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

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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
Oct 23, 2015	2015_191107_0014	H-002882-15	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

MICHELLE WARRENER (107), CATHIE ROBITAILLE (536), SUSAN PORTEOUS (560)

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): July 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, 2015

The following inspections were conducted concurrently with this Resident Quality Inspection:

001119-15
006214-15
018584-15

During the course of the inspection, the inspector(s) spoke with Residents, family members, Executive Director (ED), Director of Care (DOC), Business Manager, Resident Services Coordinator, Food Services Manager, Registered Dietitian, Environmental Services Manager, Programs Manager, both Associate Directors of Care (ADOC), Minimum Data Set (MDS) Coordinator, Behavioural Support Ontario (BSO) lead, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), front line dietary and environmental staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
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
Residents' Council
Skin and Wound Care

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

19 WN(s)
13 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. 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. (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).

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 has failed to ensure that the nutrition plan of care for resident #026 was based on the resident's needs and preferences. The resident had a plan of care that

required a dietary restriction. Nutritional interventions were revised by the Registered Dietitian, after a significant weight loss warning, to include nutritional strategies that included the restricted item. The nutritional strategies were then discontinued a month later due to the items containing the restricted item. The nutritional interventions implemented were not based on the resident's assessed need for a restricted menu. [s. 6. (2)]

2. The licensee has 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 #037 had a plan of care related to incontinence that stated the resident required a specific incontinence product. The resident and staff confirmed the resident had always worn this product. Three separate Resident Assessment Instrument Minimum Data Set (RAI-MDS) Resident Assessment Protocol (RAP) assessments identified different types of incontinence products for the resident. The Continence Program Lead confirmed the incontinence products noted in the RAP were in error. Different staff completed the incontinence product list and the RAP for incontinence and staff stated the person completing the RAP did not always have access to the list of incontinence products being worn by the residents. Information between the assessments was not consistent and accurate.

The bladder continence assessment for resident #037, completed on Point Click Care (PCC), identified the resident was continent; however, the RAI-MDS assessment completed during the same time frame identified the resident was incontinent of bladder and required an incontinence product. The Continence Lead confirmed the resident had required an incontinence product since admission and the assessment that identified the resident as continent was incorrect.

Not all continence assessments were consistent and complemented each other. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care for residents was provided to the residents as specified in the plan.

A) The licensee has failed to ensure that the care set out in the plan of care for resident #026 was provided to the resident as specified in the plan at the afternoon snack pass July 27, 2015.

The resident's plan of care required additional fluids to be offered at each snack. The resident was not offered additional fluid at the observed snack pass. The PSW delivering the snack cart was unaware the resident required additional fluids at the snack pass and stated that residents who required additional fluids would have a labeled beverage glass. Residents requiring additional fluids did not have labeled beverage glasses and only 125 mL beverage glasses were available on the snack cart. The Nutrition Manager stated that the requirement for additional beverages was identified in the snack service binder. The snack service binder was not placed on the snack cart until half way through the snack pass. Food and fluid intake records reflected the resident was not consuming the additional fluids at all snacks (with the exception of four) over a two month period from when the intervention was initiated. The resident was at nutrition risk and consistently failed to meet their target hydration requirement. (107)

B) The licensee has failed to ensure that the care set out in the plan of care for resident #030 was provided to the resident as specified in the plan at the afternoon snack pass July 27, 2015.

The resident's plan of care identified "potential for inadequate fluid intake" and required additional fluids to be offered at each snack. The resident was not offered an additional fluids at the observed snack pass. The PSW delivering the snack cart was unaware the resident required additional fluids at the snack pass and stated that residents who required additional fluids would have a labeled beverage glass. Residents requiring additional fluids at snacks did not have labeled beverage glasses and only 125 mL beverage glasses were available on the snack cart. The Nutrition Manager stated that the requirement for additional beverages was identified in the snack service binder. The snack service binder was not placed on the snack cart until half way through the snack pass.

C) The licensee failed to ensure that the care set out in the plan of care was provided to resident #030 as specified in the plan.

Resident #030 had a plan of care that required the resident to have their call bell within reach. The resident stated that their call bell was placed out of reach by a staff member. The resident had bed mobility limitations, requiring two staff assistance and the resident stated it was difficult for them to get to the call bell after it was moved. A PSW providing care to the resident the same date confirmed the call bell was moved out of the resident's reach. The resident became more agitated when the bell had been moved out of the

resident's reach. (107) [s. 6. (7)]

4. The licensee did not ensure that residents were reassessed and the plan of care reviewed and revised when the residents' care needs changed as evidenced by the following:

A) The inspector reviewed the medical record of resident #044. A fall risk assessment was completed for resident #044 which identified the resident as a high risk for falls. The previous fall risk assessment identified the resident as a moderate risk for falls. The home's written plan of care was not updated to reflect the resident was a high risk for falls until two months after the change. This information was confirmed during an interview by the RAI Coordinator who had completed the fall risk assessments and reviewed the written plan of care.

B) The licensee has failed to ensure that resident #026 was reassessed and their plan of care reviewed and revised when their care needs changed in relation to continence. The quarterly assessment identified the resident was occasionally incontinent of bowels and frequently incontinent of bladder. The resident had a decline in bowel continence to frequently incontinent at the next RAI-MDS assessment. The resident's plan of care was not revised to reflect the decline in bowel continence and did not accurately reflect the resident's level of urinary incontinence. The plan of care identified the resident was only occasionally incontinent of both bowel and bladder. The resident had a further decline with 49 occasions of being incontinent and no instances of being continent of bowels. Personal Support Workers interviewed stated the resident was completely incontinent of bowels and the incontinent product was not meeting the resident's needs. The resident's plan of care was not revised in relation to the decline in bowel continence and did not accurately reflect the resident's level of urinary incontinence. [s. 6. (10) (b)]

5. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care for resident #026 when the nutrition interventions were not effective. Nutritional interventions were revised after a significant weight loss warning was triggered. The interventions were discontinued the next month. Alternative strategies to prevent weight loss were not initiated when the interventions were discontinued. The resident experienced significant weight loss of 9% over a three month period and a weight had not been taken after the nutrition interventions were discontinued. The Registered Dietitian confirmed that alternative strategies had not been implemented when the previous strategies were discontinued. [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 with s. 6(2), s.6(7), s.6(10)(b), and s. 6(11)(b), to be implemented voluntarily.

WN #2: 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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A) The licensee has failed to ensure that the home's policy "Nutrition and Hydration Management LTC-G-80", revised August 2014, was complied with by staff for resident #026.

The policy stated that the Registered Dietitian would assess each resident's hydration requirement from fluids alone (i.e. 80% of overall hydration needs) and document on the care plan. Residents with poor food intake 100% of the minimal fluid requirements would be documented in the the care plan. Residents would be encouraged to drink fluid or consume high fluid content foods immediately, and a referral would be made to the Registered Dietitian if the resident's daily fluid intake was recorded as less than the

recommended minimum intake from fluids alone for three consecutive days and based on the clinical judgement of the nurse.

Resident #026's plan of care identified a goal for hydration.

Over a four month period the resident did not meet their fluid goal with the exception of nine days. The resident did not meet their fluid goal on 12 consecutive days; four consecutive days; 41 consecutive days; 39 consecutive days; six consecutive days; three consecutive days; four consecutive days; and three consecutive days over the four month period.

The Registered Dietitian confirmed she did not receive referrals related to the resident's ongoing poor hydration according to the home's policy. (107)

B) The licensee has failed to ensure that the home's policy on Oral Care was complied with in regards to resident #031.

The home's policy "Oral Assessment and Care LTC-H-20", effective date: August 2012, revised date: May 2013 stated "An oral assessment will be completed upon admission, quarterly, annually and as required." A review was completed of resident #031's clinical record. The only oral health assessment completed on resident #031 was done seven months after the resident was admitted. This was confirmed by the Registered Nurse (RN) on July 31, 2015. (536)

C) The home's weight monitoring policy, "Height Measurement and Weight Management, LTC-G-60, revised June 2014", was not followed by staff. The policy stated that on admission, each resident's height and weight would be measured and documented by the resident's first bath day and monthly thereafter. The policy stated that residents would be weighed and the weight would be documented by the 7th day of each month and weight changes of 2.0kg or greater would be confirmed immediately. A referral to the Registered Dietitian would be initiated with the information documented in the interdisciplinary progress notes and an interdisciplinary approach would be used to determine the possible factors which may have contributed to the weight variances. The weight variances would be communicated to the resident/substitute decision maker.

Resident #012 had a significant weight loss of 16.3% over one month recorded in the resident's clinical health record. Staff confirmed a re-weigh, to verify the accuracy of the weight, was not completed and an interdisciplinary approach to the assessment of the

significant weight change was not completed. The resident was not re-weighed until the next month and that weight was consistent with a 15% significant weight loss.

Resident #007 had a 5.3% significant weight loss over one month. Staff confirmed that a re-weigh, to verify the accuracy of the significant weight loss, had not been taken and the weight had not been assessed using an interdisciplinary approach.

Resident #026 had a significant weight loss of 8.9% over three months (missing the two months weights in-between). Staff confirmed a re-weight to verify the accuracy of the weight was not taken after the significant weight loss, and the resident did not have their weight measured and entered into the computer by the 7th day of the month. Staff confirmed the resident's weight was not taken and recorded as of July 23, 2015.(107) [s. 8. (1) (a),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 with ensuring that 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, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the home's policies "Resident Non-Abuse - LP-

C-20, revised April 2011", and policy "Resident Non-Abuse - Ontario LP-C-20-ON, revised September 2014" were complied with by staff for allegations of staff to resident abuse/neglect for resident #030.

The policy defined physical abuse as, "the use of force by anyone other than a resident that causes physical injury or pain" and neglect as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being - includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

The policy also identified, "Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately. The incident must be reported following the Serious Adverse Event Reporting algorithm, located in the company-wide Enterprise manual, Risk Section. An immediate dignified and respectful investigation of the reported alleged, suspected or witnessed abuse will be initiated by the ED/designate. LP-C-20 - Appendix A - Tool Kit for Conducting an Alleged Abuse Investigation may be used as a resource in conducting the investigation. "

The Executive Director and registered nursing staff confirmed allegations that resident #030 was being hurt by staff and not being cared for were not reported to the Executive Director and confirmed that a formal investigation did not occur. Documentation did not include specific details of the resident's allegations, staff involved and statements from the staff, any evidence to support that the allegations were false, or an assessment of the resident for injuries. [s. 20. (1)]

2. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with by staff.

The home's policy, "Resident Non-Abuse - Ontario LP-C-20-ON, revised September 2014", identified examples of emotional abuse as humiliation, intimidation, scolding, threats/instilling fear, and examples of verbal abuse as inappropriate tone of voice, yelling, rude comments. The policy directed staff to immediately report the concerns to the Executive Director who would conduct an immediate and thorough investigation of the reported alleged, suspected or witnessed abuse or neglect of a resident.

Resident #037 voiced concerns to the Inspector stating that staff had yelled at and scolded the resident, and the resident stated they felt embarrassed and upset by the tone of voice and demeanor of the staff. The Director of Care was informed of the concerns and interviewed the resident. The written account of the interview, completed by the Director of Care, did not include what the allegations of the resident were, who was involved, and confirmed that staff involved were not interviewed, other residents who received care by the identified individuals were not interviewed, and the outcome was not identified. Action was not taken in response to the allegations identified by the resident.

The Director of Care did not follow the home's policy in relation to investigating alleged abuse and confirmed an investigation into the allegations of the resident did not occur. The Executive Director was not informed and involved in an investigation of the concerns voiced by the resident. [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 with ensuring 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. O. Reg. 79/10, s. 30 (1).

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 the following was complied with in respect of the organized continence care and bowel management program required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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.

The home's annual continence and bowel management written evaluation did not include 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. The lead for the home's continence and bowel management program confirmed that the evaluation did not include all of the required documentation. [s. 30. (1) 4.]

2. The licensee failed to ensure that actions taken with respect to resident #034 under the Revera Skin and Wound Care Program LTC-E-90 (the "Program") including assessments and reassessments were documented as evidenced by:

The Program defined altered skin integrity to include all skin breakdown including bruises. Under assessment the Program directed that all residents exhibiting altered skin integrity would be assessed by the Nurse on initial discovery and re-assessed with every dressing change but minimum weekly and that skin breakdown identification would be documented by the Nurse in the interdisciplinary notes.

During the inspection resident #034 was observed to have bandages on their skin which when removed revealed large bruises. The medical record of the resident was reviewed. No documentation of the initial discovery of the resident's bruises was identified in the multidisciplinary notes. Staff interviewed confirmed neither the initial discovery of this skin breakdown or regular monitoring by the Nurse was documented in the resident's medical record. During an interview the DOC stated her expectation was that the resident's bruising would have been assessed by the Nurse on initial discovery, re-assessed weekly and these assessments documented in the interdisciplinary progress notes. [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 with ensuring 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 (r. 30(2)), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program provided for reassessment instruments for changes in bowel continence. The home's policies and procedures did not include direction for staff in relation to reassessment of bowel incontinence. The Regional Manager and the home's lead for the continence care and bowel management program confirmed the program did not currently include direction for staff and reassessment instruments for changes in bowel continence after admission. [s. 48. (2) (b)]

2. The licensee has failed to ensure that the skin and wound care program provided for a standardized assessment and reassessment instrument related to bruising. The Skin and Wound Care Program LTC-E-90 defined altered skin integrity to include all skin breakdown including bruises and required assessment and documentation in the progress notes; however, the program did not include standardized assessment and re-assessment instruments for bruising. The home's assessment instruments related to skin referred to lesions, skin tears, and wounds; however, did not include bruising.

A) Resident #026 had an area of bruising on the resident's skin observed during the Resident Quality Inspection. PSW staff interviewed on July 31, 2015, stated the resident had multiple areas of bruising at the time. Documentation did not reflect an assessment of the bruising and not all staff were aware of the process for assessing and documenting bruising.

B) Resident #030 had a large area of bruising on the resident's skin observed by the inspector during the Resident Quality Inspection. Not all staff were aware of the process for assessing and documenting bruising. The Regional Manager confirmed the home's policies and procedures did not clearly provide direction to staff in relation to bruising. [s. 48. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that each program must, in addition to meeting the requirements set out in section 30, (b) provide for assessment and reassessment instruments, to be implemented voluntarily.

WN #6: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #034, who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment as evidenced by the following:

The inspector observed bruises on the resident's skin during the Resident Quality Inspection. The resident's medical record over a two month period was reviewed by the inspector. There was no documentation of the initial discovery and assessment of the resident's identified altered skin integrity.

Under the Revera Skin and Wound Care Program LTC-E-90 (the "Program") altered skin

integrity is defined to include all skin breakdown including bruises. Under assessment the Program directed that all residents exhibiting altered skin integrity would be assessed by the Nurse on initial discovery and re-assessed with every dressing change but minimum weekly and that skin breakdown identification would be documented by the Nurse in the interdisciplinary notes.

During interviews staff reported that the Ongoing Wound Assessment-Treatment Observation Record LTC-E-90 (B)- March 2014 (Form 1) and Initial Wound Assessment - Treatment Observation Record LTC-E-90-10(A)- March 2014 (Form 2) were not completed for bruises which were to be assessed by the nurse and documented in the multidisciplinary progress notes. Staff interviewed confirmed there was no documentation of the discovery and assessment of the resident's identified bruising in the progress notes. During an interview the DOC stated her expectation was that the nurse document the initial discovery, assessment and monitoring of a bruise in the progress notes. She confirmed that the resident's identified altered skin integrity was not assessed and documented using a clinically appropriate instrument designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #002, who was dependent on staff for repositioning, was repositioned every two hours.

Resident #002’s wheelchair had a Personal Assistive Service Devices (PASD) for comfort and positioning. A review was completed of the Point of Care (POC) Personal Assistive Services Device (PASD) monitoring flow sheet over a 22 day period for resident #046. There were 27 separate times that the range in time for repositioning the resident, ranged from 3hrs to 9 hrs. This was confirmed on July 30, 2015, by the DOC. [s. 50. (2) (d)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #026, who had a decline in their level of bowel continence from occasionally incontinent to frequently incontinent at the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) review, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. Point of Care records on bowel continence reflected the resident was incontinent on 49 occasions during that 29 day period with no instances of being continent of bowels. The resident had a significant change in bowel movements and PSW staff interviewed stated the incontinence product was insufficient to contain the bowel movements. The RN on the unit stated she was not aware of the problems with the incontinence products. An assessment of the resident's decline in bowel continence was not completed using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence. The Revera Regional Manager confirmed that the home did not currently have a policy in place that included assessment of changes in bowel continence after admission and the use of a clinically appropriate assessment instrument. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

During interviews the week of July 20, 2015, multiple staff identified resident #030 had responsive behaviours with identified triggers. Routinely on a particular shift, staff put measures in place to manage the identified trigger; however, not all staff interviewed were aware of the trigger for responsive behaviours. Written approaches to care and written identification of behavioural triggers were not in place to ensure consistent strategies were in place and that the resident was assessed and reassessed as required in relation to the identified triggers.

Registered staff interviewed stated the strategies on one shift had been in place for several months. On an identified date, an incident occurred where the resident had responsive behaviours. Written strategies and an assessment in relation to the behavioural trigger were not in place prior to the incident. [s. 53. (1)]

2. The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) were, (a) integrated into the care that is provided to all residents; (c) co-ordinated and implemented on an interdisciplinary basis.

Resident #045 had a plan of care in place that identified behavioural triggers and strategies to manage those behaviours. During an observed lunch meal, the resident appeared agitated and was demonstrating responsive behaviours. The strategies identified on the resident's plan of care were not implemented to de-escalate the behaviours. Staff did not take action and continued with their daily routines while the resident was becoming increasingly agitated.

Resident #048 was having responsive behaviours in response to a staff member's routines. The staff member did not address the resident while continuing with their duties. Strategies were not implemented to de-escalate the resident's behaviours and were not integrated on an interdisciplinary basis. [s. 53. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that written appropaches to care, including screening protocols, assessment, reassessment, identification of behavioural triggers that may result in responsive behaviours, cognitive, physical, emotional, social, environmental or other, are developed to meet the needs of residents with responsive behaviours (r. 53(1)1) and that for all programs and services the matters referred to in subsection (1) are co-ordinated and implemented on an interdisciplinary basis (r. 53(2)(c)), to be implemented voluntarily.

WN #9: 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 has failed to ensure that a weight monitoring system was in place to measure and record resident #026's weight on admission and monthly thereafter. The resident did not have a recorded weight for five out of eight months. The RPN and ADOC confirmed the weights were not available in the computer system or through a paper copy. Documentation and staff interview did not support rationale for the weights not being taken. The resident was at high nutrition risk and had a significant weight loss noted over a three month period. The two months weights inbetween the significant weight loss were not available to determine when the weight loss occurred. Staff confirmed resident weights were not always taken on admission and available monthly. [s. 68. (2) (e) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that a weight monitoring system is in place to measure and record, with respect to each resident, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #10: 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 has failed to ensure that resident #007, who had a documented 5.3% decline in weight over one month, was assessed using an interdisciplinary approach and that actions were taken and outcomes evaluated. The significant weight loss was identified in the computer at the beginning of the month. Staff confirmed a re-weigh, to verify the accuracy of the significant weight loss had not been completed and staff confirmed that weight changes were not evaluated using an interdisciplinary approach. The Registered Dietitian reviewed the weight loss; however, action was not taken to address the significant weight loss and the plan was to continue with the same interventions. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to ensure that resident #012 was assessed using an interdisciplinary approach and that action was taken and outcomes evaluated. A significant weight loss of 16.3% over one month was recorded in the weight section of the resident's clinical health record. Documentation did not reflect an assessment of the significant weight change and staff confirmed a re-weigh to verify the accuracy of the significant weight loss was not completed, as per the home's weight monitoring policy. Twenty six days after, the Registered Dietitian identified the documentation as incorrect; however, an assessment of the resident or a re-weigh was not completed at that time. The resident's weight the next month reflected a similar weight to the original weight showing the significant weight loss; still 15% weight loss. An interdisciplinary approach was not used to assess the reason for the significant weight loss and the weight loss was not assessed until the next month. During interview with the Inspector, Dietary staff identified the resident had not been eating well prior to the weight loss. [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 with ensuring that weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

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

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

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

A review of the Residents' Council minutes, from May 2014 until June 2015 was completed. The Inspector was unable to confirm on review of the minutes, that the meal and snack times had been reviewed with the Residents' Council. The Programs Manager, when interviewed, confirmed that the meal and snack times were reviewed during the Food Committee Meetings, not at Residents' Council meetings. [s. 73. (1) 2.]

2. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 4. Monitoring of all residents during meals.

Resident #012 was observed on July 24, 2015 with three beverages in-front of them (from the lunch meal) sitting alone and unattended at the table in the dining room at 1313 hours. The resident's plan of care identified they had difficulty chewing and swallowing and required extensive assistance with eating. Staff were not in close proximity to the dining room and the resident did not have a method to call staff for assistance if required (call bell was not in reach and the resident required staff assistance for mobility). The

Director of Care confirmed that the home's policy was for all residents to be supervised during meals and with food and fluids. [s. 73. (1) 4.]

3. The licensee has failed to ensure that resident #012 was provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible on July 24, 2015. The resident was observed sitting at the table in-front of three beverages. The resident's plan of care identified the resident required extensive assistance and staff confirmed the resident required extensive assistance with eating. The resident was left sitting at the table in-front of their beverages after the meal (resident was observed at the table at 1313 hours). The resident requested assistance with their beverages when speaking with the inspector. [s. 73. (1) 9.]

4. The licensee has failed to ensure that resident #026 was provided with any eating aids and assistive devices at the afternoon snack pass July 27, 2015. The resident's plan of care directed staff to provide the resident's fluids in special cups. The resident was provided fluids in a regular cup. The special cups were not available on the snack cart at the observed snack pass and were not offered or provided to the resident. Staff confirmed the resident required special cups for beverages and had been receiving them at the observed lunch meals. [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring the monitoring of all residents during meals (r. 73(1)4), to be implemented voluntarily.

WN #12: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has 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 apply the physical device in accordance with any manufacturer's instructions.

Instructions provided to the home on the "Use & Care of Wheelchair Hip Belts" directed staff to allow just enough space for two fingers to fit between the hip belt and the person's body, at any one point along the belt.

A) On July 27, 2015, at 1030 hours, resident #047 was observed with a very loose seatbelt while sitting in the lounge. The space between the belt and the resident was more than two fists. The resident's plan of care stated they were a high risk for falls. The staff confirmed the seatbelt was too loose, and that the resident was unable to undo the seatbelt. The seatbelt was then tightened.

B) On July 27, 2015, at 1045 hours, resident #046 was observed with a very loose seatbelt while sitting in the lounge. The space between the belt and the resident was two fists. The resident's plan of care stated they were a medium risk for falls. The staff confirmed the seatbelt was too loose, and that the resident was unable to undo the seatbelt. The seatbelt was then tightened.

C) On July 27, 2015, at 1100 hours, resident #034 was observed with a very loose seatbelt while sitting in the lounge. The space between the belt and the resident, was more than two fists. The resident's plan of care stated they were a high risk for falls. The staff confirmed the seatbelt was too loose, and that the resident was unable to undo the seatbelt. The seatbelt was then tightened. [s. 110. (1) 1.]

2. The licensee has failed to ensure that resident #012, #034, #046 and #047 were released from the physical device and repositioned at least once every two hours.

A) A review was completed of the July, 2015, Point of Care (POC) restraint monitoring flow sheet, which referred to resident #012's restraint application, release, repositioning, and re-application. Over a 21 day period, there were 29 different times that the range between checking on the resident and repositioning or releasing the seatbelt, ranged from 3 hours (hrs) to 14 hrs. This was confirmed on July 30, 2015, by the Director of Care (DOC). Resident #012's plan of care stated that they were a medium risk for falls.

B) A review was completed, of the July, 2015, Point Of Care (POC) restraint monitoring flow sheet, which referred to resident #034's restraint application, release, repositioning, and re-application. Over a 21 day period, there were 35 separate times that the range between checking on the resident and repositioning or releasing the seatbelt ranged from 3 hrs to 8.5 hrs. This was confirmed on July 30, 2015, by the DOC. Resident #034's plan of care stated, that they were a high risk for falls.

C) A review was completed, of the July, 2015, POC restraint monitoring flow sheet, which referred to resident #046's restraint application, release, repositioning and re-application. Over a 21 day period, there were 31 separate times that the range between checking on the resident and repositioning or releasing the seatbelt ranged from 3hrs to 9 hrs. This was confirmed on July 30, 2015, by the DOC. Resident #046's plan of care stated that they were a medium risk for falls.

D) A review was completed of the July, 2015, POC restraint monitoring flow sheet, which referred to resident #047's restraint application, release, repositioning and re-application. Over a 21 day period, there were 30 separate times that the range between checking on the resident and repositioning or releasing the seatbelt ranged from 3hrs to 9 hrs. This was confirmed on July 30, 2015, by the DOC. Resident #047's plan of care stated, that they are a high risk for falls. [s. 110. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that with respect to the restraining of a resident by a physical device under section 31 or section 26 of the Act: staff apply the physical device in accordance with any manufacturer's instructions (r. 110(1)1) and that where a resident is being restrained by a physical device under section 31 of the Act the resident is released from the physical device and repositioned at least once every two hours (r. 110(2)4), to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs complied with the manufacturer's instructions for expiration dates and pharmacy directives.

On July 26th and 27th, 2015, all the medication rooms in the home were checked for expired medications.

The inspector noted the following:

i) Chalmers House: ten ampules of haloperidol 5 milligrams (mg), expiry date: June 2015; bottle of childrens liquid gravol, expiry date: April 2015
ii) Willilams House: Bisacodyl 10 mg suppositories, expiry date: January 2015
iii) Harbour House: 2 bottles Cavilon barrier film, expiry: March 2015; Bisacodyl 10 mg suppositories, expiry date: March 2015; Povidone-iodine swabs, expiry: October 2014

On July 26th and 27th, 2015, all medication carts in the home were checked for eye drops and insulins to ensure they were dated as to when they were opened, and when they were to be discarded 30 days later as per the home's pharmacy directive.

The inspector noted the following:

i) Howell House - 3 bottles of eye drops and 2 different cartridges of insulin were not dated
ii) Chalmers House – 4 bottles of eye drops were not dated
iii) Harbor House - 2 bottles of eye drops were not dated
iv) Williams House - 2 different cartridges of insulin were not dated [s. 129. (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 with ensuring that drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Personal Assistive Services Device (PASD) was approved by a physician for resident #034.

On July 28, 2015, a review was completed of resident #034's clinical record. The inspector was unable to locate a physician's order for a PASD, which had been in use for four months. On July 29, 2015, the Registered Nurse (RN) advised the inspector that an order had just been received from the physician for the PASD for resident #034. The RN advised the inspector that a previous order was not located in the resident's physician's orders. [s. 33. (4) 3.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consult regularly with the Residents' Council, and in any case, at least every three months.

A review of the Residents' Council minutes from May 2014 until June 2015 was completed. The inspector was unable to confirm on review of the minutes, that the home had consulted with the Residents' Council regularly, or at least every three month. This was confirmed by the Programs Manager on July 23, 2015, and by the Executive Director on July 24, 2015. [s. 67.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle, (e) was approved by a registered dietitian who was a member of the staff of the home.

The menu was revised to remove bread from the home's menu at the lunch and dinner meals, resulting in inadequate servings of grains being offered to residents on some menu days. The Registered Dietitian was unaware that bread had been removed from the menu for all residents. The Registered Dietitian stated that bread was to be offered but not provided unless requested for residents who were able to make meal choices and provided for those who were unable to make meal choices. Bread had been removed from the menu for all residents for the lunch and dinner menu.

The menu changes had not been approved by the Registered Dietitian to ensure nutritional adequacy of the menu being provided to residents. [s. 71. (1) (e)]

2. The licensee has failed to ensure that resident #026 was offered a snack at the afternoon snack pass July 27, 2015. The resident was offered a beverage; however, was not offered a snack. The PSW serving snacks stated the resident usually didn't take a snack in the afternoon and was unable to have the available snack (oatmeal muffin) because they were on a texture modified diet and the alternative snack was unsuitable for the resident. The therapeutic extension menu for Week 1 Monday afternoon snack directed staff to offer the oatmeal muffin for residents requiring the texture modified menu. The resident was at nutrition risk with a history of significant weight loss. [s. 71. (3) (c)]

3. The licensee failed to ensure that an individualized menu was developed for each resident whose needs could not be met through the home's menu cycle.

Resident #006 did not have an individualized menu in place that provided direction to staff both preparing and serving meals to the resident. The Nutrition Manager confirmed the resident required alteration of the home's menu to meet their needs.

Direction provided for serving staff on what to offer the resident did not include special directions for the lunch meal. The serving list directed staff to follow one of the therapeutic menus; however, the Nutrition Manager confirmed they were not following that therapeutic menu for the resident.

At the lunch meal July 23, 2015, the specified therapeutic extension menu included items the resident was not to receive and the menu offered to the resident was not consistent

with the planned menu staff were directed to follow (as per the serving list).

The Nutrition Manager stated the staff were told what to make verbally each day. During interview, the two cooks confirmed there was no written direction on what they were to make for that resident for the noon meal. One of the cooks stated they just followed the regular menu and production numbers and was unaware if there was something special required for the resident.

A planned individualized menu that provided direction to staff preparing and serving meals was not in place. [s. 71. (5)]

WN #17: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for cleaning of carpets in resident's rooms.

During stage one interviews of the Resident Quality Inspection (RQI), it was identified that there were concerns about scheduled cleaning of carpets in resident's rooms, as well as odour of carpets. The inspector reviewed the homes policies, procedures, schedules, and audits for carpet cleaning. It was identified that schedules were in place; however, the schedules identified cleaning of the common areas, not cleaning of carpets in resident's rooms. The Environmental Services Manager (ESM) stated resident's rooms were being cleaned as needed; however, acknowledged that the schedule needed to be revised to address regular cleaning of carpets in the resident's rooms. On an identified home area it was noted that the odour of urine was evident more frequently in hallways and in an identified room. The schedule was revised on July 29, 2015, in order to address these concerns. [s. 87. (2) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that every calendar year they conduct an evaluation to determine the effectiveness of the policy, and identify what changes and improvements are required to minimize restraining.

A review was completed of the "Least Restraint 2014 Yearly Overview" which was provided to the inspector by the Executive Director on July 30, 2015. The Overview provided a definition of a restraint statistics chart for 2012/2013 and a statement stating "we continue to audit the restraints and approach POA's for trials of removing the restraints. A QI (Quality Indicator) will be implemented in September of 2014 to review/reduce the number of restraints." The Executive Director confirmed on July 31, 2015, that this was the only annual program evaluation for restraints that she was able to locate at this time. [s. 113. (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A review was completed on July 30, 2015, of the Medication Program Evaluation, dated September 15, 2014. The committee members that attended did not include the home's Registered Dietitian. This was confirmed by the Executive Director on July 31, 2015. [s. 116. (1)]

Issued on this 16th day of November, 2015

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

Original report signed by the inspector.