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
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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
Dec 19, 2014	2014_188168_0029	H-001679-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WEST OAK VILLAGE
2370 THIRD LINE OAKVILLE ON L6M 4E2

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

LISA VINK (168), LAURA BROWN-HUESKEN (503), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 8, 9, 10, 11, 12, 15, 16, 17, and 18, 2014.

This Inspection Report may contain findings of non-compliance identified during inspections which were conducted concurrently with this RQI Inspection, specifically: Complaint Inspections H-000302-14, H-000621-14, H-000810-14, and H-0001047-14, and Critical Incident Inspection H-000368-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Resident Services Coordinator (RSC), Recreation Manager, Nutrition Manager (NM), Environmental Services Manager (ESM), Registered Dietitian (RD), Corporate Environmental Services Consultant, registered nursing staff, recreation staff, dietary and environmental staff, personal support workers (PSW's) families and residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **14 WN(s)**
- **10 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of residents were fully respected and promoted. That every resident was protected from abuse.

Resident #51 had a long standing history of responsive behaviours, including verbal and physical aggression towards others, without identified provocation. Records reviewed and staff interviewed identified that on an identified date in 2014, during meal service, resident #51 abused a co-resident. Resident #51 was agitated and staff attempted to redirect when the resident motioned towards resident #50 with an object. Staff were successful in preventing physical injuries to resident #50. Resident #51 remained agitated and grabbed an assistive device moving towards another resident. Resident #51 then slapped resident #56 across the face resulting in a reddened area which was provided first aid.
The resident was not protected from abuse from resident #51. [s. 3. (1) 2.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A. Resident #30 experienced falls on three dates in 2014, which were reviewed. Each fall had the required documentation completed. During these assessments a number of recommendations were made in an effort to prevent recurrence, including but not limited to: keeping the door open so they were more visible, half hour checks, a bed alarm, hi-lo bed, fall/crash mat, and call bell attached. The plan of care reviewed did not include the identified interventions as recommended during the fall assessments, which was confirmed during an interview with the DOC. (503)

B. Resident #50 sustained a fall on an identified date in 2014. The resident was

assessed post fall and documentation indicated they were unsteady when walking, required encouragement to use the call bell and supervision when ambulating. The resident sustained a second fall eight days later. The resident was again assessed and monitored post fall. Discussion was held with the Power of Attorney (POA) regarding the use of a wheelchair and a request made to have staff accompany the resident to the dining room when ambulating with the walker. A review of the plan of care on December 16, 2014, identified that the resident was "independent with transfers once aide is positioned close at hand" and "independent to ambulate once provided with assistive device". Interview with registered staff confirmed that the plan of care was not reflective of the assessment findings of the resident and their needs post falls. [s. 6. (2)]

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.

Resident #26 was identified in the May 20, 2014, Minimum Data Set (MDS) assessment to have two mood indicators during the observation period and one behavioural symptom. The MDS assessment completed August 12, 2014, identified that the resident had no mood indicators or behavioural symptoms during the observation period. Staff who completed the August 2014, assessment noted that the resident had no change in status, related to mood or behaviours, compared to the status of 90 days prior. Interview with registered staff, following a review of the assessments, confirmed that the resident did have a change in status, an improvement, and that the two assessments did not 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.

A. Resident #50 sustained a fall in 2014, which required transport to hospital for assessment. As a result of the fall, staff revised the plan of care to include a bed alarm, when in bed, in an attempt to prevent recurrence. The resident was monitored on December 15 and 16, 2014, during the day shift. It was observed that the alarm was in place, on the bed, but not in the on position, when the resident was in bed, following the noon meal on December 15, 2014, or following the noon meal on December 16, 2014. Registered nursing staff confirmed that the alarm was not on,on December 16, 2014, and activated the device once identified. (168)

B. Resident #50 was assessed on November 27, 2014, and received an order for staff to

"auscultate chest daily". On December 12, 2014, the order was changed and the assessment was no longer required. Interview with registered staff confirmed the order and indicated that the assessment would be documented in the progress notes. A review of the notes did not include documentation that the resident's chest was auscultated during the identified period of time, as confirmed by registered staff. (168)

C. The plan of care for resident #32 directed staff to provide total feeding assistance during meals. During the lunch meal on December 8, 2014, the resident was observed to receive intermittent encouragement and assistance with eating. The resident consumed half of the meat and half of the potatoes that were served, with consumption occurring when being provided assistance and encouragement from staff. Interview with the NM confirmed that the resident was not provided the feeding assistance as specified in the plan of care. (503)

D. The plan of care for resident #10 directed staff to provide a nutritional supplement after meals if the meal was consumed at 50 percent or less. Intake records for a 30 day period between November 13, 2014 and December 12, 2014, identified that the resident had consumed less than 50 percent of the meal during 24 identified meals. The Medication Administration Record (MAR) identified that the supplement had not been administered during the 30 day period. The RD confirmed that the resident was not provided the nutritional supplement as specified in the plan of care. [s. 6. (7)]

4. The licensee failed to ensure that if the plan of care was being revised because care set out in the plan had not been effective, the licensee would ensure that different approaches were considered in the revision of the plan of care.

A. Resident #14 experienced monthly unplanned weight loss between January and June 2014. The resident was below their goal weight range in March and April, 2014. Between February and April 2014, the RD assessed the resident monthly and no revisions were made to the plan of care. In May 2014, the resident experienced further weight loss and the RD completed an assessment and adjusted the goal weight range to a lower range with no other revisions made to the plan. In June 2014, the resident experienced further weight loss and the RD again completed an assessment, however, no revisions were made to the plan. Interview with the ED and DOC confirmed that the plan of care was not effective as evidenced by the weight loss and that different approaches were not considered in the revision of the plan. (503)

B. In October 2014, resident #10 experienced a weight loss of 9.4 percent of their body

weight over one month. They had an order for the administration of a nutritional supplement when less than 50 percent of their meal was consumed. The RD assessed the resident and noted that the nutritional supplement was not administered during the previous month, however, different approaches were not initiated. Interview with the RD confirmed that the care had not been effective, as the supplement was not being administered. Interview with the ED and DOC confirmed that different approaches were not considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, and that the care set out in the plan of care is provided to the resident as specified in the plan and that if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home's policy, Height Measurement and Weight Management, LTC-G-60, directed staff to weigh residents monthly, and if there was a gain or loss of greater than two kilograms, the weight was to be confirmed immediately.
i. A review of clinical records found that resident #10 experienced a weight change greater than two kgs per month, for five months, between August and December 2014. Interviews with the ADOC and the NM confirmed that the weights had not been confirmed on the identified months and that the home's policy had not been complied with. (503)

B. The home's procedure, Fall Interventions Risk Management – Ontario, LTC-E-60-ON, directed staff to complete the resident post fall assessment documentation when a resident experienced a fall.
i. A review of clinical records found that resident #56 experienced a fall in 2014, and the post fall assessment documentation was not completed. Interview with the DOC confirmed that the assessment had not been completed and that the home's procedure not been complied with. (503)

C. The home's policy, Medication Administration, LTC-F-20, identified that "resident confidential information will be protected during and after medication administration".
i. The noon medication pass was observed on Howell House on December 11, 2014. Medication was administered to resident #42, from a pouch, which included the resident's name, medication name and dosage. Staff were observed to place the empty pouch into the regular garbage container, which contained other medication pouches, cups, spoons and nutritional supplement containers. The registered staff indicated that she would dispose of the garbage in the regular trash bin. Interview with the DOC confirmed the expectation that the medication pouches be separated from regular garbage and that confidential information on the pouches be destroyed. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's policy Resident Non-Abuse - Ontario LP-C-20-ON, identified that "Section 24(1) of the LTCHA requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. The LTCHA provides that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long-Term Care (the "Ministry"). Abuse of a Resident by anyone or neglect of a Resident by the licensee or staff that resulted in harm or a risk of harm to the Resident".

A. Progress notes and staff interviewed confirmed that in 2014, resident #51 hit resident #56 on the side of the face resulting in a red area, which was treated with first aid. Under Ontario Regulation 79/10, the reddened area would be considered a physical injury and therefore abuse. Home management confirmed that they did not report the incident to the Director. (168)

B. The home's investigation records were reviewed and it was identified that a written letter, in 2014, of concern was submitted and received by the family of resident #23, which included an allegation of abuse to the resident by staff. The ED and DOC confirmed that they did not notify the Director, via the Critical Incident System, of this allegation of abuse. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team was held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker (SDM).

A. The family of resident #18 identified that they were not invited to the attend the 2014 care conference. The RSC was unable to provide documentation that the family was invited to the resident's care conference, which was scheduled for September 2014. Family identified a willingness to attend the conference. (123)

B. A review of clinical records for resident #16 identified that care conferences were held in 2012 and 2014. Interview with the RSC confirmed that a care conference was not held in 2013 for the resident. [s. 27. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a care conference of the interdisciplinary team is held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker (SDM), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. Progress notes for resident #51 identified involvement in an incident with a co-resident, in 2013. Registered staff identified the co-resident as resident #50, after reviewing the note. Progress notes for resident #50 did not include a description of the incident, an initial assessment or the resident's response, as confirmed during an interview with staff, who indicated that the resident was assessed and cared for post incident. (168)

B. Progress notes for resident #51 identified involvement in an incident with two co-residents, in 2014. Interview with the author of the note identified one of the co-residents as resident #56. Progress notes for resident #56 did not include a description of the incident, an initial assessment or the resident's response, as confirmed during an interview with staff, who indicated that the resident was assessed and cared for post incident. (168)

C. Progress notes for resident #51 identified involvement in an incident with a co-resident, in 2014. Interview with the author of the note identified the co-resident as resident #57. Progress notes for resident #57 did not include a description of the incident, an initial assessment or the resident's response, as confirmed during an interview with staff, who indicated that the resident was assessed and cared for post incident. (168)

D. Resident #40 sustained a skin tear sometime in February 2014. A progress note

dated March 1, 2014, identified an "old skin tear" which had a dressing in place and the Skin Monthly Summary Report of March 2014, which noted the area was acquired internally in February 2014. There was no documentation available to indicate when the tear was sustained, how, actions taken by the staff or the resident's response. Staff interviewed confirmed the lack of documentation regarding the skin tear when it was first identified. (168)

E. Progress notes for resident #51 identified involvement in an incident with a co-resident, on tow dates in 2014. Staff identified the co-resident as resident #59, after reviewing the notes. Progress notes for resident #59 did not include a description of the incidents, initial assessments or the resident's response. Staff interviewed confirmed that the resident was assessed and cared for post incident. (168)

F. The Treatment Administration Record (TAR) for resident #31 directed staff to monitor the resident's device every shift. A review of the TAR for December 2014, identified that on the day shift of December 4, 8 and 10, 2014, the TAR was not signed as care being completed. Interview with the registered nursing staff confirmed that the monitoring of the device had not been documented on the identified dates, when the care was provided. (503)

G. The plan of care for resident #56 directed staff to monitor the resident every 30 minutes to ensure safety. A review of the 30 Minute Safety Checks sheets from November 23, 2014 until December 8, 2014, identified that staff had not consistently documented the safety checks as being completed. The following checks were not documented: on November 23, 2014, from 0730 until 1330 hours; on November 24, 2014, from 1730 until 2230 hours; on November 28, 2014, from 1530 until 2230 hours; on November 29, 2014, from 0730 until 1430 hours; on November 30, 2014, from 0730 until 1430 hours; on December 1, 2014, from 1730 until 2230 hours; on December 4, 2014, from 0730 until 1430 hours; on December 5, 2014, from 0730 until 1430 hours; on December 7, 2014, from 0800 until 1430 hours; and on December 8, 2014, from 0001 to 2330 hours. Registered staff reviewed the documentation and confirmed that the care completed was not recorded in the record. The DOC confirmed that the monitoring checks for safety had not been documented on the identified dates. [s. 30. (2)]

Additional Required Actions:

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

WN #7: 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 the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

Progress notes for resident #55 identified on March 1, 2014, "old skin tear, 1.3 cm long, dressing changed due yellow drainage". The notes were reviewed from January 1, 2014,

until March 1, 2014, and this was the first notation of the altered skin integrity, as confirmed during an interview with registered staff. The area was not assessed initially by registered staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment. The March 2014, Skin Monthly Summary Report, identified only the presence of the tear sometime in February 2014, that it was internally acquired and healing. The TAR noted the tear in March 2014. Registered staff confirmed the absence of an initial assessment and the expectation that an assessment be completed which included the location, size, appearance and treatment applied. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A. Resident #14 was observed on December 8 and 10, 2014, with a healing skin tear covered with a tegaderm dressing. Interview with registered staff confirmed the presence of the altered skin integrity and the clinical record identified that it was first identified in 2014. The area of altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff. The last recorded entry regarding the area was a progress note of October 23, 2014, identifying that the dressing was intact. The TAR's for October, November and December, 2014, did not include identification of the area. Registered staff confirmed the absence of documented reassessments and the expectation that the area be reassessed and the findings documented at least weekly in the progress notes. (168)

B. Resident #24 was observed on December 8 and 10, 2014, with a scabbed lesion. Interview with registered staff confirmed the presence of the altered skin integrity and the clinical record identified a diagnosis and an as needed treatment prescribed. The area of altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff. The last recorded assessment of the area was a progress note of November 14, 2014, which noted the location of the area, drainage and treatment provided. The TAR's for October, November and December, 2014, identified that the area rarely required treatment and was last completed November 16, 2014. Registered staff confirmed the absence of documented reassessments and the expectation that the area be reassessed and the findings documented at least weekly in the progress notes. [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 that the resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutritional care and hydration program included a weight monitoring system, to measure and record, with respect to each resident, body mass index and height upon admission and annually thereafter.

A. A review of clinical records for resident #22 included only one height measurement, recorded and dated in 2011. Interview with the DOC confirmed that the height had not been completed annually. (503)

B. A review of clinical records for resident #10 included only one height measurement, recorded and dated in 2009. Interview with the DOC confirmed that the height had not been completed annually. (503)

C. A review of clinical records for resident #14 included only one height measurement, recorded with no date of entry. The resident was admitted in 2008. Interview with the DOC confirmed that the height had not been completed annually. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutritional care and hydration program includes a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for cleaning of the home, including resident bedrooms and common areas.

A. Resident's #14, #15, #16, and #27 had their bedrooms monitored from December 11, 2014, at approximately 1600 hours until December 15, 2014, at approximately 1530 hours. Rooms belonging to resident #14, #16, and #27 were not completely cleaned during the identified period of time, as the floors and tops of wardrobes contained the same debris during the monitoring period. Interview with the ESM confirmed the expectation that resident floors be swept daily with any visible debris removed. (123)

B. The following observations were noted on December 8, 2014:
i. The tub lift seat in the Chalmers House Spa was soiled.
ii. Table legs in the Harbour and Howell House dining rooms were soiled with food debris.
iii. Fabric on chairs in the Chalmers and Bronte House dining rooms and in the Bronte House lounge area were soiled.
iv. The privacy curtain in the Harbor House Spa was soiled in the mid to lower section.
v. Mildew was observed in the grout along the left and center walls at floor in the Howell House Shower.
Interview and tour with the ESM on December 16, 2014, confirmed the observations identified above and plans to address the concerns. (123) [s. 87. (2) (a)]

2. The licensee failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Resident #15 used a wheelchair. The left side of the chair seat cushion and both sides of the lower frame were noted to be soiled with debris on December 11 and 15, 2104. Interview with registered staff indicated that wheelchairs were to be cleaned the night before the resident's scheduled bath, and recorded on the 24 Hour Unit Profile Tracking Tool. The bath schedule was reviewed and indicated that resident #15's bath days were Mondays and Fridays. The 24 Hour Unit Profile sheets for Monday, December 8, 2014, and Friday, December 12, 2014, were reviewed and did not include that the wheelchair was cleaned on either day. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are implemented for cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

Resident #40 was administered a medication that was prescribed for resident #41 in 2014. Interview with ADOC confirmed that resident #40 was administered one dose of the medication that was not prescribed for them. Review of the records indicated the resident was monitored following the administration and did not require additional treatment. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is administered to a resident unless the drug had been prescribed for the resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to forward a written complaint concerning the care of a resident, or the operation of the long-term care home, immediately to the Director.

The RSC received a written complaint via e-mail regarding the care of resident #31 in 2014. The DOC and ED confirmed that the complaint was received and not forwarded to the Director, as required. [s. 22. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was restrained by the use of a physical device, other than in accordance with section 31 (included in the resident's plan or care) or under the common law duty described in section 36.

Resident #26 was observed on December 10, 11 and 12, 2014, to use a seat belt when in the wheelchair, which could not be removed on request. A review of the clinical record and staff interviewed identified that the device was used as a restraint. Point of Care (POC) records from November 13, 2014, until December 12, 2014, a 30 day period, identified that registered staff were not consistently documenting their reassessment and effectiveness of the device at least every eight hours as required. Interview with registered staff, confirmed that during the 30 days, the reassessment of the device and its ongoing need, was documented only once a day, with five exceptions, where it was documented twice a day, on November 16, 22, 23, and December 5 and 7, 2014. Staff confirmed that the reassessment and documentation was to be completed every eight hours in POC records. [s. 30. (1) 3.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an injury in respect of which a person was taken to hospital, no later than one business day after the occurrence of the incident.

Resident #30 experienced a fall in 2014, for which they were admitted to the hospital for treatment of injuries sustained. The home did not inform the Director, of the incident, until five days later. The resident experienced a second fall, for which they were admitted to hospital, for treatment of injuries sustained. The home did not inform the Director of the incident until four days later. The resident had a significant change in health status from the injuries sustained during the falls. The DOC confirmed the Director had not been notified of either incident within one business day of the occurrence. [s. 107. (3) 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was created and maintained for each resident of the home.

A review of the clinical record for resident #56 identified that they experienced a fall in 2014. Post fall assessment documents, as required in the home's policy, could not be located in the chart. Interview with the DOC confirmed that the assessment had been completed, as an Internal Incident Report was generated, but that the record was not maintained as the assessment could not be located. [s. 231. (a)]

Issued on this 19th day of December, 2014

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

Original report signed by the inspector.