nine identified rooms). Pillow surfaces were cracked, exposing an absorbent layer underneath. A sufficient supply of pillows was identified in the storage area, however the health care aides who were responsible for making the beds were not identifying when a pillow needed to be replaced. The home's policy D-15-15 stated that linen would be maintained in a good state of repair. However the policy did not identify who would check pillows or whether pillows were included as part of the linen supply. [s. 89. (1) (a) (iii)]

2. [O.Reg. 79/10, s. 89(1)(b)]
A sufficient supply of clean linen and face cloths was not available for use by residents on June 7, 2013. No hand towels were available for 4/4 residents in an identified room at 1130 hours, 1/4 residents in an identified room at 1100 hours and 3/4 residents in an identified room and 1/4 residents in an identified room at 1400 hours. [s. 89. (1) (b)]

3. [O.Reg. 79/10, s. 89(1)(c)]
On June 4, 2013, the majority of clothing protectors being used by residents on the

second floor during the meal service were frayed and worn around the edges. [s. 89. (1) (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 with regulations s. 89(1)(a)(iii), 89(1)(b), and 89(1)(c), to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 91]
Hazardous substances were not kept inaccessible to residents at all times. Hazardous chemicals (two bottles of Viroxx solution) were stored on a shelf in the Activity room in the basement that was accessed daily by residents. Management was notified on June 12, 2013 and the chemicals were moved to a locked room. [s. 91.]

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 with ensuring that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #28: 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. (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. [O.Reg. 79/10, s. 229(10)3]
The licensee failed 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.
A) Interview with the Clinical Director of Care on June 24, 2013 confirmed that the treatment consent form signed by residents did not include tetanus and diphtheria, and therefore, there was no documentation to support that the home had offered immunization against tetnus and diphtheria to the residents in the home.
B) Three out of five (#265, #703 and #704) residents' health records reviewed did not have documentation to support that they were offered immunization against Diphtheria or Tetanus and no further documentation to reflect their refusal to these vaccines. [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 with ensuring that residents are offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #29: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 79(3)(h)]
The name and telephone number of the licensee was not posted and communicated. A tour of the home with the Business Manager on June 14, 2013 confirmed that the home's telephone number was not posted in the home in a conspicuous and easily accessible location. [s. 79. (3) (h)]

WN #30: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 85(3)]
The licensee had not sought advice of the Residents' Council and the Family Council in developing a carrying out the survey, and in acting on its results. The home used ABAQIS as their satisfaction survey and completed the surveys monthly. Results were reviewed at the CQI committee monthly. A review of the Residents' Council minutes indicated residents were not consulted in the development of the survey or carrying out of the survey or acting on its results. ABAQIS was also not able to be changed to include the suggestions of the residents, even if they were asked for advice. The home confirmed that other methods had not been implemented. [s. 85. (3)]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 85(4)(c)]
The licensee had not ensured the survey results and actions taken to improve the home, were made available to residents and their families. A review of Residents' Council minutes indicated there were no results provided to Residents. [s. 85. (4) (c)]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 114(2)]
The licensee failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.
Interview with the Director of Care (DOC) and the Pharmacist on June 19, 2013 confirmed that the home had not developed a written protocol for the destruction and disposal of non-narcotic medication system in the home. [s. 114. (2)]

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 131(5)]
The licensee had not ensured that resident #920 had approval from the prescriber to self administer their puffers. Nursing staff indicated resident #920 self administered their puffers. Observation in the resident's room revealed their puffers were sitting on their bedside table visible and accessible. There were no physician's orders to direct self administration. [s. 131. (5)]

Issued on this 4th day of September, 2013

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

M Warrener, RD

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107), BERNADETTE SUSNIK (120), LALEH NEWELL (147), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2013_191107_0006
Log No. / Registre no:	H-000271-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 2, 2013
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	DUNDURN PLACE CARE CENTRE 39 MARY STREET, HAMILTON, ON, L8R-3L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBBIE BOAKES

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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that summarizes the following;

1. How will residents be assessed to determine the risk factors associated with their bed system, if they require the use of one or more bed rails. Who will conduct the assessments and by when?
2. What interventions will be implemented to mitigate risks to residents, who require the use of one or more bed rails where an entrapment zone has been identified on their bed system?
3. What long term plans will be implemented to ensure that all residents continue to be assessed?
4. What long term plans will be implemented to ensure that all bed systems are evaluated for entrapment zones?
5. Who will train all staff involved in caring for the residents regarding bed safety and by when?

A copy of the policy and procedure for the above noted issues shall be submitted with the plan.

The plan shall be submitted to Bernadette Susnik, LTC Homes Inspector, either by mail or e-mail to: 119 King St. E., 11th Floor, Hamilton, ON, L8P 4Y7 or Bernadette.susnik@ontario.ca by August 31, 2013.

Note: If an extension of the compliance date is required, please contact the Inspector at least one week before the original compliance date .

Grounds / Motifs :

1. [O.Reg. 79/10, s. 15(1)(a)]
Where bed rails were used, residents were not assessed when the bed systems were evaluated for entrapment zone risks. Beds that did not meet the measurement guidelines outlined in Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" that could not be altered or modified, continued to be used by residents.

The home evaluated all of their 201 beds on December 17-19, 2012 for entrapment zones one through seven. Approximately 115 beds failed one or more entrapment zones. Beds were adjusted where possible (head board, foot board, bed rails or mattress) and 62 new beds were purchased and installed June 19-21, 2013. Another evaluation was conducted June 25-27, 2013, identifying that 73 beds remain non-compliant with one or more entrapment zone guidelines.

According to both the Director of Care and Assistant Director of Care, no measures to mitigate risks had been instituted and residents had not been assessed for bed safety other than for falls risk. Foam wedges were purchased in February 2013 for approximately 12 residents to prevent falls from bed where one bed rail was removed.

During the inspection, beds were identified to be missing mattress keepers (hold the mattress in position and prevent it from sliding side to side - two identified rooms) and large gaps were noted between the end of the bed rail and the headboard (two identified rooms), between the headboard and the mattress (one identified room - a blanket was rolled up in the space), between the mattress and bed rail (three identified rooms) and between the mattress and the foot board (two identified rooms). Wobbly loose rails that could be moved from side to side were also noted in two identified rooms. Air mattresses were available in the home and used by residents (three identified rooms) who used bed rails, but had not been evaluated for the inherent risks associated with a very soft and compressible mattress. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that clear direction is provided to staff and others providing direct care to residents in relation to oral care, positioning at meals, and feeding techniques, including but not limited to, a review and revision to the plan of care for residents #198, #802, and #807.
The plan is to be submitted by August 23, 2013, to Long-Term Care Homes Inspector, Michelle Warrener, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)] Previously issued March 29, 2011 as a VPC, March 30, 2011 as a VPC
The written plan of care for residents did not provide clear direction to staff and others who provided direct care to the residents.
A) The plan of care for resident #198 did not provide clear direction to staff in relation to oral care and was not individualized.
i) The plan stated the resident required total assistance with oral hygiene, however, did not direct staff on how or what care to provide. Staff stated the resident did not have any teeth and required specific interventions for oral hygiene and required a cream to be applied to the lips due to dryness. The plan of care did not include direction for staff on either of these interventions. The resident had thick ropey saliva and very dry flaking lips when observed on several occasions (June 5, 19, 24, 2013) during this review. (107/169)
B) The plan of care for resident #802 did not provide clear direction to staff positioning the resident at meal times. The resident was in a specialized tilt wheelchair and the chair was required to be in an upright position during meals (as per staff interview). The resident was observed in a reclined position and was coughing during the lunch meal service June 4, 2013. The plan of care did not include the requirement of the chair to be in an upright position during meal service. (107/169)
C) The plan of care for resident #807 did not provide clear direction for staff assisting the resident with eating. Staff stated that he resident required special feeding techniques, however, these techniques were not included on the resident's plan of care. The resident was being fed at the lunch meal June 4, 2013, however, staff stated the person assisting the resident did not know how to feed the resident in a way that worked for the resident and the resident did not eat well. Staff stated that the resident wouldn't eat unless the special techniques were used (not used by the person assisting) and the Registered staff then proceeded to assist with an additional bowl of soup at the end of the meal service. The resident did not consume an entree that day. (107) (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures the care set out in the plan of care is provided to residents, including residents #803, #260, #806, #801, and #198, as specified in the plan, related to bathing, falls, fluid consistency, and fluid restriction.
The plan is to be submitted by August 23, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued November 16, 2011 as a WN
The care set out in the plan of care for residents was not provided as specified in their plans.
A) Resident #803 was not provided care as set out in their plan of care related to bathing.
i) The resident had an order for medication which was required for bathing only. Staff stated they were often unable to provide showers and nail care for the resident due to the resident's behaviours, however, the medication was not offered to the resident prior to bathing for two months reviewed. Registered staff were not coordinating the provision of the medication with the bathing schedule. The resident was not bathed at minimum twice weekly during the two months.
B) Resident #260 was not provided care according to their plan in relation to falls. Clinical records indicated the resident had ten falls over a one year period. The plan of care, and interview with the registered staff, confirmed that the home had initiated interventions for the resident to minimize further falls. On June 12, 2013 at 1124 hours the resident was in bed without the interventions in place to minimize the risk of any further falls. (147)

C) The care set out in the plan of care for resident #806 was not provided to the resident as specified in their plan related to required fluid consistency. The resident's plan of care required thickened fluids at meals, however, at the lunch meal June 19, 2013, the resident was provided and was drinking thin fluids. A PSW then came and took the thin fluids away from the resident (after had been consuming them) and replaced them with the required consistency thickened beverages.(107)
D) The care set out in the plan of care was not provided to resident #801, as specified in the plan related to hydration and required fluid consistency.
i) The resident had a plan of care requiring a fluid restriction. At the lunch meal June 17, 2013, the resident was offered more than twice their allotted fluid amount for that meal. The resident was documented as consuming more fluids than their required fluid restriction on 13 days in one month and nine days the subsequent month.
ii) The resident had a plan of care requiring thickened fluids. The resident received thin coffee at the lunch meal June 17, 2013. Staff stated they added a bit of the resident's thickened milk to the coffee, however, it was not the required consistency. The resident was observed coughing after consuming the thin coffee. (107) (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2013

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that residents are re-assessed and their plans of care reviewed and revised when their care needs change or care in the plan is no longer necessary in relation to: cognitive status; mobility; health status; recreation; nutritional needs.
This includes residents #276, #265, and #194.
The plan is to be submitted by August 23, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued March 30, 2011 as a VPC, June 28, 2011 as a VPC, August 12, 2011 as a VPC, May 25, 2012 as a VPC, January 30, 2012 as a WN
Residents were not re-assessed and their plan of care reviewed and revised at least every six months and at any other time when the residents' care needs changed or the care set out in the plans was no longer necessary.
A) The plan of care for resident #276 was not revised when their care needs changed related to cognitive status.
i) The resident's plan of care stated the resident was confused and not aware of their location, however, interview with the resident and staff confirmed the plan of care was not updated to reflect the current cognitive status of the resident (able to converse and was not confused about location). (107)
B) Resident #265 was not reassessed and their plan of care reviewed and

revised when their care needs changed in relation to mobility.
The resident's plan of care, and three Resident Assessment Protocol (RAP) summaries, identified that the resident was reassessed for the use of their mobility device three weeks prior and did not pass the cognitive and safety assessment completed by the authorizer. The resident was now utilizing a manual wheelchair for mobility on an off the unit. Interview with the Physiotherapist also confirmed that the resident was no longer using the mobility device. The resident's plan of care was not revised to indicate that the resident's mobility needs had changed and that the care set out in the plan was no longer necessary. (147)
C) The recreation plan of care for resident #194 was not revised when the resident's health status changed.
i) The resident had a significant change in status and was noted to be confined to bed due to a significant pressure ulcer. The resident's recreation plan of care was not revised and still reflected the resident was attending structured activity programs, however, the resident was no longer able to leave their room. There was no re-assessment of the resident's recreation needs and no change to the plan of care to ensure their recreation needs were met while the resident was in their room during the day. The Recreation Manager confirmed that the recreation plan of care was not revised for the resident based on their change in condition. (107)
ii) The resident had deteriorated and was bed bound, however, the resident's plan of care was not revised to reflect the change. The care plan stated the resident was eating meals in the dining room, however, the resident had been eating meals in their room.
iii) The Dietitian re-assessed the resident's energy and protein requirements after the development of an open area, however, the care plan was not revised to include the revised requirements. The resident lost a substantial amount of weight, however, the goals on the resident's plan of care were not revised in relation to the weight change. (107) (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 005

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

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 prepare and submit and implement a plan that summarizes the following;
1. Time frame for the installation of activation stations in all areas where residents have access.
2. Measures to ensure that each resident has access to their staff-resident communication and response system when in bed or using the toilet.
3. Measures to ensure that when a resident activates the system, that staff are aware of the location of the signal and can respond to the signal at any time.
4. Measures to monitor stairwell and perimeter doors to ensure that the alarms are functioning and that the signal is connected to the system and visual display panel at the nurse's station that is located closest to the door.
5. When and how all staff will be informed of the home's amended staff-resident communication and response system policies and procedures.
6. What contingencies are in place for staff and residents should the system malfunction.
A copy of the policy and procedure for the above noted issues shall be submitted with the plan.
The plan shall be submitted to Bernadette Susnik, LTC Homes Inspector, either by mail or e-mail, to: 119 King St. E., 11th Floor, Hamilton, ON, L8P 4Y7 or Bernadette.susnik@ontario.ca by August 31, 2013.

Note: If an extension of the compliance date is required, please contact the Inspector at least one week before the original compliance date .

Grounds / Motifs :

1. [O. Reg. 79/10, s. 17(1)(a)]
The home's resident-staff communication system was not easily seen, accessed and used by residents and staff.
A) On June 10, 2013, resident #320 was brought to the Activity room in the basement by a staff member so the resident could use the washroom. The resident was instructed to use the call bell when they were finished. The resident activated the call bell, however, staff did not come to answer the bell for at least 20 minutes. The resident was visually impaired and used a mobility aide and was unable to get out of the washroom without assistance. The resident was assisted by an inspector. Staff that eventually came to answer the call bell stated that call bell lit up on the panel on the second floor and they were unsure where the bell was coming from. (107)
B) The home did not have the call bell accessible to resident #250 while they

were resting in bed. The call bell was wrapped over the bed rail and under the pillows and not within reach on June 6, 2013. The plan of care directed staff to pin the call bell to the resident's bedlinen to ensure it was accessible while in bed. (107)
C) On June 6, 2013 at 1136 hours resident #294 did not have their call bell within reach. The resident asked the inspector to activate the call bell for them and stated that staff always put the call bell on the other side of the bed which the resident could not reach. The resident required assistance with toileting. (107)
D) On Jun 26, 2013 at 1050 hours, resident #9051 did not have their call bell within reach. The resident stated that staff do not always place the call bell within reach and they could not use it. The resident described an incident that happened the day prior (June 25, 2013) where the resident could not reach their call bell and was calling out for staff assistance with toileting. (107)

[O.Reg. 79/10, s. 17(1)(e)]
A) The resident-staff communication and response system was not available in the second, third and fourth floor resident lounges and dining rooms.
B) The resident-staff communication and response system was not functional and therefore could not be used in the washroom of an identified room. The cording was strung from the activation station located behind the toilet all the way around the toilet to the side. When the cord was pulled, it could not activate the station.

[O.Reg. 79/10, s. 17(1)(g)]
The home was not equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.
A) On June 6, 2013, the call bells in the 2nd and 3rd floor shower area in the spa were not audible to staff. Both call bells were activated in the shower area and the light outside the shower room clearly indicated it was activated. Staff confirmed the call bells were also to use sound to alert staff, which the two call bells by the shower area did not.
B) On June 5, 2013, the call bell in resident #163's room was not audible and did not clearly indicate where the signal was coming from to alert staff. Interview with the registered staff confirmed that the call bells were to light up and be audible when activated to ensure that the staff were properly alerted.
C) On June 6, 2013, the call bell in resident #309's room was not audible to alert

staff when activated. Interview with the registered staff confirmed that the call bells were to be audible when activated to ensure that the staff were properly alerted. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2013

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 : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that a registered dietitian who is a member of the staff of the home, (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). The plan should include:
a) a review and revision of the home's current policy and procedure related to hydration and referral to the Registered Dietitian
b) a system for identifying residents with poor hydration
c) a system for the implementation of strategies that address poor hydration
This includes a review of residents #194 and #800 related to hydration.
The plan is to be submitted by August 23, 2013 to Long-Term Care Homes Inspector Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 26(4)(b)]
A) The registered dietitian did not assess resident #194's hydration status at a quarterly nutritional review. The resident's daily food and fluid intake records reflected the resident met their minimum fluid requirement of 1500ml/day on only 1/31 days for an identified month. The resident's hydration status was not mentioned at the review during the subsequent month. The resident was noted to have a significant weight loss of 13% over six months (identified in the subsequent month) and the resident had a significant open area on the skin. The resident continued to have poor hydration and did not meet their minimum fluid requirement on any day for the subsequent two months. A referral to the Dietitian related to poor hydration did not occur (only referrals for weight loss noted). There was no assessment of the resident's poor hydration or interventions to correct the poor hydration until the Dietitian assessed the resident three months later.
B) A referral to the dietitian did not occur for resident #800 when their food and fluid intake records reflected they did not meet their hydration requirement on 12/31 days for one month (9/15 days the second half of the month). The resident had a significant weight loss warning triggered the next month and the resident's hydration status was not assessed at that time in relation to the weight loss.
(107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2013

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 : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that summarizes both the short term and long term actions for the following;

1. Measures to ensure that the exhaust system is functioning as intended and maintained clean.
2. Measures to ensure that interior doors in the home are kept in good repair so that they can open, close and latch.
3. Measures to ensure that furnishings, equipment and cabinetry in the home are maintained in good repair.
4. Measures to ensure that windows are properly sealed to keep out drafts and kept in good repair.
5. Measures to ensure that the surfaces of walls, doors, ceilings are maintained in good condition on an ongoing basis.
6. Measures to ensure that lighting levels are maintained as per regulatory requirements.
7. Measures to ensure that the roof is maintained in good repair and repaired in a timely manner when necessary.
8. When and how relevant staff will be informed of the home's amended maintenance policies and procedures.

A copy of the policy and procedure for the above noted issues shall be submitted with the plan.

The plan shall be submitted to Bernadette Susnik. LTC Homes Inspector, either by mail or e-mail to 119 King St. E., 11th Floor, Hamilton, ON, L8P 4Y7 or Bernadette.susnik@ontario.ca by August 31, 2013.

Note: If an extension of the compliance date is required, please contact the Inspector at least one week before the original compliance date .

Grounds / Motifs :

1. The licensee has not ensured the furnishings are maintained in a good state of repair. On June 4, 2013 observation of the dining chairs on an identified floor was completed. The wooden dining chairs were noted to be very worn with several ares of the wood worn. The stools used by staff to assist residents with feeding were observed to have several cracks in the vinyl and the square table with the microwave on it had four legs which were extremely rusty. Dining furniture in another dining area was also noted in poor repair. (169)

2. The maintenance services program does not have procedures in place for routine, preventive and remedial maintenance for the home's exhaust system, roof, windows, doors, walls, cabinetry, nurse call system, lighting and beds. Negative outcomes in these areas were identified as follows;

1. Exhaust system was not functioning in four identified bathrooms, and third and fourth floor tub rooms (1 unit not exhausting out of two). Many of the interior exhaust units were observed with thick layers of dust, some had their exterior baffles closed and two had paper taped over the opening. The one exhaust unit in the third floor tub room was noted to be blowing into the room instead of out of the room. The exhaust system was observed to be inadequate in all tub rooms. Tub rooms were stuffy and moist. Only two exhaust grilles were identified in all but the first floor tub room. These tub rooms had three showers, a toilet and a tub in each room. Procedure E-40-01 for the exhaust system required a bi-annual cleaning and procedure E-40-10 required that the exhaust motors were inspected monthly. According to the environmental manager, the exhaust system was checked by an outside contractor on May 28, 2013. However, no routine monitoring of the system was conducted to determine adequate function and cleaning was not done according to need and was not identified in any existing procedure.

2. Interior bathroom doors were observed to be misaligned and not able to close in four identified rooms. Maintenance records, reviewed for January to June 2013 completed by staff, identified that hinges or door closing issues were a problem in six identified rooms. These doors were all adjusted, but staff reported that they continued to come loose from the door frame. Maintenance staff reported that the frames were not secure and needed to be replaced. No procedures were identified to deal with interior door preventive maintenance.

3. Cabinetry in several lounge spaces and the second and fourth floor dining rooms were not in good condition. The laminate on the lower cabinets in the dining rooms was peeling away and was rough. The wooden cabinetry in several lounges was noted to be worn, exposing raw wood. An over bed table surface was damaged in an identified room, a gray shower chair seat was cracked exposing foam underneath in the 4th floor tub room, and a stool seat cover was cracked in the 4th floor dining room. Mattresses were noted to be in poor condition in two identified rooms. The water resistant cover had peeled

away, exposing an absorbent inner layer. The home did not have any policies or procedures related to maintaining furnishings and equipment (bathing and bed equipment) in good condition.

4. Water was noted to be dripping down into the first floor dining room from a pipe located in the ceiling on June 4 and June 27, 2013. Staff completed a maintenance request on May 29, 2013 indicating that a leak was coming from the ceiling. The maintenance supervisor stated that the roof company had been contacted but could not confirm when the roof could be repaired or what exactly was causing the leak. No procedures were available to identify what tasks were required of either in house staff or external contractors to keep the roof in good condition.

5. Windows located in the home were observed to be in poor condition. The seals and window hardware for the hopper windows on the fourth, third and second floors were not functioning as intended. Evidence of poorly sealed windows were observed in various bedrooms and dining rooms. Duct tape had been used to seal around the window where it connected with the frame to keep out drafts. Residents who were interviewed reported that it is drafty in the winter. The window locking hardware was observed to be worn down, incapable of locking or sealing shut the windows. The home, therefore, fixed slide locks onto the frames. The locks served to keep the windows from swinging open on their own but did not keep the windows sealed adequately to keep out drafts. The home's policy and procedure for windows E-75-20 required that the windows were in good condition, including the screens and that the opening be no greater than 10 centimeters. The policy did not provide any other guidance to staff.

6. Procedures were not available to determine how lighting would be maintained in the home and by whom. Burnt out bulbs were noted in the first floor dining room, resident washrooms and first floor corridor. Lighting levels varied due to the type and age of the tubes or bulbs. Lighting levels were lowered by staff based on a corporate policy requiring staff to keep indoor air temperatures more comfortable during heat alerts. However, this practice is no longer accepted for safety reasons and the requirements of O.Reg. 79/10, s. 18 to maintain acceptable lighting levels.

7. The resident-staff communication and response system policy and procedure

E-75-5 did not include checks on the entire resident-staff communication and response system. The procedure required that call bell cords, hallway lights and the audio system be checked monthly, however it did not include checking the stairwell or perimeter door alarms and their connectivity to the panels located at the nurse's station.

9. Holes in walls were noted in three identified rooms, wall surfaces were peeling in five identified rooms and cracked or chipped wall tile was noted in three identified washrooms. An audit was conducted of wall condition on March 19, 2013 and identified three washrooms to be cracked or damaged. The environmental services supervisor stated that the walls throughout the home would be repaired and repainted by the end of the summer. A policy or procedure was not available to advise staff how walls and tiles would be maintained throughout the year.

10. The licensee had not ensured the furnishings were maintained in a good state of repair. On June 4, 2013, the dining chairs on the second floor were noted to be very worn with several areas of the wood worn down. The stools used by staff to assist residents with feeding had several cracks in the vinyl and the square table with the microwave on it had four legs which were extremely rusty. Dining furniture in the first floor dining area was also noted in poor repair. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 07, 2013

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 : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 231. Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that written records are created and maintained for each resident of the home and that a records management system is in place that allows staff to access the required information in a timely manner.
The plan is to be submitted by August 23, 2013 to Long-Term Care Homes Inspector, Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 231(a)]
Resident records were not maintained for each resident of the home and records were not accessible to staff.
A) Flow sheets were requested for resident #198, however, several of the flow sheets were unable to be found. Flow sheets from April 15-May 26 and June 1-9, 2013 were unavailable for review.
B) Flow sheets were requested for resident #802, however, several of the flow sheets were unable to be found. Flow sheets from May 13-June 9, 2013 were not available for review.
C) Flow sheets were requested for resident #803, however, several of the flow sheets were unable to be found. Flow sheets from April 8-May 12, 2013 were not available for review.
D) Resident records were not kept in an accessible location (stacked in a closet or stored in various locations at the nursing station) and were not available for staff to review/use for the three month quarterly reviews. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2013

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
Performance Improvement and Compliance 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

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

and the Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
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 2nd day of August, 2013

Signature of Inspector / Signature de l'inspecteur : M Warrener, RD

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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