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
Mar 24, 2015	2015_321501_0005	T-1749-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE WEXFORD RESIDENCE INC.
1860 Lawrence Avenue East TORONTO ON M1R 5B1

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

THE WEXFORD
1860 LAWRENCE AVENUE EAST SCARBOROUGH ON M1R 5B1

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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)

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): March 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, and 17, 2015.

During this inspection complaint and critical incident reports T-1844-14, T-1107-14, T-1173-14, T-1251-14, T-1779-15 and T-995-14 were inspected.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), director of programs and services, activationists, coordinator staff development/CQI & ICP, environmental manager (EM), director of finance, food services manager (FSM), registered dietitian (RD), physiotherapist (PT), dietary aides, personal support workers (PSWs), housekeeping aides, nurse managers (NM), registered staff, residents and substitute decision makers (SDMs).

The inspectors conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of clinical health records, complaint and critical incident record log, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 129. (1)	CO #001	2014_220111_0009	600
O.Reg 79/10 s. 230. (7)	CO #001	2014_357101_0056	589
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2014_220111_0009	501

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

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

On a specified date, the inspector observed resident #11 being transferred from the wheelchair to the bed by one PSW. Record review of resident #11's plan of care for transferring stated that he/she requires extensive assistance of two staff with transfer from bed to wheelchair using a ceiling lift. The plan of care also states to provide minimum assistance of one staff with transfer from bed to chair. Interview with the

registered staff revealed that the plan of care was not completely revised when the resident's condition changed and was able to self transfer. Registered staff confirmed that the plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

On specified dates, the inspector observed a half bed rail in an up position for resident #7 and #10. Record review indicated and interviews with resident #7 and #10 and staff confirmed that the residents were assessed and required bed rails for mobility and transfer.

Interviews with an identified registered staff confirmed that the use of bed rails is not included in the residents' plan of care. Resident #7 and #10's plan of care was not based on an assessment of the resident and the resident's needs. [s. 6. (2)]

3. The licensee has failed to ensure that the plan of care is provided to the resident as specified in the plan.

On a specified date, the inspector observed that resident #51 was served three pieces of a sandwich that had crusts on. Record review of the plan of care revealed that resident #51 is to have crusts cut off pieces of bread. Interview with the dietary aide and FSM confirmed that the resident should have been served sandwich pieces with the crusts removed as specified in the resident's plan of care. [s. 6. (7)]

4. Interview with a family member revealed that residents often sit and are not engaged in activities enough. On a specified date, the inspector observed an activity commencing on resident #9's unit that engaged residents who were already in the common area and the activation staff did not invite resident #9. A PSW was observed to invite resident #9 and bring him/her to the activity. Record review of resident #9's plan of care states that an activationist should invite resident #9 to attend programs. Record review of resident #9's participation record revealed he/she has only been invited three times in which he/she has refused to participate from the period October to December 2014. Interview with the director of programs and services confirmed that resident #9 should have been invited by an activationist to attend the program on the specified date. [s. 6. (7)]

5. Record review revealed that safety tread tape is to be on the bedside floor to prevent

resident #15 from sliding off the wheelchair and/or bed.

On specified dates, the inspector observed that there was no safety tread tape in place on the floor for resident #15.

Interview with an identified registered staff confirmed that the above mentioned intervention was initiated in 2012 and that in resident #15's current room the safety tread tape was not in place.

Interview with an identified PT confirmed that safety tread tape is not in place for resident #15 as the product is on back order from the manufacturer. The safety tape was not in place as specified in the plan of care.

On an identified date, the inspector observed that safety tread tape was applied to the floor for resident #15. [s. 6. (7)]

6. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Record review revealed that resident #12 was assessed for a newly identified pressure ulcer on a specified date, and the plan of care stated the resident was to be turned and repositioned every two hours. Record review revealed that turning and repositioning was not documented in point of care (POC) every two hours on identified dates and times.

An interview with the registered staff confirmed that the provision of the care set out in the plan of care was not documented on the above noted dates and time.

Interview with the coordinator of staff development in the home confirmed that staff are expected to document every two hours if that is the provision of the care set out in the plan or care. [s. 6. (9) 1.]

7. The licensee has failed to ensure that the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

Record review revealed the following interventions for resident #15:
1. A specified supportive device is to be worn related to a fracture in 2012
2. Use of a non-slip cover applied to top of wheelchair cushion to minimize slipping.

On specified dates, the inspector observed a cervical collar was not worn by the resident and that a non-slip cover was not applied to the wheelchair seat cushion.

Interviews with an identified registered nurse and an identified PSW revealed that resident #15 has not worn a cervical collar for approximately one year and that the non-slip seat cover is not applied to the wheelchair seat cushion.

Interview with the PT confirmed that the plan of care was not updated to reflect the cervical collar was not being worn and that the non-slip cover was not being applied to the wheelchair seat cushion. [s. 6. (10) (b)]

8. On a specified date, the inspector observed that resident #11's catheter bag was lying on the floor and on another, it was hanging from a bed rail. Record review of the resident's plan of care for urinary continence stated that the catheter bag is to be taped to the resident's leg. Interview with an identified registered staff revealed that a nurse practitioner had recommended that the resident not have a leg bag and record review confirmed that this recommendation was made on a specified date. The registered staff confirmed that the plan of care had not been updated after resident #11's needs changed. [s. 6. (10) (b)]

9. Record review revealed the plan of care outlined the following interventions after the diagnosis of a fractured body part on a specified date:
1. Immobilize body part to fully heal
2. Daily observe and check skin integrity and observe for redness/skin irritation.
3. Prevent swelling with elevation/protect from injury.
4. Re-apply temporary splint when loosens
5. Keep splint on at all times, cover with plastic during showers. Observe for skin irritation/breakdown while in splint. Re-apply splint when loosens.
6. PT, occupational therapist evaluation and treatment per orders

Interview with an identified PT revealed that a six week follow-up post diagnosis of the fracture was not completed including a repeat x-ray to assess the status of the fracturd and, confirmed that the outcome of above mentioned interventions related to resident #3 were not revised in the plan of care. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, is based on an assessment of the resident and the resident's needs and preferences, is provided to the resident as specified in the plan, that the provision and outcome set out in the plan of care is documented and the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices when assisting residents.

Record review revealed that resident #16 had a fall during a shower on a specified date, and sustained a fracture as confirmed by a hospital x-ray.

Record review and an interview with an identified PSW revealed that a commode chair instead of a shower chair was used when showering resident #16. The PSW further stated that resident #16 attempted to stand and fell sideways onto the shower room floor and this incident was not reported to registered staff immediately. The next day, the resident's SDM reported that resident #16 had fallen in the shower room the previous evening and now was complaining of pain.

Record review of the home's investigation into this incident revealed that the PSW admitted to using a commode chair instead of a shower chair when showering resident #16. Interview with an identified NM confirmed that the PSW should have used a shower chair with a safety belt and had not used a safe positioning device when providing a shower to resident #16, resulting in a fall with injury. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident has been assessed and, a post fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review revealed that on a specified date, resident #3 experienced a fall while up in his/her wheelchair and that a post fall assessment was not completed.

Interviews with an identified registered staff, NM and DOC confirmed that a post fall assessment using a clinically appropriate assessment instrument was not completed for resident #3 after he/she fell. [s. 49. (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 when a resident has fallen, the resident has been assessed and, a post fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds has been assessed by a registered dietitian (RD) who is a member of the staff of the home.

Record review revealed that resident #12 had altered skin integrity and had not been assessed by an RD.

Review of the home's policy #E-20 titled Skin Care and Wound Management revised November 6, 2012, states residents with altered skin integrity are to be referred to and assessed by an RD.

Interviews with an identified NM and the DOC confirmed residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds must be referred to and assessed by an RD. Interview with the RD confirmed that a nutrition assessment for resident #12's altered skin integrity had not been completed. [s. 50. (2) (b) (iii)]

2. Interview with an identified registered staff revealed resident #2 presented with multiple areas of altered skin integrity and was sent to the hospital for assessment.

Record review revealed that on a specified date, resident #2 was diagnosed with an identified skin ailment after a biopsy. Interview with an identified RD confirmed that he/she has no recollection of receiving a referral for resident #2's altered skin integrity and as a result a nutritional assessment was not completed. [s. 50. (2) (b) (iii)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds has been assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #5: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Record review revealed that a medication incident report was completed on a specified date, as resident #61 was given the wrong medication by a student registered practical nurse (RPN). The medication incident report revealed that the student RPN did not look at resident #61's arm band and the registered staff was not supervising the student at that time of the medication administration.

The registered staff documented in resident #61's plan of care that as he/she walked towards the medication cart, he/she noticed the student RPN administering medication to the resident and when he/she inquired why, the student realized he/she had given the medication to the wrong resident. Interview with an identified NM confirmed that the medication was administered by the student RPN without supervision and it was reported as a medication error. [s. 131. (3)]

2. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On a specified date, the inspector observed identified over the counter medications in resident #32's room.

Interview with resident #32 revealed family members had supplied the medications and he/she takes them on his/her own. Record review revealed that there was no prescriber's order for the medications.

Interview with an identified registered staff revealed that residents who are self-medicating must have a physician's order for the medications and resident #61 did not have such an order. Interview with the DOC confirmed that residents who are self-medicating must have an order from the physician for those medications. [s. 131. (5)]

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 person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse and that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions are reviewed and analyzed and (b) corrective action is taken as necessary, and

(c) a written record is kept of everything required under clauses (a) and (b).

Record review of three medication incidents revealed the following:

Resident #39 - order of an analgesic patch. Remove at 2200 hours. The medication incident report indicated that on a specified date, there were three old analgesic patches that were not removed.

Resident #60 - Medication incident report from a specified date, indicated that resident received wrong medication.

Resident #61 - Medication incident report from a specified date, indicated that resident received wrong medication. The medication was given by a student nurse.

Record review revealed no evidence that the above medication incidents were reviewed, analyzed and that any corrective action was taken.

The home's policy #G-60 titled Medication Incident states that the medication incident report must be completed and returned to the DOC and the medication incident report will be analyzed by the DOC/NM and the consultant pharmacist to determine whether pharmacy and/or nursing procedures require modification.

Interview with an identified NM confirmed that the above mentioned medication incidents were not reviewed, analyzed and corrective action was not taken. [s. 135. (2)]

2. The licensee has failed to ensure that (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b).

Record review revealed there is no documentation whether a quarterly review was undertaken of all medication incidents since the time of the last review. Interview with an identified NM confirmed that there is no documentation of a quarterly review of all medication incidents. [s. 135. (3)]

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) all medication incidents and adverse drug reactions are reviewed and analyzed and (b) that corrective action is taken as necessary, and (c) there is a written record of everything required under clauses (a) and (b)., to be implemented voluntarily.

WN #7: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly groomed and cared for in a manner consistent with his or her needs.

On specified dates, the inspector observed food debris around resident #4's mouth at specified times. The home's policy #N-15 titled Assistance in the Dining Room and revised May 2, 2012, states that residents should be assisted to use a towelette after each meal. Interview with an identified PSW, registered staff and nurse manager confirmed that resident #4's face had not been cleaned and food debris removed after meals. [s. 3. (1) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's activity patterns.

Record review of resident #9's plan of care revealed a goal to participate in a program four times a week and this was last updated in January 2015. Record review of resident #9's participation report revealed he/she attends programs on average three times a month from October to December 2014. Interview with the director of programs and services confirmed that resident #9's plan of care was not based on his/her recent activity patterns. [s. 26. (3) 16.]

WN #9: 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 has 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 are documented.

Record review revealed that an RD assessed resident #4 to need a nutritional supplement in 2014. Record review revealed this supplement was discontinued in 2015 without any explanation. Interview with another RD and the FSM revealed they were unaware whether the resident had been receiving the supplement and could not explain why the supplement was discontinued. Interview with the RD confirmed that he/she did not document his/her reassessment or the resident's response to this intervention. [s. 30. (2)]

2. The licensee has 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, are documented.

Record review of resident #9's participation in programs revealed that he/she participates in an average of three programs per month from December 2014 to March 2015. There is no documentation of how many times he/she has been invited to a program and has refused to participate during this time period. Interview with an identified activationist revealed that resident #9's participation may not always be documented because he/she attends the programs with his/her SDM. Interview with the director of programs and services confirmed that resident #9's refusals to attend programs between the time period of December 2014 to March 2015 were not documented. [s. 30. (2)]

WN #10: 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 residents receive an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Record review of resident #11's Resident Assessment Instrument (RAI) Minimum Data Set (MDS) admission assessment revealed that the resident was incontinent of bowel on admission. Record review and interview with an identified registered staff revealed that upon admission all residents who are incontinent are assessed using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. Interview with an identified NM confirmed this assessment must have been missed. [s. 51. (2) (a)]

WN #11: 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 actions are taken when residents have weight change that compromises their health status.

Record review revealed that resident #5 had slow progressive weight loss over a three month period. In a specified month the resident weighed a specified weight and three months later, the resident weighed 2.6 kilograms less. Record review revealed an RD assessed the resident, noted that he/she was now below his/her ideal body weight and provided a goal to improve oral intake and prevent further weight loss without any intervention. Interview with another RD confirmed that no action had been taken to prevent further weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal.

On a specified date, the inspector observed that many residents in the sixth floor dining room were being served only three pieces (or three quarters) of a sandwich at lunch. Record review revealed some of these residents were not on an altered portion diet. Interview with the dietary aide revealed he/she serves three or four pieces of sandwich depending on whether the resident eats a lot or not. Record review revealed that the therapeutic menu indicates the serving size of the sandwich is one whole with two pieces of bread and 60 grams of meat. Interview with the FSM confirmed that all residents should be offered one whole sandwich as planned and the dietary aide should not deviate from the therapeutic menu unless it is on the resident's plan of care. [s. 71. (4)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulation.

On March 2, 2015, the inspector observed that the following inspection reports were not posted:
2013_220111_0012
2013_195166_0018
2013_195166_0023
2013_220111_0025
2013_195166_0028
Interview with the ED confirmed these reports were not posted and proceeded to have these reports posted immediately. [s. 79. (3) (k)]

WN #14: 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,
(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).

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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance service devices and assistive aides.

On specified dates, the inspector observed that resident #4's walker and resident #5's wheelchair were unclean. The home's policy #F-60 titled Equipment Care and Maintenance revised March 5, 2012, states that night PSWs are responsible for the cleaning of wheelchairs and walkers on each unit and are to initial in the assignment book when completed. Record review revealed that according to the cleaning schedule the cleaning of the ambulation devices for resident #4 and #5's takes place every Monday. Interview with an identified registered staff confirmed that these devices did not look clean and probably had not been cleaned as scheduled. [s. 87. (2) (b)]

2. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

On specified dates, the inspector smelled a lingering offensive odour in an identified room. Interview with an identified housekeeper revealed that some rooms, especially those that have residents with catheters, have a strong odour of urine due to spills on the floor and/or safety mats and when a resident is in bed it is difficult to clean properly. Review of the home's policy #11.3 titled Odour Control revealed there are no specific procedures to explain what actions should be taken to identify and address incidents of offensive odours. Interview with the EM confirmed that this policy and procedure needs to be more developed. [s. 87. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to a staff member concerning the operation of the home has been investigated, where possible, and response provided within 10 business days of receipt of the complaint.

Interview with resident #7 indicated that his/her music compact disc went missing and he/she had told a staff member. Interview with an identified PSW confirmed that about three weeks ago, resident #7 told him/her that someone stole a music compact disc that his/her family member made.

Record review of the home's complaints binder and interview with an identified NM indicated that the resident's complaint was not brought forward by the staff member for investigation. [s. 101. (1) 1.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Record review revealed that the Medication Administration General Policy was initiated May 23, 2008, reviewed August 9, 2010 and revised August 8, 2013. Interview with the DOC confirmed that this policy has not recently been updated and that they are revising the policy at the moment. [s. 114. (3) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Record review revealed that a medication had been prescribed for resident #31 as needed. Record review revealed that on seven days during March 2015, the resident had received this medication but there was no documentation of the resident's response to the medication and the effectiveness of the drug. Interview with identified registered staff confirmed that the response and the effect of the medication was not documented.

Interview with the DOC confirmed that all as needed medications must be evaluated and the resident's response and effect of the medication must be documented. [s. 134. (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On March 2, 2015, the inspector observed unlabelled oral care products in two identified shared washrooms. The first shared washroom contained two unlabelled kidney shaped basins, one with an unlabelled toothbrush and the second one with an unlabelled plastic tumbler, a tube of unlabelled toothpaste and one unlabelled toothbrush. The second shared washroom contained an unlabelled urinal on top of the toilet tank, an unlabelled white specimen collection hat resting over the raised toilet seat and an unlabelled toothbrush resting in a glass of water on the bathroom counter.

Interview with two identified PSWs and an identified registered staff revealed and confirmed that these items should be labelled. On March 3, 2015, the inspector observed that the above mentioned unlabelled items had been labelled. [s. 229. (4)]

2. On March 3, 2015, the inspector observed unlabelled towel racks, toothbrushes, cup and soap container in an identified shared washroom. Interview with the registered staff confirmed that these items should be labelled for infection control purposes.

On the same day, the inspector observed an unlabelled towel rack in an identified shared washroom. Interview with a NM confirmed that these towel racks should be labelled and she was in the process of doing so. [s. 229. (4)]

Issued on this 26th day of March, 2015

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

Original report signed by the inspector.