Additional Required Actions:

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

WN #8: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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. Not all residents exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

A) Resident #056 was admitted to the hospital twice. The resident returned to the home from the hospitalizations on specified dates. Staff interviewed confirmed that there was no record of completed skin assessments, by a member of the nursing staff, upon return from the hospitalizations, in the clinical record. On March 22, 2013, it was noted that there was a "Re-Admission Pathway" checklist on the front of the chart. This document indicated that the resident was to have a skin assessment completed, however this was not checked off as being completed. [s. 50. (2) (a)]

2. Not all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #056 was noted to have multiple areas of skin breakdown which were being treated with medical interventions and/or monitored by a specialist. These pressure areas were not consistently assessed weekly, by a member of the registered nursing staff, during the time periods of November 20, 2012, until December 2, 2012, December 15 - 26, 2012, January 8 - 30, 2013, or February 13 - 24, 2013. Interview with the staff confirmed that all skin assessments would be recorded in the progress notes or on the "Wound Care Assessment and Treatment Form".
B) Resident #744 was identified as having a pressure ulcer in 2012. An assessment completed April 21, 2012, indicated the Enterostomal (ET) Nurse would assess the resident the following week however; the home's wound care nurse confirmed there was no assessment completed by the ET nurse and there was no weekly assessment completed by registered staff for the week of April 29, 2012. [s. 50. (2) (b)]

3. Not all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound was assessed by a registered dietitian who is a member of the staff of the home.

Resident #744 had a wound identified in 2012. The referral process to the dietitian for assessments was confirmed by the dietitian however; there was no evidence that a referral was initiated and there was no assessment conducted by the dietitian that included the identification of the wound. [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 receives a skin assessment by a member of the registered nursing staff upon any return from hospital, the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated and that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #9: 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. Not all planned menu items were offered and available at each meal and snack.

A) The therapeutic menu for resident's requiring a specialized therapeutic diet indicated residents requiring the diet were to have roast pork or a cottage cheese fruit plate including watermelon, cantaloupe, grapes and a lemon cranberry muffin however; the resident received a cottage cheese fruit plate including watermelon and apricots and a bran muffin. Staff confirmed there was no roast pork and lemon cranberry muffins available to offer resident #056 during the lunch meal March 19, 2013. The home's therapeutic menu for residents requiring the diet indicated those requiring the specialized diet were to have sliced cucumbers and angel cake offered and available during the lunch meal March 26, 2013, however; staff confirmed sliced cucumbers and angel cake were not available to offer resident #056.
B) It was observed and resident #744 confirmed that dessert was not offered to them during the lunch meal March 19, 2013.
C) The planned lunch menu for March 19, 2013, indicated that residents were to receive puree pineapple however; this was not available for residents requiring puree diets in the 2nd floor dining room. Staff confirmed that puree pineapple was not available and apple sauce was used instead.
D) The planned menu indicated pear slices however; fruit cocktail was served during the lunch meal March 26, 2013, instead. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #10: 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).
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The following requirements were not consistently 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.

Resident #100 was observed on March 21, 2013, at 1001 hours and again on March 27, 2013, at approximately 0940 hours, to be in the wheelchair wearing a side fastening seat belt. The belt, on both occasions, was noted to be loosely secured, around the resident's abdomen, approximately the distance of four fingers width. The belt was tightened by staff during routine repositioning on March 27, 2013, at approximately 0950 hours, without prompting of the Inspector. Interview with staff confirmed that the device in use was a restraint and was not applied according to manufacturer's specifications, which was to be fastened snugly approximately the distance of two fingers width between the belt and the resident's abdomen. [s. 110. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff apply physical devices in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #11: 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. Not all drugs were stored in an area of the medication cart that was secured and locked.

A) On March 26, 2013, on the fourth floor the registered staff member was observed administering medications to residents in the dining room at the breakfast meal. The staff was noted to pour medications and take these medications to the adjacent dining room leaving the medication cart accessible, unlocked and out of their line of vision while administering the medications, at the far end of the dining room.
B) The medication cart located outside the second floor nursing station was left unlocked, unattended and an insulin pen with a cartridge on top of the medication cart March 20, 2013, at 1312. The RPN locked the medication cart when identified by the Inspector. [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 to ensure that all drugs are stored in an area that is secured and locked, to be implemented voluntarily.

WN #12: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Not all drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #050 was to receive insulin at a specified time with a change in dosage until a specific criterion was achieved. According to the March 2013, MAR:
i) On March 5, 2013, the resident received 30 units of insulin less than ordered.
ii) On March 6, 2013, the resident received one unit of insulin less than ordered.
iii) On March 9, 2013, the resident received two units of insulin less than ordered.
iv) On March 13, 2013, the resident received three units of insulin less than ordered.
v) The insulin dosage administered the remainder of the month of March 2013, was three units below the prescribed dosage, if the medication was administered according to the directions. Staff and the DOC confirmed the resident did not receive the correct dosage of insulin on the identified dates. [s. 131. (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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #13: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. Not every medication incident involving a resident was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) According to the physician's order, resident #050 was to receive insulin at a specified time with a change in dosage until a specific criterion was achieved. According to the March 2013, MAR:
i) On March 5, 2013, the resident received 30 units of insulin less than ordered.
ii) On March 6, 2013, the resident received one unit of insulin less than ordered.
iii) On March 9, 2013, the resident received two units of insulin less than ordered.
iv) On March 13, 2013, the resident received three units of insulin less than ordered.
v) The insulin dosage administered the remainder of the month of March 2013, was three units below the prescribed dosage, if the medication was administered according to the directions. Staff and the DOC confirmed the resident did not receive the correct dosage of insulin on the identified dates. The DOC confirmed these medication incidents were not reported by staff and there was no incident report completed related to the errors.
B) Resident #145 was administered a medication over a 10 day period of time, as ordered by the physician. The resident, who was not able to make own care decisions, was administered the medication, in error, without the consent of the Power of Attorney, according to the clinical record. The DOC confirmed this medication was administered in error and that there was no incident report completed related to the incident. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident is (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #14: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Not all staff participated in the implementation of the infection prevention and control program.

A) Interviews conducted with PSW's on all home areas, confirmed that the shower chairs were cleaned using a disinfectant in a spray bottle that was stored in the shower/tub area or in the housekeeping area nearby. None of the staff interviewed, during the morning of April 3, 2013, were able to locate any disinfectant for the shower chairs in the shower/tub or service area on their floors when requested. Staff reported that the disinfectant was filled by the housekeeping staff. The DOC indicated that the night staff on each unit replenish the supply of disinfectant for the shower chairs. The policy related to disinfecting of shower chairs "RC-05-07-24" directed staff to wash the chair with soap and water and then use designated disinfectant after each usage.
B) The home had procedures in place related to the labeling of resident items, number "RC-05-07-02A" and "NA-08-14-04". Procedure "RC-05-07-02A" identified that rooms with more than one resident should have all personal care items in a care basket, labeled and that items were to be used solely for the identified resident and not shared. Procedure "NA-08-14-04" identified that each resident's belongings were to be individually labeled to ensure that staff and residents were aware of who they belonged to.
i) In the spa areas on third and fourth floors, unlabeled combs, brushes, toothbrushes and roll on deodorant was found.
ii) An unlabeled toothbrush, unlabeled towel bar and unlabeled soap were found in shared washroom in room 109.
iii) An unlabeled soap and unlabeled nail clipper were found in the shared washroom in room 120. [s. 229. (4)]

2. Not all residents were offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

During a review of the health files for five recently admitted residents it was noted that these residents were not offered immunization against tetanus and diphtheria when they were admitted to the home. Interviews with the DOC and the Infection Control Lead, identified they were not aware of the need to offer these immunizations. The home's policy related to immunization for residents did not address offering immunization against tetanus and diphtheria. [s. 229. (10) 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 all staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Not all plans of care were based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident, vision.

The MDS assessment and RAI completed for resident #008 on March 12, 2013, indicated that the resident had impaired vision and was able to see large print, but not regular print in newspapers or books. The RAP indicated that this need would be care planned. The resident was noted to have a previous history of cataracts and did not wear glasses. Staff confirmed that the resident did not wear glasses. During a review of the plan it was noted that there was no focus statement related to vision loss, nor interventions in place to address this need. [s. 26. (3) 4.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. Not all residents received individualized personal care, including hygiene care and grooming on a daily basis.

A) Resident #056 was observed on March 20 and 22, 2013, to have facial hair growth on the upper lip. The resident reported a preference to have to area free of unwanted hair. The plan of care identified that staff were to provide constant supervision with physical assist for hygiene and grooming, including shaving, however no frequency was identified. The home's policy "Shaving Resident Client - #RC-05-07-06" stated "each male or female resident client will be shaved or assisted to shave daily unless the resident client's choice is to grow a beard or another routine is established on the Care Plan." The resident was not provided grooming on a daily basis.
B) Resident #554 was observed on March 20 and 26, 2013, to have facial hair growth on the chin. The plan of care indicated that staff were to provide constant supervision with physical assistance for hygiene and grooming, including shaving. Staff confirmed the resident required assistance. The resident was not provided with personalized grooming according to assessed needs.
C) Resident #025 was observed on March 20, 21, 22 and 26, 2013, to have facial hair growth on the chin. The plan of care indicated that staff were to provide constant supervision with physical assistance for hygiene and grooming, including shaving, and staff confirmed the resident required assistance. The resident was not provided with personalized grooming according to assessed needs. [s. 32.]

WN #17: 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:
1. Communication of the seven-day and daily menus to residents. 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:
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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. Not all daily and weekly menus were communicated to residents.

On March 19, 20 and April 5, 2013, in the Jackson Dining Room, the weekly menu was not posted nor communicated to residents. The board labeled for this purpose was blank with no information posted. Staff confirmed that the menu was not posted on April 5, 2013. [s. 73. (1) 1.]

2. The dining and snack service did not included a review of the meal and snack times by the Residents' Council.

Interview conducted with the President of Residents' Council and a review of the "Resident Client Council Minutes" for 2012 and 2013, and available minutes for the "Food Committee" for November 2012 and 2013, identified that the Council was not included in a review of the meal and snack times. [s. 73. (1) 2.]

3. The dining and snack service did not consistently included at a minimum, food and fluids being served at a temperature that was both safe and palatable to the residents.

Some residents interviewed indicated that hot foods were served cold. Resident food committee minutes for November 28, 2012 and January 30, 2013, indicated that residents raised concerns regarding hot food being served cold. Temperatures during the lunch meal service April 2, 2013, at 1230 hours, indicated the vegetables were 53 degrees Celsius. Staff confirmed that the "Servery Temperature Audit" sheet for April 2, 2013, did not include a temperature for the vegetables prior to service. A review of the "Production Temperature Sheets" and the "Servery Temperature Sheets" revealed that temperatures were not consistently taken and recorded for menu items. [s. 73. (1) 6.]

4. Not all residents who required assistance with eating or drinking were served a meal when someone was available to provide the assistance.

During the lunch meal service on March 19, 2013, in the Jackson Dining Room, a PSW was observed to leave residents #070 and #145, who required total assistance with eating at 1242 hours, cleared dishes and served desserts, before returning to feed the residents at 1247 hours. [s. 73. (2) (b)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The advice of the Residents' or Family Council was not sought in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the President of Residents' Council, Chair of Family Council and the Director of Recreation and Leisure confirmed that the licensee did not previously seek the advise of councils in developing and carrying out the satisfaction survey and in acting on the results. This requirement was identified by the home at the end of 2012, and a new policy was developed, to be implemented to meet this identified need. [s. 85. (3)]

2. The licensee did not make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Interview with the President of Residents' Council and the Director of Recreation and Leisure confirmed that the licensee did not previously make available to the Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. This requirement was identified by the home at the end of 2012, and a new policy was developed, to be implemented to meet this identified need. [s. 85. (4) (a)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2012_205129_0005	168
O.Reg 79/10 s. 8. (1)	CO #002	2012_205129_0005	168

Issued on this 30th day of May, 2013

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