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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2014	2014_278539_0016	H-000790-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

MALTON VILLAGE LONG TERM CARE CENTRE
7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1

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

VALERIE GOLDRUP (539), DARIA TRZOS (561), DIANNE BARSEVICH (581), LALEH NEWELL (147), LEAH CURLE (585), VIKTORIA SHIHAB (584)

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 2, 3, 4, 8, 9, 10, 11, 2014

The following complaints were reviewed during this inspection: H-000525-13, H-000700-13, H-000850-13, H-000247-14, H-000083-14, H-000701-14. The following complaint H-0000022-14 was reviewed during this inspection. It was addressed under a separate inspection report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Supervisors of Care(SOC), the Resident Assessment Instrument (RAI) Coordinator, Documentation Support Coordinator, registered staff including Registered Nurses(RN)and Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Worker, Physiotherapist, Registered Dietitian, Dietary Services Supervisor, Dietary Team Lead, Cook, dietary aides, Activation Supervisor, Family Council Assistant, Family Council President, residents and family members of residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed health care records, investigation reports, files, relevant policies, procedures and practices and interviewed staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home did not ensure that the following rights of residents were fully respected and promoted: 2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

In December, 2013, resident #602 entered resident #601's room. Resident #601 became angry that resident #602 had entered their room and began to yell at the resident to leave. Resident #602 did not leave. Resident #601 then pushed resident #602 to the ground and began engage in a physical altercation with the resident. The residents were separated by staff. Resident #602 was assessed and transferred to hospital. The resident had sustained severe bruising and required hospital admission and surgery for a fractured. The Supervisor of Care confirmed the following events had occurred on the Dementia unit.

The home contacted the physician, police, next-of-kin and submitted a Critical Incident report to the Ministry of Health and Long Term Care. Upon the #602's resident's return from hospital the home continued to follow the steps outlined in the home's Prevention and Management of Responsive Behaviour Program. Resident #601 was referred to the Behavioural Support team and was moved to a unit where residents would not wander in to their room.

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 be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 did not ensure there was a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident in relation to the following;

On July 4, 2014, resident #108's room was observed to have a crash mat up against the wall. The written plan of care did not indicate a crash mat was being used as an intervention for falls prevention. The Personal Support Worker (PSW) stated that the resident did have a crash mat in their room and it was placed on the floor beside the bed when the resident was in bed. The PSW confirmed that there were no clear

directions on the plan of care or kardex to put the crash mat on the floor when the resident was in bed. The Resident Instrument Assessment Coordinator confirmed that the plan of care and kardex related to resident #108 use of a crash mat did not provide clear directions to the Personal Support Workers. [s. 6. (1) (c)]

2. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other. 2007, c. 8, s. 6 (4) (b).

A)On July 2, 2014 resident #136 was seen by a Registered Nurse for a pain assessment. The information was located in the paper chart as a consultation note. The physician and Substitute Decision Maker agreed with the recommendations. The plan of care that directed the staff was not updated to state the following "Do not use right shoulder / arm for transferring or lifting the resident".

A registered staff and the Supervisor of Care both confirmed that the information should have been updated in the electronic plan of care by the registered staff to direct staff who would transfer the resident. The information was added to the plan of care on July 10, 2014 after it was brought to the registered staff's attention.

B)On March 15, 2014 resident #136 was seen by a Psychiatrist for a consultation. The information was located in the paper chart under multidisciplinary progress notes. The physician and Substitute Decision Maker agreed with recommendations made. The Medication Administration Record was updated to state the following Quetiapine 25 mg; Give 1 tablet by mouth daily at 1900 hours. If resident does not settle within 2 weeks increase to 50mg at 1900.

The resident had continued to be resistant with care and had been followed by the Behavioural Support Officer. A registered nurse and the Supervisor of Care both confirmed that the resident should have been monitored for the two weeks and the referral made to the physician to reassess the medication. This was not completed and the resident remained on the same dose.

C)On January 8, 2014 resident #601 was seen by a Psychiatrist for a consultation. The information was located in the paper chart under multidisciplinary progress notes. The Psychiatrist recommended that the resident be referred to the psychogeriatric resource consultant.

The resident had continued to be resistant and refusing of care and had been followed by the Behavioural Support Officer. Documentation could not be located to validate that the referral or follow-up had been completed. The Supervisor of Care confirmed that there was no referral and no further follow-up completed by the psychogeriatric resource consultant. [s. 6. (4) (b)]

3. The licensee failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Resident #500 had a plan of care specific to positioning at mealtime. On July 9, 2014, during lunch meal service, the resident was observed receiving full assistance with their meal by a PSW. The resident was in a wheel chair, positioned at 90 degrees, with their neck in a forward flex position, and head tilted to the left. The PSW stated they were not sure what the resident's care needs for positioning at mealtime were. Registered staff stated the resident was to be fed positioned in a slight recline position to assist with raising their head. Review of kardex accessible to PSW's did not state how to position the resident at meals. The resident's care plan accessible to registered staff stated to "position the resident at mealtime in tilt wheelchair only to the degree that maintains a midline position for head and neck.". Staff providing direct care did not have access to the resident's plan of care. [s. 6. (8)]

4. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary, in relation to the following;

Review of the home's policy and procedure titled, Continence Care and Bowel Management Program, revised May 5, 2014 stated that a comprehensive best practice continence assessment would be completed within seven days of admission and quarterly the MDS assessment should be completed including a bowel and bladder assessment (according to the RAI-MDS schedule), and after any change in health status that may affect bladder or bowel.

A. Resident #141 was admitted on March 28, 2013. Review of MDS assessment on admission dated March 28, 2013, noted that resident was coded to be continent of bowels and usually continent of bladder. Review of MDS quarterly assessment for July

5, 2013 confirmed that resident was coded to be incontinent of bowels and frequently incontinent of bladder. Furthermore, the March 26, 2014 MDS annual assessment indicated that resident was frequently incontinent of both bladder and bowel and incontinent of both bladder and bowel on the June 24, 2014 MDS quarterly assessment. Review of resident's health records and registered staff interview confirmed that the bowel and bladder assessment was not completed when there was a change in resident's continence status. Registered staff reported that there was an expectation to perform the assessment only within seven days of admission and when there was a significant change in status such as change from being continent to becoming incontinent. Director of Care (DOC) confirmed that according to the home's policy, staff were expected to complete a bowl and bladder assessment when there was any change in resident's continence. The licensee did not ensure that the resident was reassessed when there was a change in health status.

B. Resident #142 was admitted on June 14, 2013. On review of MDS assessment on admission dated June 14, 2013, it was noted that resident was coded as being occasionally incontinent of both bladder and bowel. On the September 19, 2013 quarterly MDS assessment staff had coded resident to be frequently incontinent of both bowel and bladder. There was a change in continence according to the MDS quarterly assessment in May 14, 2014 where resident was coded as incontinent of bowel and frequently incontinent of bladder. Review of resident's health records and registered staff interview confirmed that the bowel and bladder assessment was not done when there was a change in resident's continence status. DOC confirmed that the home's expectation is to perform an assessment when there is any change in resident's continence. The licensee did not ensure that the resident was reassessed when there was a change in health status. [s. 6. (10) (b)]

5. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary, in relation to the following;

Resident #108 was observed on July 4 and 9, 2014 sitting in a tilt wheelchair with no lap belt fastened. The plan of care for resident #108 identified that the lap belt was in place for safety and the resident could undo the belt on command. The Personal Support Worker stated that the resident has not had a lap belt fastened since November, 2013. The Resident Assessment Instrument (RAI) Coordinator confirmed that the resident no longer used a lap belt and that the plan of care for application of a

lap belt was not updated to reflect this change. Resident #108's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed. [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 be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Review of the home's Skin and Wound Care Program related to the skin tears currently in use was not in compliance with and was not implemented in accordance with applicable requirement under the Act.

Skin and Wound Care Program, revised August, 2013, did not direct registered staff to make a referral to a Registered Dietitian when a resident had a skin tear. The policy stated that a referral to a Registered Dietitian was to be made for stage 2-4 and unstageable ulcers only and stage 1 if there was no improvement in 6 days. Director of Care and registered staff confirmed the same. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee did not ensure that the Hypoglycemia Protocol, included in the Medical Directive, NF-023, was complied with. A complaint was received alleging that the facility did not have appropriate practices in relation to management of Diabetes Mellitus, specifically in the areas of hypoglycemia, with low blood glucose not treated effectively.

The hypoglycemia protocol, under section 12 of the Medical Directive, stated that episodes of hypoglycemia were to be treated with three to four dextrose tablets or teaspoons of sugar dissolved in water if the resident was conscious. If the resident was unconscious the specified treatment was one milligram of Glucagon.

Two registered staff members on the third floor were asked to describe the contents of the hypoglycemia protocol and to locate a copy of the protocol on July 3, 2014. Registered staff could not locate a copy of the hypoglycemia protocol. In an interview, a registered staff member stated that they use the following hypoglycemia treatments: a glass of milk with four teaspoons of sugar, a glass of orange juice with three to four teaspoons of sugar or one to two individual packs of jam. The hypoglycemia treatments reportedly utilized by the staff member did not match the treatment set out in the protocol.

3. A.On June 28, 2014 resident #136 sustained an unwitnessed fall and the clinical record revealed that a Physiotherapist post falls assessment was not completed. The home's Falls Management Program, revised April, 2013, indicated that the Physiotherapist was to assess all residents post fall and implement additional interventions to prevent further falls. The Physiotherapist confirmed that a post falls assessment was not completed after resident #136 fell. The registered staff confirmed that the Physiotherapist did not complete a post falls assessment as was required by the home's policy.

The clinical record for resident # 136 indicated that the resident sustained an unwitnessed fall in their room on June 28, 2014. The home's Fall Management Program indicated when a resident had fallen that registered nursing staff were to monitor the resident seventy-two hours post fall, including assessment of vital signs or injury and to record assessment in progress notes. As well, they were to notify the Physician, initiate Head Injury Routine for all unwitnessed falls and update the resident's care plan to reflect the date and time of the fall. The plan of care indicated their last fall was April 2, 2014. The review of the clinical record, registered staff and Supervisor of Care interview confirmed there was no documentation for seventy-two

hours post fall, no head injury routine completed post fall, the physician was not notified, and the resident's care plan was not updated to reflect the date and time of the fall.

B.The clinical record for resident # 108 indicated that the resident sustained an unwitnessed fall in their room on June 19, 2014. The home's Fall Management Program indicated when a resident had fallen the registered nursing staff are to complete a Morse Falls Risk Assessment and notify the physician. Review of the clinical record revealed that a Morse Falls Risk Assessment was not completed post fall and the fall was not recorded in the doctor's book. Supervisor of Care and the registered staff confirmed that the assessment was not completed and the physician was not notified as was required by the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: 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 did not ensure the use of a Personal Assistance Services Device (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 had 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.
3.The use of the PASD had been approved by, i. a physician, ii. A registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapist of Ontario, v. a member of the college of Physiotherapist of Ontario, or vi. Any other person provided for in the regulations.
4.The use of the PASD had 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.

(A)The licensee did not ensure alternatives to the use of a PASD had 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.

Resident #111 was observed sitting in a tilt wheelchair on July 2 and 8, 2014. Review of the clinical record indicated that the resident was assessed for a tilt wheelchair on approximately June 12, 2012. When the resident received the tilt wheelchair, the resident was not assessed if the tilt wheelchair was being used as a Personal Assistance Services Device (PASD). A PASD assessment was not completed until July 2, 2014 after the RQI was initiated.

Resident #116 was observed sitting in a tilt wheelchair on July 3 and July 8, 2014. Review of the clinical record indicated that the resident was assessed for a tilt wheelchair on approximately November 19, 2012. When the resident received the tilt wheelchair, the resident was not assessed if the tilt wheelchair was being used as a PASD. A PASD assessment was not completed until July 2, 2014 after the RQI was initiated.

Resident #136 was observed sitting in tilt wheelchair on July 3,8 and 9, 2014. Review of the clinical record indicated that the resident was assessed for a tilt wheelchair on approximately May 28, 2012. When the resident was positioned in a tilt wheelchair, the resident was not assessed if the tilt wheelchair was being used as a PASD. A PASD assessment was not completed until July 3, 2014 after the RQI was initiated.

The Supervisor of Care and the registered staff confirmed that resident # 111, #116 and # 136 assessments were not completed at the time they received a tilt wheelchair to determine if the tilt wheelchair was being used as a PASD or a restraint. They stated the home has just started to assess all of their tilt wheelchairs as PASD's or restraints.

(B)The licensee did not ensure that the use of the Personal Assistance Services Device (PASD) was approved by any person provided for in the regulations.

Review of the clinical records for resident #111, #116 and #136 indicated there were no documented approvals for the use of the tilt wheelchair as a PASD until July 2 and 3, 2014. The registered nursing staff and the Supervisor of Care confirmed there were no approvals for the use of PASD until July 2, 2014.

(C)The licensee did not ensure that the use of the PASD was consented to by the resident or, if the resident is incapable, a substitute decision maker of the resident with authority to give consent.

Review of the clinical record indicated resident #111, #116, #136 or their substitute decision maker (SDM) did not provide consent for the use of their tilt wheelchair as a PASD. The Supervisor of Care and the registered staff confirmed there was no consent from the residents or their SDM for use of the PASD. [s. 33. (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 be implemented voluntarily.

WN #5: 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 did not ensure that a resident exhibiting altered skin integrity, including skin tears had been assessed by a Registered Dietitian.

Resident #126 sustained a large skin tear on their left knee as a result of a fall on June 7, 2014. Resident had a diagnosis of Type 1 diabetes. Upon review of resident's health records it was noted that there was no referral made to a Registered Dietitian and registered staff confirmed the same. Director of Care confirmed that only skin tears that were not healing or get worse were being referred to the Registered Dietitian. [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 be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure all menu items were prepared according to the planned menu.

A) Pureed peas and carrots were on the supper menu on July 9, 2014. During meal service, in the second floor servery for Avro and Victory dining areas, pureed peas and carrots were observed in the steam table and had a thick liquid consistency, and poured out of the scoop. The Cook was present in the servery during meal service and confirmed that the vegetable texture was too thin. The recipe instructed the vegetables to be blend until smooth, until a pudding-like consistency was reached. The Dietary Services Supervisor confirmed that all menu items should be prepared as per the recipe.

B) Pork roast was on the supper menu on July 9, 2014. The recipe called for unsweetened applesauce to add as a garnish to the pork. During meal preparation, the Cook reviewed the items used to prepare the roast pork and stated that sweetened applesauce was prepared, and identified the product to the inspector in the dry storage. The empty can of sweetened applesauce can was observed in the garbage can. The applesauce was observed being served with the pork to residents in the second floor dining rooms. The Dietary Services Supervisor confirmed that all menu items should be prepared as per the recipe.

C) Buttered corn was on the supper menu on July 9, 2014. The recipe called for 4 mL of black ground pepper, and to mix well. During meal production, the Cook was observed sprinkling pepper on the corn, and did not measure the pepper and did not mix the pepper into the corn. The Dietary Services Supervisor stated all recipes were to be prepared as per their instructions.

D) Fluffy rice was on the supper menu on July 9, 2014. The therapeutic menu called for a #10 scoop for regular texture. During supper meal service, in the second floor servery for Avro and Victory dining areas, a #6 scoop observed to portion the rice. A dietary aide confirmed they used the #6 scoop for the meal service. [s. 72. (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 , to be implemented voluntarily.

WN #7: 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. (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. The licensee failed to ensure that a resident who required assistance with eating or drinking was served a meal when someone was available to provide the assistance.

During meal service on July 8, 2014, in the Morning Star dining room, resident #500 was observed at their table at 1230 hours, with two cups of untouched thickened fluids at their place setting. No staff were present to assist the resident until 1245 hours. The PSW who assisted the resident confirmed they were unable to assist until that time as they needed to complete assisting other residents with their meals before moving on to resident #500. Registered staff confirmed the home's expectation was that residents were not to be served their meal, including drinks until staff were able to assist with feeding.
The home's policy, Meal Service - Dining Room Responsibilities - Personal Support Worker (PSW), LTC 09-05.06.03, effective April 30, 2014, stated "meals or drinks shall not be served to any residents who require assistance with eating or drinking until a staff is available to provide assistance." [s. 73. (2) (b)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee did not ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under O. Reg. 79/10, s. 75 (4), without including any hours spent fulfilling other responsibilities.

The minimum nutrition manager hours were calculated under O. Reg. 79/10, s. 75 (4) to be 51.84 hours weekly. The Dietary Services Supervisor confirmed that the home has 162 residents and verified the calculation of minimum hours.

During an interview on July 4, 2014 the Dietary Services Supervisor confirmed that weekly scheduled hours were 40.0 for the Dietary Services Supervisor and 12 for the Dietary Team Lead. The Dietary Services Supervisor indicated that the Team Lead did not work at the facility from April 1, 2014 onward and the facility's Registered Dietitian (RD) and the Dietary Services Supervisor were each planned to work an additional six weekly hours to compensate for the hourly shortage. A review of Registered Dietitian invoices and the Dietary Services Supervisor overtime logs confirmed that during the 13 weeks since April 1, 2014, the Registered Dietitian and the Dietary Services Supervisor were not consistently accumulating an additional six weekly hours each to fulfill the minimum weekly requirements. The Registered Dietitian invoices for the time period showed a single entry of six hours worked during the week of April 28, 2014, to cover the absence of the Team Lead. On July 9, 2014 the Dietary Services Supervisor confirmed that the minimum requirements for nutrition manager hours were not consistently met each week since April 1, 2014. [s. 75. (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 be implemented voluntarily.

WN #9: 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:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the infection prevention and control program.

On July 9, 2014 after review of resident #126's records it was noted that resident was placed on isolation precautions. On the same day, it was observed that Personal Protective Equipment (PPE) was not available and the precautionary signage was not posted at resident's door. Registered staff confirmed that it was an expectation to post signage at the door and have PPE available for staff when a resident was placed on precautions. Registered staff confirmed that they had forgotten to do so. The staff did not participate in implementation of infection prevention and control program. [s. 229. (4)]

2. On Wednesday, July 9, 2014 at 1300 hours, a shower room on Morning Star was observed. There were unlabeled nail clippers and a used razor in the sink. The Personal Support Worker who completed the last resident shower confirmed that she had used the items on resident #111. The Personal Support Worker also confirmed that she should have disposed of the razor after use. Infection Prevention and Control Policy; Section: Cleaning and Disinfecting of Equipment, Subject: Disposable and Single Use Products LTC8-04.01 dated June 9, 2011 stated that "products that are manufactured and sold as single use products should not be reprocessed or reused and should be discarded after single use".

The PSW confirmed as well, that the nail clippers were obtained for a resident because their present pair were dull and should have been labeled. The Nursing Policy; Section: Residents' Care and Services, Subject: Personal Hygiene and Grooming- Care of the Nails LTC9-05.03.03 dated April 5, 2011 stated that staff were

to "use resident's nail clippers, labeled with the resident's name to trim nails".

On Wednesday, July 9, 2014 at 1400 hours, in McKechnie House, a Personal Support Worker was approached by the inspector and asked to direct the inspector to a resident's room after completing their work. The Personal Support Worker had come out of a room and had proceeded to place dirty items in a hamper. They then removed the gloves and placed them in the hamper and wheeled the hamper to the side. The Personal Support Worker walked with the inspector to the resident's room, opened the door, approached the resident and touched the resident after speaking to them. The staff member was not observed to have used hand soup or hand disinfectant during this time. Infection Prevention and Control Policy; Section: Routine Practices and Additional Precautions, Subject:Routine Practices- Gloves LTC8-03.02 dated April 5, 2011 stated that "hands must be washed as soon as the gloves are removed as they may become contaminated through glove removal or through glove defects. Failure to wash hands when gloves are removed will negate the benefit of wearing gloves". [s. 229. (4)]

3. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

Resident #200 was admitted to the home on August 8, 2013. There was no documentation found in the resident's records indicating that resident was screened for tuberculosis. Review of resident's clinical health records and interview with registered staff and Supervisor of Care confirmed that resident was not screened for tuberculosis within 14 days of admission or 90 days prior to admission.

Resident #201 was admitted to the home on June 13, 2013. There was no documentation found in resident's records indicating that resident was screened for tuberculosis. Review of resident's clinical health records and interview with registered staff and Supervisor of Care confirmed that resident was not screened for tuberculosis within 14 days of admission or 90 days prior to admission. [s. 229. (10) 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 be implemented voluntarily.

WN #10: 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).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident vision.

Review of the resident #105's Minimum Data Set (MDS) coding and Resident Assessment Protocol (RAP) summary for the past three quarters (November 12, 2013, February 11 and May 14, 2014) indicated that the resident has impaired vision and sees large print, but not regular print, however review of the the plan of care last updated on June 6 , 2014 did not include any strategies and interventions with respect to the resident's vision needs. [s. 26. (3) 4.]

2. The licensee did not ensure that resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

Resident #141 was incontinent of bladder and bowel according to the June 24, 2014 MDS quarterly assessment. Resident's care plan was reviewed on July 8, 2014 and indicated that the continence care and any interventions related to continence care were not addressed in resident's care plan. Registered staff reviewed the care plan and confirmed that it did not address continence care for this resident. [s. 26. (3) 8.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee did not respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations in relation to the following;

A review of the Residents' Council Meeting Minutes from February 24, 2014 until June 30, 2014 identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes for May 26, 2014 included an update on whether or not stoves would be put in the activity rooms and if the exercise program could be moved back to the dining room instead of the television lounge area. The Activation Services Supervisor responded in writing to the Residents' Council fourteen days later on June 9, 2014.

Meeting minutes for May 26, 204 included a concern related to table cloths specifically the blue squares were looking worn and may need to be replaced. This concern was not responded to by the licensee.

The Social Worker confirmed that the appropriate department heads did not respond to the Residents' Council in writing within ten days. [s. 57 (2)] [s. 57. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not ensure that concerns or recommendations received by Family Council were responded to in writing within ten days.

A review of the Family Council Meeting Minutes from January 14, 2014 to June 24, 2014 identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes from February 25, 2014 included a concern that top sheets were missing on the first floor resident's beds and resident's personal toiletries were missing and/or were used up too quickly as they may be left in the spa room and were used by other residents. These concerns were not responded to by the licensee.

Meeting minutes from May 13, 2014 included a suggestion that a board be put up in the home areas to identify registered staff and person support workers on duty that shift. This suggestion was not responded to by the licensee.

Meeting minutes from June 24, 2014 included a question to determine if family members could purchase alcohol at the residents' Pub Social. The Acting Activation Services Supervisor did not respond in writing until July 8, 2014.

Interview with the Family Council Assistant and the Family Council President confirmed that written responses to concerns and recommendations were not always completed and/or not completed within ten days. [s. 60. (2)]

Issued on this 2nd day of September, 2014

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