Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2015	2014_337581_0024	T-000101-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION
60 RICHVIEW ROAD ETOBICOKE ON M9A 5E4

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

UKRAINIAN CANADIAN CARE CENTRE
60 RICHVIEW ROAD ETOBICOKE ON M9A 5E4

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

DIANNE BARSEVICH (581), KATHLEEN MILLAR (527), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 9, 10, 11, 12, 15, 16, 17, 18 and 19, 2014.

This inspection was completed concurrently with Critical Incident Inspections T-000242-13 and T-009443-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Manager of Programs, Documentation Nurse, Administrative Assistant RCS, Director of Support Services, Physiotherapist, Registered Dietitian, Infection Control Nurse, Administrative Accountant, Manager Nutrition and Food Services, Dietary Aides, Personal Support Workers (PSW), families and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
6 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents' rights were fully respected and promoted to ensure all residents were treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

A) On December 10, 2014, during the dining observation, it was observed that all residents were not provided with forks and knives; however, were only provided spoons. The registered nursing staff identified there was one resident who liked to touch other residents knives on their table and so the staff removed all knives and forks from all residents. Only one resident had a plan of care that directed staff to remove knives due to a safety issue. The Registered Dietitian and Director of Care confirmed this was not treating all residents on the fourth floor with respect, individuality and dignity.
During the same meal, one resident was not provided any utensil to eat their peaches, therefore was observed using their fingers. Staff were asked about the reason for not providing any utensils and they confirmed they forgot to give the resident a spoon. After the spoon was provided, the resident consumed all their dessert of peaches. This was confirmed by the Personal Support Workers.

B) On December 16, 2014, resident #008 was observed in the lounge beside the dining room. The resident was sitting in their wheelchair and was flailing their arms and legs and was calling out. The resident had fluids in front of them on an over bed table. The

resident was thrashing in the chair. The resident vomited a large amount of emesis. Staff were observed washing the table top and the floor around the resident. A Personal Support Worker wiped the residents mouth with a tissue. The resident continued to have copious amounts of phlegm in their mouth and staff did not clean their mouth or suction the phlegm as per plan of care. Staff did not take vital signs nor did they complete a chest assessment to rule out aspiration, according to the plan of care. The resident had decayed teeth and oral care was not provided until the inspector mentioned it. The nursing staff confirmed this. The documentation was reviewed and confirmed care was not provided in a way to treat the resident with dignity. [s. 3. (1) 1.]

2. Every licensee of a long-term care home shall ensure that the following rights of residents were fully respected and promoted to be afforded privacy in treatment and in caring for his or her personal needs.

A) On December 17, 2014, resident #210 was in the hallway. The resident had a physician's order to have their blood sugar checked prior to lunch and depending on the results, may receive insulin. The RPN tested the resident's blood sugar and then administered insulin in the abdomen in a hallway. The LTC Inspector observed, and could hear the conversation between the RPN and the resident. The RPN did not offer privacy prior to exposing the resident and administering the insulin. The RPN and DOC confirmed that residents were to be offered privacy prior to providing care and treatment. (527)

B) The shower rooms on all floors were not equipped with privacy curtains resulting in possible visibility of the resident from the hallway when receiving a shower. The SPA room on the fourth floor had a track for a privacy curtain at the entrance to the room, however there was not a curtain in place. This was observed on December 9 and 18, 2014. This was confirmed by the Director of Care (DOC) and Director of Support Services. (169) [s. 3. (1) 8.]

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 all residents' rights are fully respected and promoted related to the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, and the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

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

Resident #003's plan of care was reviewed and the Bladder and Bowel Continence

Assessment dated on an identified day in December 2014, indicated that the resident wore medium white briefs on all three shifts. The written plan of care stated they wore medium white incontinence product and the kardex indicated brief size medium. Review of the Medical Mart Continence Management Program form updated on October 31, 2014, stated they required a medium night yellow brief on days and evenings and a large night green brief on nights. Interview with a PSW stated the resident wore a medium white brief on days and evenings and a green brief on nights. Another PSW stated the resident wore the medium yellow brief on days and evenings and the green brief on nights.
The DOC and PSW's confirmed that resident #003's plan of care and kardex did not provide clear direction related to incontinent products. [s. 6. (1) (c)]

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

The Physiotherapist(PT) had completed an assessment for resident #008 related to seating. The resident had a specific diagnosis and required seating that supported their entire body and limbs. The Registered Dietitian completed an assessment related to swallowing issues as part of the disease process. The assessment and subsequent plan of care directed staff to put the resident in a position that supported effective swallowing; however, this position did not support the tilt position recommended by the PT and Occupational Therapist(OT). The nursing staff also identified the resident was at high risk due to a swallowing decline related to the disease process. The resident should of been fed meals in a position to reduce their risk of aspiration. The plan of care did not clearly demonstrate a collaborative approach between all the professional disciplines had occurred, to ensure staff were provided with clear direction to provide care. The DOC and Manager Nutrition and Food Services confirmed this. [s. 6. (4) (a)]

3. The licensee failed to ensure that care was provided to residents as specified in the plans of care.

A) The plan of care directed staff to provide thin fluids to resident #110; however, on an identified date in December 2014, the resident was provided with thickened eighteen percent cream and thin water and juice. The resident returned from hospital in December 2014,and the re-admission assessment by the Registered Dietitian (RD), directed staff to give thin fluids. The RD confirmed the cream was thickened by the dietary aide and was not according to the plan of care. The dietary aide also confirmed the cream was

thickened; however, not according to the plan of care. (169)

B) On December 16, 2014, during a meal, resident #132 was provided two scoops of sour cream, potatoes and carrots. They were also provided a bowl of food, thick and pureed in appearance. The menu identified a specific food item was to be provided also. The resident did not receive the planned menu items. The plan of care directed staff to provide one bowl of food with a specific texture at meals, in addition to the regular meal. The resident was not provided the regular meal. The registered staff confirmed this was not provided. The Manager Nutrition and Food Services and Director of care confirmed the plan of care directed staff to provide the regular meal in addition to the specific texture meal. The documentation confirmed the care was not provided according to the plan of care. (169)

C) Resident #200 had a physician order to be up in the wheelchair for each meal three times per day and then back to bed to rest. The resident was interviewed and stated that they get up in their wheelchair for breakfast and do not go back to bed until after lunch and then get up in the wheelchair for supper. The RPN and PSW confirmed the resident did not go back to bed as identified in the plan of care. The Inspector observed on December 16, 17 and 18, 2014 that the resident was up in their wheelchair from breakfast until after lunch each day. The plan of care was not provided to the resident as specified in the plan. (527) [s. 6. (7)]

4. The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

The physician wrote an order in April 2013, which identified that resident #200 was to be up in the wheelchair for each meal three times per day and then back to bed to rest. The PSW and RPN were expected to sign the documentation for June, July and August 2013, that the resident was returned to bed after the meal three times per day. The documentation was inconsistently signed off by the PSW and the RPN. The PSW, RPN and the clinical record confirmed that the care set out in the plan of care was documented inconsistently. [s. 6. (9) 1.]

5. The licensee failed to ensure that the resident was reassessed and the care plan was reviewed and revised when the resident's care needs changed and the care set out in the plan was no longer necessary.

The physician wrote an order in April 2013, which identified that resident #200 was to be

up in the wheelchair for each meal three times per day and then back to bed to rest. The RPN confirmed on an identified day in December 2014, that the physician's order was not discontinued. The resident had subsequent Minimum Data Set (MDS) assessments on a quarterly basis, with the last assessment in October 2014. The assessment identified that the resident's care needs changed and they were able to tolerate being up in the wheelchair for longer periods. The RPN, PSW and DOC, and the clinical record confirmed the resident's care needs changed since admission. The care plan that staff used to direct the resident's care was not revised when the care needs changed and the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct
care to the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are
integrated, consistent with and complement each other, that care set out in the plan of care is provided to the resident as specified in the plan of care, that the provision of the care set out in the plan of care is documented and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(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).

Findings/Faits saillants :

1. The licensee failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) A review of resident #003's written plan of care indicated that they required the use of two quarter bed rails in the raised position for bed mobility and positioning, when in bed. On December 15, 16, 17, 2014, the resident was observed in bed with two quarter bed rails raised. A review of the written plan of care did not include an assessment of the bed rails being used. The registered staff and DOC confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B) A review of resident #016's written plan of care indicated they required the use of two quarter bed rails in the raised position for bed mobility and repositioning when in bed. Interviews with the PSW and RPN confirmed that the resident has their bed rails raised when in bed. A review of the written plan of care did not include an assessment of the bed rails being used. The DOC and the registered staff confirmed that the home did not have a formalized assessment for the use of bed rails in place.

C) A review of resident #020 written plan of care indicated that they required the use of two quarter bed rails in the raised position for bed mobility and for safety. On December 15, 17, 2014, the resident was observed in bed with both quarter bed rails raised. A review of written plan of care indicated that they required the use of two quarter bed rails in the raised position for bed mobility and safety; however, did not include an assessment of the bed rail being used. The DOC confirmed that the home did not have a formalized assessment for the use of bed rails in place. [s. 15. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living may be included in a resident's plan of care only if the following were satisfied, that alternatives to the use of a PASD had been considered and tried where appropriate, the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, and the PASD had been consented to.

A. Resident #003 was observed in bed on December 15, 16, 17, 2014, with two quarter bed rail raised. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for their use. The DOC confirmed that the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint nor did they have documented consent or approvals for the bed rails in place.

B. Resident #020 was observed in bed on December 15, 17, 2014, with two quarter bed rail raised. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rails nor any documented consent or approvals for their use. The DOC confirmed the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint nor did they have a documented consent or approval for the bed rails in place.

C. Resident #016's bed was observed with two quarter bed rails raised on their bed on December 15, 16, 17, 2014. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rails, nor any documented consents or approvals for their use. The DOC confirmed the resident's bed rails were not assessed to determine if the bed rails were being used as a PASD or a restraint nor did they have a documented consent or approval for the bed rails in place. [s. 33. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living is included in a resident's plan of care only if the following are satisfied, alternatives to the use of a PASD are considered and tried where appropriate, the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, and the use of the PASD has been consented to, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all equipment in the home was kept in good repair.

There were two century bathing fixtures on the third floor and one on the second floor. All three tubs were "locked out" and non functional. The nursing staff stated the tubs were out of commission since May 2014. The Director of Support Services, DOC and ED confirmed the three tubs had not been functional since May 2014. Three new tubs had been ordered as confirmed by the purchase order and were planned to be installed in January 2015. The century bathing fixtures were not maintained in good repair for eight months. This was confirmed by documentation and the ED. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that, all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #6: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the program.

On December 15, 16, 17 and 18, 2014, the Long Term Care Inspector observed that hand hygiene was not being performed consistently by the registered staff in between administering medication to residents. The registered staff confirmed they had forgotten to perform their hand hygiene. The DOC confirmed that staff were expected to perform hand hygiene when administering medications. [s. 229. (4)]

Additional Required Actions:

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

WN #7: 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 respond in writing within ten days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council Meeting Minutes on June 18, and September 17, 2014 identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes from September 17, 2014, included concerns from family members regarding oral care, behaviours, the dentist and staff actions. These concerns were not responded to, as confirmed by the ED. [s. 60. (2)]

WN #8: 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).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

A review of the Resident Council Meeting Minutes from January to November 2014, indicated that a review of the meal and snack times was not approved by the Residents' Council and this was confirmed by the Manager of Programs. [s. 73. (1) 2.]

2. The licensee failed to ensure that milk was served at a temperature that was safe and palatable for a resident who was being provided with tray service.

On December 16, 2014, during a meal service a tray was observed sitting on the counter in front of the servery. The name of resident #181 was written on the napkin and there was a glass of milk, juice and water on the tray. The dietary aide stated the tray was set up to go to resident #181 after all the residents in the dining room were assisted. The milk was checked and the temperature was 17.3 degrees Celsius and was warm to touch. The dietary aide confirmed it was too warm and poured a fresh glass of milk for the resident which was direct from the fridge. The plan of care for the resident was reviewed and it was not identified the resident liked warm milk. [s. 73. (1) 6.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who have received training, received retraining in areas at times or at intervals provided for in the regulations.

A review of the staff training records for 2014, specific to Resident Rights, Zero Tolerance of Abuse and Neglect, Duty to Report and Whistle Blowing Protection indicated that 87.4 percent of employees had received the annual mandatory training. The DOC confirmed that not all staff employed by the home had completed the mandatory education in 2014 and they were unable to identify how many staff or what percentage of staff had received mandatory retraining in 2013. [s. 76. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents receive the training provided for in the Act, based on the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

In reviewing the home's training records for direct care providers, it was identified that only 94.4 percent of PSWs and 90 percent of registered nursing staff who are currently providing direct care to residents received training in abuse recognition and prevention. The DOC confirmed that not all direct care providers had received annual training in the recognition and prevention of abuse. [s. 221. (2) 1.]

Issued on this 13th day of February, 2015

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

Original report signed by the inspector.