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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 6-8, 11-15, 18-20, 26, 27, 2011	2011_169_9592_13Apr134207	RQI-Annual Log#H-000959-11

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

Yvonne Walton, Shar McNally, Michelle Warrener, Laleh Newell

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an annual inspection.

During the course of the inspection, the inspectors spoke with:

Administrator, Associate Director Of Care, Registered Dietician, Administrative Assistant, Business Office Supervisor, E-Records Co-ordinator, Nurse Practitioner, Infection Control Practitioner, Admissions/Volunteer Co-ordinator, Social Worker, Supervisor of Resident Services, Recreational staff, Director of Building Services, Registered Staff, Personal Support Workers, Dietary Aides, Cook, Housekeepers, Residents, Family members, Resident Council President, Family Council President, Manager of Quality Initiatives, Physiotherapy Assistant, During the course of the inspection, the inspectors:

Reviewed clinical health records, observed care and environment, reviewed policy and procedures, observed meal service, observed activities, and reviewed meeting minutes.

The following Inspection Protocols were used during this inspection:
Admission process, dining observation, family council interview, infection prevention and control, medication, quality improvement, resident's council interview, resident charges, accommodation services-maintenance, accommodation services-housekeeping, hospitalization and death, reporting and complaints, continence care and bowel management, falls prevention, minimizing of restraining, pain management, personal support services, recreation and social activities, responsive behaviours, nutrition and hydration, dignity choice and privacy, safe and secure home, skin and wound care, prevention of abuse, neglect and retaliation and safe and secure home.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

21 WN
9 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(a)(c).

(2)Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:

1. April 6, 7, 11, 2011. The home has not ensured equipment is kept clean. The sit to stand lift was observed in the shower room, with a sling attached which was visibly soiled. The strap that goes around the resident's back had a large stain on it. The lift was observed being used by multiple residents in their rooms using the same sling.
Staff interviewed stated they use one sling for all residents on the sit to stand lift and the slings are to be washed weekly.
The policy of the home stated: the slings are to be rinsed and wiped daily as needed and the sling is to be cleaned between each resident by cleaning with disinfectant spray or laundered if soiled. Slings are sent to the laundry weekly, as per laundry schedule.
The sling was observed to be soiled for over an 8 day period.

2. April 15, 2011. 1100 hours.
The grout in the shower area was observed in poor condition, at the point where the wall meets the floor. The grout had loosened and the joint was observed blackened.

3. April 15, 2011. 1100hours.
The chairs and the lamp tables in the lounge area at the entrance to the home area were visibly worn.

4. April 15, 2011. 1100 hours.
The chairs in the dining room were observed to show signs of wear on the arms.

Inspector ID #:	169

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.5.

Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Findings:

1. Apr 20, 2011, 1400 hours. A safe and secure environment was not provided to residents. The door to the outside courtyard through the activity room was unlocked and the wind was blowing the door wide open. Residents had access to the outside courtyard which was unsupervised and unattended.

2. Nursing and recreation staff identified safety concerns with the paving stones being uneven in the outdoor courtyard causing a risk for falls. Staff indicated residents were not to be left alone or have unsupervised

access to the outdoor area. Management staff confirmed they were aware of the safety risks of the courtyard since 2009, after a resident had a fall. Courtyard improvement committee (sub-committee of Family Council) minutes dated September 17, 2009 identify the safety concerns and strategies for improvement.

Inspector ID #:	107

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 that ensures the home is a safe and secure environment for all residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 57(1)9iii.

(1) A Residents' Council of a long-term care home has the power to do any or all of the following:

9. Review,

iii. the financial statements relating to the home filed with the Director under the regulations or provided to a local health integration network, and

Findings:

1. The home has not provided the Residents' Council with financial statements for their review. This was confirmed by the President of the Resident Council on April 18, 2011. The Resident Council meeting minutes confirm the home's financial statements have not been reviewed with the Council.

Inspector ID #:	147

WN #4 The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(1)(b)(c)

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(b) the goals the care is intended to achieve; and

(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. An identified resident's plan of care does not set out clear directions to staff that provide direct care to the resident regarding the use of bedrails. The resident was observed in bed with two half bed rails up on April 9 and 10, 2011 during the day shift.

The resident's written plan of care does not direct the use of bedrails. An 8 ½ x 11 piece of paper was found with the plan of care related to bedrail use, however only provided direction to the 3-11 staff. This sheet of paper was not dated and did not include goals the care is intended to achieve for the resident while in bed. Nursing staff for the 7-3 shift confirmed the bed rails are used to prevent the resident from falling out of bed

and the resident sometimes uses the rails to reposition in bed.

2. The plan of care for an identified resident does not set out clear directions to staff and others who provide direct care to the resident in relation to responsive behaviors. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment identifies the resident has behavioral symptoms and depressed mood, however, a plan of care was not developed with strategies to address the identified behaviors. Registered staff confirmed the resident has behaviors, however, a plan of care was not in place to address the behaviors. A Personal Support Worker (PSW) stated she used specific strategies to manage the resident's behaviors, however these were not communicated in the plan of care to provide clear direction to other staff that provides direct care.

3. The written plan of care for an identified resident does not provide clear direction to staff providing care in relation to diet texture when the resident is having difficulty chewing. The resident has a physician order for a diet with chopped texture (may provide pureed meat if difficult to chew), however, the plan of care states a diet with chopped texture (may provide minced meat if difficult to chew). The directions on the physician's order conflict with the directions on the plan of care. Staff confirmed the directions regarding diet texture were not clear.

Inspector ID #:	141, 107

WN #5: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6 (10)(b)(c).

(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,

(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.

Findings:

1. The plan of care for an identified resident was not revised when the resident's care needs changed in relation to the required level of assistance for eating. The progress notes and RAI MDS identified the resident has had a change in health status resulting in increased assistance required at meal times. The plan of care directs staff to provide intermittent assistance instead of constant assistance, The resident and his family expressed concern to the inspector that he was not receiving enough assistance with eating.

2. The progress notes and physician order for an identified resident identified a treatment in 2011. The resident's written plan of care was not revised to include the treatment until 2 months later. The wound progressed from a Stage 2 wound to a Stage 4 wound during this period.

3. The licensee did not ensure that an identified resident was reassessed and the plan of care reviewed and revised when the care set out in the plan related to nutrition was not effective. The resident has a plan of care to provide a specific menu with specific goals. The resident was not provided the specific diet. Nursing and dietary staff confirmed the resident does not take the specific menu. The resident had documentation in 2011 of abnormal nutritionally relevant laboratory results and had a weight loss over one year from 2010 to 2011. The Registered Dietitian confirmed she was unaware of the resident's poor intake at meals.

4. The plan of care for an identified resident was not revised when the care set out in the plan was not effective

in relation to constipation. Nutritional strategies were initiated April 9, 2010 to address constipation. The resident had an increase in the amount of constipation in March 2011, without an evaluation of the effectiveness of the nutritional interventions at the March 30, 2011 quarterly review related constipation. According to the Medication Administration Record (MAR) for February 2011, the resident required two as needed medications for the treatment of constipation, however, in March 2011 the resident required a significant increase in the "as needed" medications for the treatment of constipation with multiple progress notes indicating constipation (28 notes related to constipation from February 2011 to April 2011). The Registered Dietitian verified that the plan of care was not revised in relation to the resident's change in status.

5. The plan of care for an identified resident was not revised when the care set out in the plan was not effective in relation to nutritional consumption at meals. The progress notes reflect the resident was missing the lunch meal frequently in the month of March 2011, however the plan of care was not revised in relation to the poor intake.

6. The plan of care for an identified resident was not revised when the care set out in the plan was not effective in relation to weight gain. Interventions for the prevention of further weight gain were implemented December 2010, however, the resident continued to gain weight without an evaluation of the effectiveness of the strategies. The resident had a significant weight gain from December 2010 to January 2011, and the plan of care was not revised. The resident has gained body weight since December 2010 – April 2011 without revision to the strategies in the plan of care.

Inspector ID #:	107, 141

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 that ensures all plans of care are 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 #6: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6 (7).
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.

Findings:

1. The licensee did not ensure that the care set out in the plan of care was provided to the following residents at the lunch meal April 6, 2011:

2. An identified resident has a plan of care to provide a specific menu, however, the resident was not provided the specific menu. The resident is at high nutrition risk with a goal for the prevention of weight loss.

3. An identified resident has a plan of care to provide one item at a time at meals to minimize confusion at meals. The resident was provided all entrée items together and dessert (ice cream) was placed on the resident's table while the resident was consuming the entrée.

4. An identified resident has a plan of care to present one item at a time to minimize confusion at meals, however, the resident was provided her dessert (ice cream) while the resident was being fed her entrée.

5. An identified resident has a plan of care to provide constant encouragement at meals, however, the resident was provided no assistance and did not consume the meal.

6. An identified resident has a plan of care to provide total feeding assistance, however, the resident received intermittent assistance only and consumed less than a ¼ of the meal.

Inspector ID #:	107

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 care set out in each resident's plan of care is provided according to each resident's plan, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 60(2).
(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.

Findings:

1. The licensee does not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.
Family council submitted a request from the residents and staff on Maple Home Area (secured area) to modify the Maple courtyard to ensure safety for residents. The administrator has not responded to this request sent September. 2009. Recreation staff on Maple and the President of Family council confirm the administrator has not responded.

2. Family council also requested the gate at the front of the building be opened to allow residents and family's access into the building from the sole bus stop. The management of the home has not responded in writing to this recommendation.

Inspector ID #:	169

WN #8: The Licensee has failed to comply with O.Reg. 79/10, s.134 (a).

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Findings:

1. The licensee of the home does not consistently ensure that when a resident takes a drug or combination of dugs that there is monitoring and documentation of the resident's response and effectiveness of the drug.

2. Medication Administration Records (MARs) reviewed on April 18, 2011 for period from April 1 to 20, 2011 for an identified resident. Resident was administered a medication, as needed on April 3, 2011 and effectiveness of intervention not documented.

3. Medication Administration Records (MARs) reviewed on April 18, 2011 for period from April 1 to 20, 2011 for an identified resident. Resident was administered a medication, as needed on April 3, 9, 14, and 15, 2011 and effectiveness of intervention not documented.

4. Medication Administration Records (MARs) reviewed on April 18, 2011 for period from April 1 to 20, 2011 for an identified resident. Resident was administered a medication, as needed on April 3, 4, 8, 9, 13, 2011 and effectiveness of intervention not documented.

5. Medication Administration Records (MARs) reviewed on April 19, 2011 for period from January1 to April 19, 2011 for an identified resident. Resident was receiving as needed (PRN) pain medication in addition to a scheduled dose of medication, however the effectiveness of the pain medication was not documented.

6. The policy and procedure "PRN administration and documentation (8-4)" states nursing staff are to document assessment and follow-up on progress notes or reverse side of MAR sheets. Staff confirmed they document on the back of the MARS, when a PRN medication is given. The effectiveness of the drug is not documented according to the policy.

Inspector ID #:	141, 147

WN #9: The Licensee has failed to comply with O.Reg. 79/10, s.17 (1)(a).

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

Findings:

1. April 11 and 20, 2011. A bathroom call bell was not easily used by the resident. The call bell cord was observed to have broken away from the ring that held it to the support rail next to the toilet. The cord was tied around the rail in a manner that did not allow the bell to be activated by pulling the cord at the end. The bell could be only be activated if reached for the cord between the rail and the wall.

2. April 26, 2011. A bathroom call bell is approximately 6 inches long and not accessible, if sitting on the toilet.

3. April 26, 2011 A call bell was hanging on the floor in the bathroom and not accessible, if sitting on the toilet.

Inspector ID #:	169, 141

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 that ensures the home has a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg. 79/10, s.228.3 and 228.4 iii.

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,

   iii. the communications under paragraph 3.

Findings:

1. The home's quality improvement and utilization review system does not ensure that improvements made to the quality of the accommodation, care, services, programs and goods provided to residents are not recorded or communicated to Residents' Council, Family Council, and staff of the home on an ongoing basis.

2. Review of the Resident and Family council minutes confirmed the results of the quality improvement and utilization system have not been communicated.

3. Staff interview with the Manager Quality Initiatives confirmed the home does not have a system in place to document or communicate the quality management program results to the Residents' Council, Family Council, and the staff of the home on an ongoing basis.

Inspector ID #:	169

WN #11: The Licensee has failed to comply with O.Reg. 79/10, s.229 (2) (e) and 229(4).

The licensee shall ensure,

(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

(4) The licensee shall ensure that all staff participates in the implementation of the program.

Findings:

1. The home does not have a written record of an annual Infection Prevention and Control program evaluation. Interview with Infection Control Practitioner (IPC) on April 27, 2011 - confirmed the home does not have a written record of an annual IPC program evaluation.

2. Not all staff participates in the implementation of the infection, prevention and control program. During the lunch meal, the Registered Practical Nurse (RPN) was observed placing soiled spoons into a cup on top of the medication cart. The soiled cup and spoons were observed beside and touching the applesauce container.

Inspector ID #	147, 169

WN #12: The Licensee has failed to comply with O.Reg. 79/10, s.26(3)17,19.

(3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

17. Drugs and treatments.

19. Safety risks.

Findings:

1. An identified resident's plan of care did not include strategies related to the assistance required by the resident in medication administration. At the lunch meal service the identified resident was observed to have a white medication cup with a tablet in it, in front of them at the table for 5 minutes. At this time the nursing inspector inquired with the resident if the medication was theirs and the resident replied they was unaware the medication was there. The resident's plan of care states the resident has a significant visual impairment. Registered staff confirmed this.

2 An identified resident's plan of care did not include an interdisciplinary assessment of the use of two half bed rails related to the resident's safety risk. The resident was observed in bed on April 9 and 10, 2011 with two half bed rails in the raised position. The quarterly review assessment completed March 30, 2011 does not include an assessment of the bed rails under the Risk Assessment Protocol (RAPs) for falls. Staff confirmed the rails are used as prevention for falls.

Inspector ID #:	141

WN #13: The Licensee has failed to comply with O.Reg. 79/10, s.30 (1)1 and 30(2).

1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources

where required.

(2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Findings:

1. The licensee has not ensured the following programs required under Section 8-16 of the LTCHA, and Section 48 of the Regulation includes methods to monitor outcomes: nursing and personal support services, restorative care, recreational and social activities, dietary services and hydration, medical services, information and referral assistance, religious and spiritual practices and volunteer program.

2. The licensee did not ensure that actions taken with respect to a resident under the recreational and social activities program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.
Resident participation in recreational programming was not documented on the home's Multi-Month Participation report, for the month of January 2011 for 6 residents. Staff confirmed that attendance in recreational programming should be documented on these reports. Recreational staff confirmed the information was not recorded for the month of January, 2011. Staff also confirmed the reports for 2 home areas continue to be incomplete and do not accurately reflect each resident's participation in programming in that home area.

3. The licensee did not ensure that documentation in an identified resident's clinical record under the nursing and personal support services program, included incidences of responsive behaviours with interventions and the residents responses to the interventions to behaviours during the 7 day observation period completed prior to the completion of the RAI-MDS assessment. This assessment identified the resident was verbally and physically abusive, one to three days, during the 7 Day observation period. Documentation in the progress notes does not include any incidence of responsive behavior for the 7 day period.

Inspector ID #:	169, 107

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 that ensures each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, have a written description of the program that includes a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. Also to ensure any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg. 79/10, s.50 (1)3 and 50(2) (b) (iv).

(1) The skin and wound care program must, at a minimum, provide for the following:

3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

(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,

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

Findings:

1. An identified resident had a Stage 2 pressure ulcer identified and progressed to a Stage 4 within 5 weeks. Weekly wound assessments were not completed consistently for the pressure ulcer. Assessments, using the Wound Assessment Flow Sheet (WAFS), were completed There were no weekly assessments for four out of 8 weeks.
Home's policy and procedure for Skin and Wound Management Program (RC-08-9-04) section Wound Assessments states Registered Nurses (RN) will assess and document wound progress weekly using the WAFS.
Nursing staff confirmed that the Registered Nurse is responsible for completion of the weekly wound assessments using the WAFS tool.

Inspector ID #:	141

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 home skin and wound care program must, at a minimum, provide for the following: Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids. Also, ensure all resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg. 79/10, s.53 (1)2.

Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Findings:

1. Written strategies including techniques and interventions to prevent, minimize and respond to an identified resident's responsive behaviours, were not in place.
A staff member providing care for the identified resident was able to identify strategies used to reduce the Behaviours for this resident, however, these identified strategies were not written or communicated to all staff.

Inspector ID #:	107

WN #16: The Licensee has failed to comply with O.Reg. 79/10, s.65(2)(b)(c).

(2) Every licensee of a long-term care home shall ensure that the program includes,

(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;

(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests.

Findings:

1. The Recreational and Social Activities program does not include communication of the recreation schedule to all residents and family members and activities that are of a frequency and type to benefit all residents of the home and reflect their interest.

2. Not all programming offered is communicated to residents and families through the posted schedule. Examples of programs not posted include: Getting to know you program on Trillium April 6, 2011, Pet therapy on Maple Lane Apr 11, 2011; Diner's club on Lilac and Beech April every Monday evening, 1:1 programming on Maple and Trillium April 10, 2011, Horticultural Program on Lilac and Beech every Friday morning.

3. On Maple Lane, evening programming is not available for residents who are not able to independently go to activities off the unit. Staff verified, not all residents are able to attend programming outside of the home area due to safety, responsive behavior, or staffing issues. It is noted for the month of April, every Sunday includes church service in the chapel. Residents unable to go to the chapel independently do not receive an activity.

4. An organized recreational and social activities program to meet the interests of the residents is not in place.
   - An identified resident indicated "there is a lack in the number of activities to meet my interests. Many scheduled activities get cancelled. There was a big change since construction of the new building. Activities have all been divided up and even in the big room downstairs; there is not enough room for everyone. Do not think there is enough variety in the programs, like they used to have crafts and baked bread once a week. They have activities that only have 5 or 6 residents attend. There are not enough weekend activities. There are not enough evening programming because two evenings are all there is

and one celebration a month." Documentation reflects this resident has attended 5-7 activities per month between February and April, 2011.

- An identified resident, on April 11, 2011 stated "On Sundays there are no activities other than church which I don't attend. The sidewalks generally fold up after supper. I would attend activities if offered."
- On April 8, 2011 an identified resident indicated there are no activities offered on the weekend. Documentation reflects this resident attended only one 1:1 program for the month of April up to and including April 20, 2011.
- On April 8, 2011 an identified resident stated "No activities on the weekend that I know of".
- A family member of an identified resident voiced concerns about the frequency of recreation programs offered to residents on the Maple (locked) unit and the frequency of outdoor activities provided by the home. Documentation reflects this resident has received 100 minutes of outdoor activities in one year.
- April 27 there was music in the Atrium, off the home area and then Bingo in the afternoon in the Atrium. Otherwise, there are no activities for residents on Maple for April 27.
- There is only one day in April that has an evening activity offered for Maple home area (secured area).

Inspector ID #:	107, 169

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 that ensures the recreation program includes, the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends and recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests, to be implemented voluntarily.

WN #17 The licensee has failed to comply with O.Reg. 79/10, s.71 (4).

(4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack.

Findings:

1. Maple home area. April 6, 2011. Not all residents were offered a choice of dessert at the lunch meal. Multiple residents were given vanilla ice cream and were not offered a choice of dessert, although an alternative desert choice was available.

Inspector ID #:	107

WN #18: The Licensee has failed to comply with O.Reg. 79/10, s.72 (3) (a).

(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

Findings:

1. Maple home area. April 6, 2011. Not all foods were served using methods which preserve taste, appearance and food quality at the lunch meal. Two residents had their pureed menu items mixed/stirred together without their consent. Mixing/stirring of food items does not preserve the taste and appearance of the food. Staff who were feeding a resident confirmed the resident did not request the items be mixed together. The written plan of care for both residents' does not direct staff to mix food items.

Inspector ID #:	107, 141, 147

WN #19: The Licensee has failed to comply with O.Reg. 79/10, s73 (1)10 and73 (2) (a).

(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.

(2) The licensee shall ensure that,

(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking

Findings:

1. April 6, 2011. Proper feeding techniques were not used to assist an identified resident with eating at the lunch meal. A table spoon was being used to feed the resident, creating a risk for choking due to a large volume of food being placed on the spoon.
The plan of care identifies the need for monitoring related to a progressive diagnosis and choking.

2. April 6, 2011. During the lunch meal staff did not provide proper feeding techniques to assist residents with eating. Staff stood to feed a resident a glass of thickened fluid while the resident was seated in their wheelchair. The staff feeding the resident was not at eye level with the resident creating a barrier to monitoring the swallowing ability of the resident. An identified resident was fed by a PSW while their wheelchair remained in a tilt back position. The plan of care states the resident is total feed and should be in the upright feeding position.

3. April 6, 2011 an identified resident was sitting in their wheelchair, in the reclined position during the lunch meal. Staff was providing total feeding assistance and the identified resident's neck was observed hyper

extended, creating a risk for choking.

4. April 15, 2011. A staff member was assisting more than two residents at the same time, whom needed total assistance with eating and drinking during the lunch meal. One staff member was assisting four residents. Three residents required total assistance with eating and drinking and one resident required intermittent assistance. An identified resident sat in front of the meal for extended periods of time without assistance being provided and did not consume their meal. The identified resident has had a significant weight loss in one year. An identified resident has had a weight loss over six months. The resident's current weight is below the goal weight range and another resident is 10kg below the goal weight range, including a history of weight loss.

Inspector ID #:	107

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 that ensures that the home has a dining and snack service that includes, at a minimum, the following elements: Proper techniques to assist residents with eating, including safe positioning of residents who require assistance and no person simultaneously assists more than two residents who need total assistance with eating or drinking, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg. 79/10, s.8 (1) (b).

(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,

(b) is complied with.

Findings:

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, and is complied with.

2. An identified resident reported they lost money at the time of their admission. The home failed to comply with their own policy and procedure "Theft and Loss" AM-06-01-11 by not completing a "How are We Doing Form" for this incident. The missing money has not been located to date.

3. Documentation in an identified resident's clinical record did not include informed consent, or a physician order, or nurse practitioner order for the use of bedrails as a personal assistive safety device (PASD). The home's policy and procedure "Least Use of Restraint" RC-08-03-09 states that for the use of PASD's staff must obtain an informed consent and a physician or nurse practitioner order. The resident was observed on April 9 and 10, 2011 with two half bed rails up while in bed. The staff confirmed that two half bed rails are used when resident is in bed to prevent falls and assist resident to independently move in bed.

Inspector ID #:	141, 147 and 141

WN #21: 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 labeled properly and are kept inaccessible to residents at all times.

Findings:

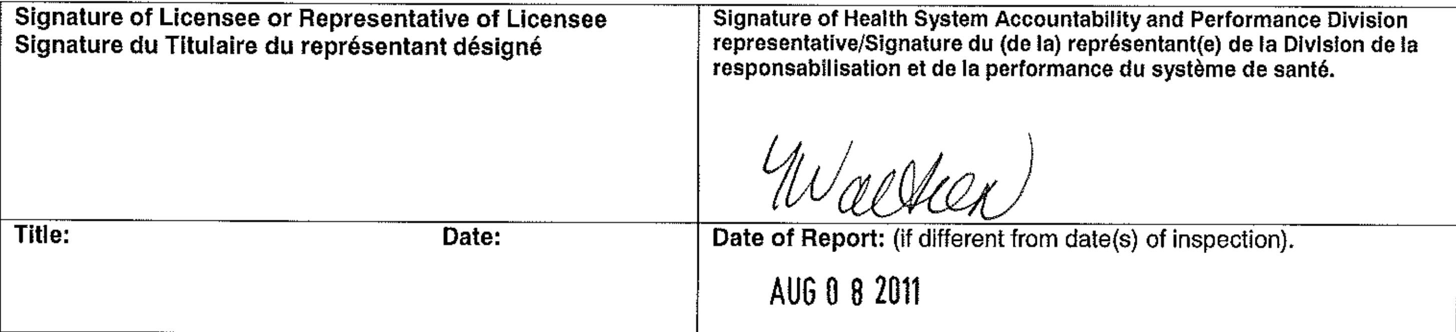
1. April 11, 2011. 0947 hours. Not all hazardous chemicals are kept inaccessible to residents at all times. The door to the soiled utility room was left propped open and unattended for more than 5 minutes, without supervision. Multiple bottles of Lemon Gard disinfectant, with a toxic and corrosive WHMIS label, and Arjo disinfectant with a poisonous and corrosive WHMIS label were sitting on the counter and accessible to residents. The housekeeper verified the door to this room is to be locked at all times.

2. April 14, 2011 at 1452 hours and April 26, 2011 at 1116 hours. The door to the dishwashing area of the servery and the housekeeping cupboard within the dishwashing area were propped open and unattended by staff. Numerous hazardous chemicals with corrosive, poisonous WHMIS labels were accessible to residents from the home area. On April 14, 2011, staff confirmed they usually lock the door, however due to floor cleaning, it was left propped open and unattended.

Inspector ID #:	107

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



Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). AUG 0 8 2011