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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jan 20, Apr 30, 2015	2015_306510_0002	H-001863-15	Resident Quality Inspection

Licensee/Titulaire de permis

MIRDEM NURSING HOMES LTD
176 VICTORIA AVENUE NORTH HAMILTON ON L8L 5G1

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

VICTORIA GARDENS LONG TERM CARE
176 VICTORIA AVENUE NORTH HAMILTON ON L8L 5G1

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

IRENE SCHMIDT (510a), BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 19-23, 2015 and January 26-28, 2015

During this inspection, Critical Incident, log #H-001311, was also inspected.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing (DON)- also referred to as Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, registered nurses (RN), registered practical nurses (RPN), registered dietician (RD), personal support workers, housekeepers, dietary staff

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 112.	CO #901	2015_306510_0002	510a

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that the following devices were not used in the home: 3. Any device with locks that can only be released by a separate device, such as a key or magnet. O. Reg. 79/10, s. 112.

On an identified date, a resident was observed sitting in a wheelchair with a loose fitting seat belt, hanging close to the knee. The latch on the seat belt could only be released by a separate device, in this case, a pen. Resident was wheeled to the nursing station. After discussion with staff, belt was removed by staff, using a pen to release the mechanism. The Director of Care (DOC) confirmed the device had been removed from the resident and that there were no other such devices in the home. [s. 112. 3.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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 the plan of care for each resident set out clear direction to staff and others who provided direct care to the resident.

The care plan for an identified resident did not set out clear direction to staff and others who provide direct care to the resident.
i) The care plan, under the mobility focus, stated that the resident was dependent in wheelchair; however, the nutrition focus stated that the resident was restless and walked out of the dining room numerous times during meals. Staff interviewed on an identified date reported that the resident no longer walked out of the dining room.

ii) The care plan, under the nutrition focus indicated that the resident was at low nutritional risk; however, the most recent nutritional assessment indicated that the resident was at moderate nutritional risk.
iii) There were two nutritional care plans found in the binder at the nursing station which front line staff reported were used to direct care. One of the care plans indicated that the resident was restless and walked out of the dining room and the other plan of care indicated that the resident ate independently, neither of which reflected the current status of the resident as confirmed with staff. [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.

A) The plan of care for an identified resident indicated that the resident had impaired vision and staff were to ensure that the resident's eye glasses were clean, appropriate and worn by the resident. The resident was observed wearing glasses on an identified date, and registered staff confirmed that the resident always wore eye glasses. The last three Minimum Data Set (MDS) assessments, completed on identified dates, were all answered in the negative for section D, question three: visual appliances: glasses, contact lenses, magnifying glass. Registered staff confirmed on an identified date, that staff did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.
B) The most recent MDS assessment for an identified resident, completed on an identified date, section P indicated that the resident used a tilt wheelchair but no trunk restraint. On the same date, the Resident Assessment Protocol (RAP) indicated that the resident used a trunk restraint and a tilt wheelchair. The assessments completed on the same date were not consistent with each other.
C) The latest MDS quarterly assessment, section K, question 3, (weight change) completed on an identified date, for an identified resident, indicated that the resident did not have a significant weight change of 5% or more in the last 30 days. A review of the weights revealed a weight change of 7% in 30 days. The assessments were not found to be integrated, consistent with or complement each other. [s. 6. (4) (a)]

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

A) The MDS assessment for an identified resident on an identified date, indicated the resident was resistive to care. The document the home refers to as the care plan on a

particular date identified a new focus for resistive to care and directed staff to document the identified behaviors. Review of the clinical record revealed no documentation related to the resident's resistive behaviors. Registered staff and the RAI coordinator confirmed the identified behaviors were not documented in the clinical record as directed in the care plan.
B) An identified resident was not provided care as planned in the plan of care.
i) The plan of care, under the eating focus, indicated that the resident was to be provided with fruit beverage, a specific dietary supplement and milk shake as ordered by the physician (MD). On an identified date the home did not have supply of the identified dietary supplement and the cook reported that the home only ordered a different dietary supplement . The resident was provided with an alternate dietary supplement, not ordered by the MD on the identified date, as confirmed by registered staff.
ii) The dietary serving notes used at point of service and the resident plan of care, under the nutrition focus indicated that the resident was to be provided with regular texture diet. During the observed lunch meal on an identified date, the resident was provided with a a pureed textured meal. When the inspector intervened, the dietary aide confirmed that the resident was supposed to receive a regular textured meal and proceeded to change the entrée for the resident. [s. 6. (7)]

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

A) An identifed resident was not reassessed and the plan of care reviewed and revised at least every six months and when care needs changed.
i) An identified resident was assessed by the RD on an identified date, and then not reassessed again for eleven months. The progress notes indicated that the quarterly review on an identified date, was deferred as the chart was not available. On an identified date, the progress notes indicated that the quarterly reassessment was deferred as the reporting date had changed. A review of the resident's chart showed quarterly documentation on an identified date; however, the resident was in hospital during that time. The resident was not 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 as confirmed with the DOC on an identified date.
ii) An identified resident was noted to be dehydrated as per the consultation notes on an identified date, and was admitted to hospital during an identified time frame. The

resident was not reassessed and nutritional care plan reviewed and revised upon return from hospital as confirmed with the DON.

B.) An identified resident was not reassessed and plan of care reviewed and revised when the resident had a change in condition.
i) As confirmed with staff on an identified date, the nutritional plan of care found in the binders at the nursing station, which front line staff reported were used to direct care, were not reflective of the resident's current status. One of the plans indicated that the resident was restless and walked out of the dining room and the other plan indicated that the resident ate independently, which no longer reflected the status of the resident. Staff reported that the resident was no longer ambulatory and independent with eating. The resident had a change in condition and was not reassessed, nor was the nutritional plan of care reviewed and revised.
ii) The dietary serving notes used at point of service and the resident's nutritional care plans indicated that the resident was to be provided with a small serving diet, regular texture. Progress notes indicated that the small serving diet had been changed on an identified date, by nursing staff. The resident's plan of care was not updated and indicated small serving diet on an identified date. The resident was assessed by the RD on an identified date where the diet order was also noted to be changed; however, the plan of care was not reviewed and revised as 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 staff and others involved in 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, and to ensure that care is provided as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with. O. Reg. 79/10, s. 8 (1).

A) The home's policy #NM-03-07-01 titled Responsive Behavior Policy states that "Victoria Gardens is committed to prevent or minimize responsive behaviors by integrating effective strategies in the care plan and by implementing appropriate interventions with a coordinated multidisciplinary team". The procedure attached to the policy included that outcomes would be discussed with multi-disciplinary team members, including physician, pharmacist and social worker.
The Minimum Data Set (MDS) assessment for an identified resident on an identified date, indicated the resident was resistive to care.
The document the home refers to as the care plan on an identified date indicated a new nursing focus for resistive to care. Review of the clinical record revealed the absence of interdisciplinary consultation or assessment related to resistive to care. Registered nursing staff and the Director of Care confirmed the absence of interdisciplinary consultation or assessment in the resident's clinical record, as set out in policy.
B) The home had a Falls Prevention Program, (NM-02-01-32) that was reviewed on an identified date, and was not complied with for an identified resident.
The Falls Prevention Program specifically stated the following indicators would be tracked monthly and discussed at registered staff meetings, HCA meetings, general staff meetings and the Professional Responsibility Committee:
i) the high risk falls,
ii) falls resulting in injury,
iii) number of falls,
iv) frequency of falls for each resident,
v) Number of residents who fell
vi) Reviewing times during the day that falls that occur most frequently.
The goal of the Falls Prevention Program was to identify residents at risk for falls, prevent falls and minimize severity of injuries. A review of the clinical record for an identified resident indicated they had experienced increased falls in the previous 5 months. The falls occurred on identified dates. An interview with the DON confirmed the home had not tracked monthly, or discussed the above items for the identified resident with the identified staff and teams as per the home's policy with the purpose of preventing falls and minimizing the severity of falls.
The Administrator confirmed the home had not complied with the above components of their Falls Prevention Program, NM-02-01-32, for the identified resident. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iii) was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A review of the clinical record for an identified resident on an identified date, indicated a stage 2 pressure ulcer to their left buttock. Further review indicated an assessment was not completed by the RD who was a member of the staff of the home. During interview, the charge RN on duty, stated the home process was to complete a referral to the RD when there was any alteration in a resident's skin integrity. The RN confirmed a referral was not completed which resulted in the RD not assessing the resident with a stage 2 pressure ulcer. [s. 50. (2) (b) (iii)]

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

The Minimum Data Set (MDS) assessment for an identified resident on an indentified date, reported a stage 3 pressure ulcer.
The home's policy #NM-02-04-01 titled Skin and Wound Program directed that skin/wound assessment by a registered staff would be completed weekly for residents exhibiting altered skin integrity including pressure ulcers.
Registered staff confirmed that the registered staff skin/wound assessment was documented on the Treatment Administration Record (TAR). The TAR for an identified resident for a particular month, revealed wound documentation for an identified date, only. Registered staff confirmed the absence of weekly skin/wound assessment for identified dates. The resident exhibiting altered skin integrity, including pressure ulcers, was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 residents with altered skin integrity receive interdisciplinary assessments as required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

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

A) An identified resident had weights recorded as 85.3 kg, and 79.2 kg, on identified dates, which represented a weight loss of 6.1 kg or 7% over one month. The resident had a quarterly assessment and referral for open area and poor food and fluid intake completed by the RD on an identified date; however, the weight loss was not assessed. The weight loss was also not addressed on the latest MDS assessment section K on an identified date, completed by the RD.
B) An identified resident had weights recorded as 69 kg, 64.2 kg, and 62.0 kg on identified dates. In one month, the weight represented a weight loss of 7.0 kg or 10% over three months. The resident's weight change was not assessed by the RD as confirmed with the DOC.
C) An identified resident had weights recorded as 82.9 kg, and 77.9 kg, on identified dates which represented a weight loss of 5 kg or a change of 6% over one month. The resident's weight change was not assessed by the RD as confirmed with the DON. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with significant weight changes are assessed using an interdisciplinary approach, that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 4. Vision. O. Reg. 79/10, s. 26 (3).

A.) An identified resident had an identified medical diagnosis. The Minimum Data Set (MDS) assessment for the resident reported the resident had impaired vision, they saw large print, but not regular print in newspapers or books. MDS assessment indicated the resident wore corrective lenses at the time of the assessment and in subsequent MDS assessments did not wear glasses. Registered staff confirmed the resident didn't like to wear glasses. There was no focus identified for vision in the plan of care for the identified resident. The RAI coordinator and the DON confirmed there was no focus for vision deficit in the plan of care for the resident.
B.) The MDS assessment for an identified resident reported the resident had moderately impaired vision, they were not able to see newspaper headlines, but could identify objects. The MDS assessment for the resident indicated the resident wore corrective lenses at the time of the assessment and in subsequent MDS assessments was reported to not wear glasses. There was no focus identified for vision in the plan of care for the resident. The RAI coordinator and the DON confirmed there was no focus for vision deficit in the plan of care for the resident. [s. 26. (3) 4.]

2. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks

A review of the clinical record for an identified resident, indicated the resident sustained a fall on on an identified date, when they sat on their walker and used it as a mobility device to propel themselves in the hallway. The walker wheel broke from the unsafe use and the resident fell to the ground landing on their left side. The resident complained of moderate left flank area pain after the fall and required analgesia for pain. Interview with the RPN on duty confirmed the resident's walker had broken on a another, recent occasion from similar use. Progress notes confirmed, on an identified date, that despite advise from the staff the resident continued to sit and propel themselves on the wheeled walker. The resident had a health history of arthritis and excessive weight concerns and they remained at risk for wear and tear of their joints with subsequent complaints of pain to bilateral legs. A review of the resident's most recent plan of care did not identify the known safety risk for the inappropriate use of the wheeled walker as a mobility aid for sitting and propelling . [s. 26. (3) 19.]

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

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that alternatives to restraining the resident were considered, and tried where appropriate, but would not have been effective to address the risk referred to in paragraph 1.

An identified resident was admitted to the home from hospital on an identified date with a trunk restraint in place. The registered staff confirmed that no alternatives had been tried because the resident was at high risk for falls and has had previous fractures from falls. [s. 31. (2) 2.]

WN #8: 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. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

A) During the observed lunch meal on an identified date,

i) The therapeutic menu indicated that pickles were to be provided with the salami sandwich; however, pickles were not available.
ii) The therapeutic menu indicated that pureed texture salami sandwich was to be provided; however this was not available.
iii) The therapeutic menu indicated that residents on thickened fluid diets should be offered an alternate dessert when jello, ice cream, sorbet or frozen yogurt appear on the menu; however, there was no alternate dessert available for those on thickened fluids in place of the ice cream bar.
B) During the observed lunch meal on an identified date,
i) the therapeutic menu indicated that a whole wheat roll was to be provided with the cottage cheese fruit plate; however, white buns were provided instead.
C) The therapeutic snack menu for an identified date, indicated that tea, coffee and water were to be offered on the nourishment cart as alternate beverages. These beverages were not available or offered on both the second and third floors during the observed afternoon snack pass and water was not available or offered on an identified date.
D) During the observed lunch meal on an identified date, menu portion sizes were not always followed:
i) The therapeutic menu indicated that a #6 scoop was to be used for pureed texture French toast; however, a #12 scoop was used instead
ii) The therapeutic menu indicated that a #12 scoop was to be used for pureed texture bread; however a #20 scoop was used instead.
iii) The therapeutic menu indicated that a #10 scoop was to be used for minced texture salad; however, a #12 scoop was used instead.
E) During the observed lunch meal on an identified date, menu portion sizes were not always followed:
i) The therapeutic menu indicated that a #10 scoop was to be used for pureed texture marinated vegetables and pureed texture fruit; however, a #12 scoop was used for both items instead.
ii) The therapeutic menu indicated that a #12 scoop was to be used for pureed texture bread; however, a #20 scoop was used instead.
iii) The therapeutic menu indicated that a #8 scoop was to be used for regular and pureed texture cottage cheese; however, a #12 scoop was used for both textures. [s. 71. (4)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff applied the physical device in accordance with any manufacturer's instructions.

On an identified date, an identified resident was observed with a front closing restraint seat belt in place that was too loose and hanging near the knees. On an identified date, the resident was observed with a front closing restraint seat belt which was too loose and midway down the upper leg. On an identified date the resident was observed with a front closing seat belt in place which was too loose by approximately five inches. Manufacturer's instructions indicated that the belt should be no more than two fingers away from the resident's body. Registered staff confirmed that the belts should be no more than two fingers away from the resident's body. [s. 110. (1) 1.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: 2. What alternatives were considered and why those alternatives were inappropriate.

An identified resident had a restraint lap belt in place since being admitted to the home. The health record and the registered staff confirmed that no alternatives had been considered or tried. [s. 110. (7) 2.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response:

An identified resident's restraint hourly monitoring records for the seatbelt restraint were blank for identified dates. Registered staff confirmed that the resident was monitored but the documentation was not completed. The DOC confirmed that the records should have been competed. [s. 110. (7) 6.]

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

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A review of the Infection Control meeting, quarterly minutes, for an identified time frame did not indicate the program was evaluated during the identified time frame. Interview with the DOC confirmed the home had not evaluated and updated, at least annually, the home's Infection Prevention and Control program in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 229. (2) (d)]

2. The licensee failed to ensure that a staff member designated to co-ordinate the program had education and experience in infection prevention and control practices,

including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management.

The Home was identified to be in a Respiratory Outbreak during during an identified time frame. During an identified time frame, it was observed that direct care staff had not been practicing the homes' infection prevention and control measures. Interview with an identified staff member confirmed they were the designated staff member that co-ordinated the infection prevention and control program. The staff member stated they did not have education in prevention and control practices, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management. [s. 229. (3)]

3. The licensee failed to ensure that all staff participated in the implementation of the program.

A.) On an identified date, housekeeping staff were observed to arrive on third floor wearing a face mask and gloves. When interviewed, the housekeeper stated the personal protective equipment (PPE) was to protect the housekeeper from residents who were ill. The home was in respiratory outbreak on that date. The housekeeper stated that the PPE was donned on the first floor and the same PPE was worn when about to start cleaning on the third floor. The housekeeper stated that the PPE was not changed between rooms. Prevailing practice and the home's policy direct staff to remove PPE and wash hands upon leaving each room. The housekeeper did not participate in the implementation of the infection control program.
B.) During the observed lunch meal on an identified date, a staff member was observed reaching into a container of beverage thickener to retrieve a spoon partially buried in the powder. The staff proceeded to take the spoon out, scoop the thickener into a glass and provide it to a resident. The staff member did not practice hand hygiene or participate in the implementation of the infection prevention and control program when retrieving the spoon. [s. 229. (4)]

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

Progress notes for an identified resident on an identified date, reported the resident had a congested cough at meals. Vital signs and symptoms of infection, including cough, temperature, pulse, respirations and oxygen saturations were recorded in the progress

notes. A chest x-ray was ordered and on an identified date, confirmed pneumonia. After a course of antibiotics, a repeat chest x-ray was completed, showing unresolved pneumonia. A new antibiotic was ordered on an identified date. There were no progress notes reporting on the resident's vital signs and symptoms of infection for an identified time frame, while they were being treated for an infection. The registered staff and the DON confirmed that vital signs and symptoms of infection were not monitored for the identified resident during the time they were being treated for an infection. [s. 229. (5) (a)]

Issued on this 8th day of May, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	IRENE SCHMIDT (510a), BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2015_306510_0002
Log No. / Registre no:	H-001863-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 20, Apr 30, 2015
Licensee / Titulaire de permis :	MIRDEM NURSING HOMES LTD 176 VICTORIA AVENUE NORTH, HAMILTON, ON, L8L-5G1
LTC Home / Foyer de SLD :	VICTORIA GARDENS LONG TERM CARE 176 VICTORIA AVENUE NORTH, HAMILTON, ON, L8L-5G1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RANKA STIPANCIC

To MIRDEM NURSING HOMES LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 112. For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Order / Ordre :

The licensee shall discontinue the use of the prohibited lap belt which can only be released by a separate device on an identified resident, and all other residents, immediately. The licensee shall ensure there are no other prohibited, restraining devices available for use in the home.

Grounds / Motifs :

1. The licensee of a long-term care home did not ensure that the following devices were not used in the home: 3. Any device with locks that can only be released by a separate device, such as a key or magnet. O. Reg. 79/10, s. 112.

On an identified date, a resident was observed sitting in a wheelchair with a loose fitting seat belt, hanging close to the knee. The latch on the seat belt could only be released by a separate device, in this case, a pen. Resident was wheeled to the nursing station where, after discussion with the registered nurse in charge, the belt was removed by staff, using a pen to release the mechanism. The Director of Care (DOC) confirmed the device had been removed from the identified resident and that there were no other such devices in the home. (510a)

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

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 and the Director

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

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.

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 20th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Irene Schmidt

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