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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
Sep 12, 2014	2014_214146_0016	H-001100-14	Resident Quality Inspection

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

MILLENNIUM TRAIL MANOR
6861 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

BARBARA NAYKALYK-HUNT (146), MICHELLE WARRENER (107), ROBIN MACKIE (511), YVONNE WALTON (169)

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): August 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, 2014

Follow-up inspection H-000552-13, Complaint inspections H-000825-14, H-000873-14, H-001029-14 and Critical Incident inspection H-000785-14 were also inspected with this RQI. Findings from these inspections are included in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Food Services Manager (FSM), Environmental Manager (ESM), Housekeeping Manager, registered staff, housekeeping staff, dietary staff, Personal Support Workers (PSW's), maintenance staff, recreation staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home; observed residents in care areas; dining and medication administration; and reviewed policies and procedures, health records and meeting minutes.

The following Inspection Protocols were used during this inspection:

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

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

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 failed to ensure that the following rights of residents were fully respected and promoted: 1. Every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident’s individuality and respected the resident’s dignity.

A resident was involved in an incident that occurred in August 2014 when a staff person inadvertently caused the resident to have pain. A witness to the incident stated that the resident's dignity was not respected. Interview with the RPN confirmed that the resident was not treated with courtesy and respect in a way that fully recognized and respected the resident’s dignity.

2. The licensee has failed to ensure that resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was respected and promoted.

A) A resident, who was dependent on staff for personal hygiene, was observed in attendance at a social activity in the resident lounge with a soiled face. (146)
B) A resident was observed in the lounge late in the morning with a dried food around the mouth. The resident required total assistance with grooming. Staff confirmed the material on the resident's mouth was likely from the morning snack or the breakfast meal. (107)
C) A resident was observed with dried food around the mouth in the morning. The resident sat with food on their mouth until the lunch meal. 107 [s. 3. (1) 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 following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity; and 4. Every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is respected and promoted, 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. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that there was a written plan of care for each resident that set out c) clear directions to staff and others who provided direct care to the resident.

A) A resident's health record indicated that the resident had a specific identified problem. The electronic plan of care did not address this problem. The resident was observed to have an intervention in place in August. The kardex care plan did not address the problem or give direction to the staff to address the problem. (511)
B) A resident demonstrated specific behaviours. The kardex care plan used by the PSW's did not identify any behaviours, nor did it provide any directions to staff about how to manage the behaviours. (169) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) A resident's Minimum Data Set (MDS) Quarterly assessment - section H indicated that the resident was coded as a 3 (frequently incontinent of bowel i.e 2-3 times per week) during the observation period 14 days prior to the completion date. The PSW flow sheets, for the 14 days prior to the same date, did not indicate that the resident was incontinent of bowel 2-3 times per week. Another assessment at the same time stated the resident was usually continent of bowel. Interview with the RAI Coordinator confirmed that the assessments of the resident were not integrated, consistent with or complementary of each other. (511)

B) The current written care plan for a resident indicated under the focus statement for physio that the resident is at high risk of falls. The same care plan indicated in another focus statement completed by nursing that the resident is at moderate risk for falls. This information was confirmed by nursing staff and the DOC. (146) [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other in relation to a resident nutritional strategy.

The resident had a physician order in place for a certain supplement to be given at certain times. The plan of care indicated a different supplement and time. The nutritional supplements were not being recorded as offered or consumed on the food and fluid intake records for a three month period. The resident had significant weight loss noted over three months. [s. 6. (4) (b)]

4. The licensee did not ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care in relation to medication changes.
During interview, registered staff confirmed that the resident's SDM was not consulted when the resident's medications were changed. [s. 6. (5)]

5. The licensee has failed to ensure that the staff and others who provided 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.

In August 2014, according to a resident's clinical record, the resident had been identified as demonstrating behaviours. The electronic plan of care identified interventions to assist with these behaviours. The Kardex, that provided care direction and was available to the direct care staff, did not identify these behaviours nor interventions. Interview with the PSW confirmed they only had access to the Kardex and were not kept aware of the contents of the resident's plan of care and did not have convenient and immediate access to it. [s. 6. (8)]

6. The licensee has failed to ensure that the plan of care for a resident was revised when the plan was ineffective and when there was a change to the resident's hydration status.

The resident's plan of care identified the resident required a minimum of 1800 millilitres (mL) of fluids per day. The resident was consistently not consuming 1800 mL per day and the plan of care related to hydration was not revised. [s. 6. (10) (c)]

7. The licensee did not ensure that a resident was reassessed and the plan of care reviewed and revised when the plan was not effective in relation to hydration.

A resident had a plan of care that required a minimum of 1500 mls fluids per day. The resident had a reduction in their fluid intake below 1000 mL per day on several dates. The resident's plan of care related to hydration was not revised in relation to the poor hydration. Staff confirmed during interview that a referral to the RD was not completed for the poor hydration. The nutrition review identified the resident was meeting 60-75% of their fluid requirements, however, the plan of care was not revised in relation to the poor hydration. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 1. there is a written plan of care for each resident that sets out c) clear directions to staff and others who provide direct care to the resident; and 10. the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when (c) care set out in the plan has not been effective, 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 has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A) The home's fall prevention and management program policy states that staff are to complete fall risk assessments for each resident, at a minimum on admission, quarterly and with any significant change and;
that resident care plans will include interventions to reduce falls risk factors and hazards.
(i) A resident had no admission falls assessment competed as per policy. The electronic care plan identified a focus of moderate to high risk of falls but did not include interventions to reduce the falls risk as per the policy.
(ii) A resident had no falls risk assessment done with a quarterly assessment as per policy even though the resident had experienced two falls with injury in the previous eight weeks.
(iii) When interviewed, staff stated that a resident was frequently attempting to crawl out of bed and the chair and had a fall in August 2014. No fall risk assessments were completed for the resident as per policy.
This information was confirmed by the RAI coordinator, registered staff and the health records. (146)

B) The licensee has failed to ensure that the home's "Hydration Management" policy CD-05-12-2 was followed.
The policy required staff to refer residents to the RD when their fluid intake was less than 1000 mL per day over five consecutive days.
(i)Two residents' health records indicated that their fluid intake had fell below the identified criteria but no referral was made to the RD.

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, where there was a written policy to promote zero tolerance of abuse and neglect of residents, that the policy was complied with.

In August 2014, a resident reported an allegation of abuse to two staff persons. The home's "Abuse-Prevention, Reporting and Elimination of Abuse and Neglect" policy #CA-05-37-1, stated that every alleged, suspected or witnessed incident of abuse and or neglect would be treated as a serious matter and any person who received a complaint of abuse should report the matter immediately to the Administrator (or designate).
When interviewed, two PSW's confirmed that they had not reported the abuse allegation to the Administrator.

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, without in any way restricting the generality of the duty provided for in section 19, where there is a written policy to promote zero tolerance of abuse and neglect of residents, that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

In August 2014 a staff to resident abuse allegation was reported to the Administrator. The home did not immediately report the suspicion and the information upon which it was based to the Director until six days after the allegation was received. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may have occurred, immediately reports the suspicion and the information upon which it was based to the Director 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

A) A resident was involved in an incident that occurred in August 2014. A review of the clinical records did not reveal any documentation of the incident, assessment or interventions. Interview with the RPN confirmed that the nurse reported the incident to the RN on duty who assessed the resident. The RPN confirmed there was no documentation of the assessment, reassessment, interventions nor the resident’s responses to interventions. (511)

B) The home has a monthly flow sheet which registered staff are expected to sign each eight hour shift to indicate that they have reassessed the resident's specific intervention.
(i) Of four months of forms reviewed for one identified resident, the following was revealed:
April 2014 - there were 20 shifts where the nurse failed to document;
May 2014 - there were14 shifts where the nurse failed to document;
June 2014 - there were 26 shifts where the nurse failed to document;
July 2014 - there were 17 shifts where the nurse failed to document.

(ii) Of four months of forms reviewed for another identified resident, the following was revealed:
April 2014 - there were 21 shifts where the nurse failed to document;
May 2014 - there were 15 shifts where the nurse failed to document;
June 2013 - there were 29 shifts where the nurse failed to document;
July 2014 - there were 17 shifts where the nurse failed to document.
This information was confirmed by the registered staff. (146)

C) Monthly flow sheets for the two residents were not dated with the month and year as indicated on the form. (146)

D) Documentation on a resident's food and fluid intake records was incomplete. There were 18/31 missing entries for food intake at the afternoon snack pass and 24/31 missing entries for food at the evening snack pass. It was unclear if the resident was offered a snack and refused or if a snack was not offered to the resident. Significant missing entries at the afternoon and evening snack pass were noted.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 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 the resident had fallen, the resident was assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A resident fell with no injury in August 2014. No post fall assessment was competed. This information was confirmed by the health record, registered staff and the RAI coordinator. [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 the resident has fallen, the resident is assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) drugs were stored in an area or a medication cart, (ii) that was secure and locked.

A) In August 2014 the medication cart was observed to be left unlocked and unattended in the hallway. The medication nurse was not within view. The DOC confirmed that the cart was unlocked and unattended. (146)
B) The medication cart was noted to be unlocked in the hallway outside the dining room, and the staff member was in the dining room at the far side administering a medication with back to the cart. The nurse was noted to lock the cart on one occasion in between medication administration but did not lock the cart on two other occasions. Interview with the registered staff member confirmed the medication cart should be locked when the nurse is away from the cart and/or has their back to the medication cart. (511) [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, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home and furnishings were kept clean.

A) In August 2014 during the initial tour of the home and again when reviewed a week later, it was observed that the fabric dining room chairs in the dining rooms on Montrose, Stamford and Chippawa were soiled/stained.

B) On two Mondays of this inspection, it was observed that:
(i) the carpet in the lounge area of Montrose was littered with paper, straw coverings, napkins and other debris
(ii) the carpet in the small lounge area of Elgin was extremely soiled and littered with paper.
(iii) the hallway floors of Montrose had noticeable debris on the floors.
These observations were reviewed and confirmed with the housekeeping manager. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home and furnishings were maintained in a good state of repair.
A) A resident was observed to be sitting in a Broda chair which was torn and damaged on the back and arms. [s. 15. (2) (c)]

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).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A)The MDS assessment in Jan 2014 for a resident indicated the resident was frequently incontinent of bladder but had some control present. The MDS assessment a few months later indicated the resident's continence condition deteriorated and now had multiple daily episodes of bladder incontinence. A review of the resident's health record did not indicate that an assessment including identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions was completed. Interview with the RAI Coordinator confirmed that the condition or circumstances of the resident required an assessment and one was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

B) A review of the clinical records for a resident identified that the resident had a significant increase in level of incontinence from a date in 2013, from a state of usually continent of bowel and bladder to being totally incontinent of bowel and bladder in July 2014. There was no evidence, during this time period, that the resident received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific intervention using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. Interview with the MDS-RAI Coordinator confirmed that an assessment for incontinence was not completed when there was a change in the resident's condition. [s. 51. (2) (a)]

2. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

The MDS Assessment for a resident indicated the resident was incontinent of bowel all (or almost all) of the time.
A review of the resident plan of care, including nurses notes, RAPs, written care plan and PSW Kardex, did not include measures to promote and manage bowel

continence. Interview with the RAI Coordinator confirmed that the resident did not have an individualized plan, as part of the plan of care, to promote and manage bowel incontinence. [s. 51. (2) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident had a plan of care that included strategies to be implemented to respond to the resident's responsive behaviours, where possible. The plan of care identified the only strategy for the resident was to encourage verbalization and monitor mood patterns including documenting signs and symptoms of depression, anxiety and sad mood.
There are no strategies developed or implemented to respond to this resident. This was confirmed by the Assistant Director of Care and lead Personal Support Worker for responsive behaviours in the home. [s. 53. (4) (b)]

WN #12: 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 significant weight changes were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated for a resident who had significant weight change.
The resident's plan of care was not revised in relation to a significant weight change and action was not taken to address the weight change. Interview with the RD confirmed the plan of care was not revised in relation to the significant weight change. [s. 69. 1.]

WN #13: 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 all planned menu items were offered at a lunch meal in August 2014.
A) The planned menu required bread to be offered with the chicken drumsticks and vegetables. Bread and pureed bread was available; however, was not offered as part of the meal. Dietary staff interviewed stated that residents were not offered bread at meals unless they asked for it. The nutritional value of the meal was reduced.
B) The planned menu required waffles to be served, however, there were insufficient waffles available and pancakes were substituted for the last six orders.
C) The planned portion size of menu items was not followed by staff serving the meal in two dining areas observed (14 scoops did not match the planned menu). Interview with the FSM identified that insufficient quantities of scoops were available in the home.
D) The planned menu required whipped topping to be served with the fruit (for the waffles) and vanilla yogurt. Whipped topping was not offered and in one dining room strawberry yogurt was substituted. [s. 71. (4)]

WN #14: 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,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that recipes and production sheets were consistent to provide clear direction to staff preparing meals.
A) The production quantities identified on recipes were not consistent with production quantities identified on the recipes. Some examples:
frozen vegetables - 100 portions on recipe (production sheets indicate 69 portions)
minced - 5 servings (production sheets indicate 35 portions)
pureed - 5 servings - (production sheets indicate 29 servings)
orange sections - 120 servings recipe (production sheets indicate 69 portions)
minced - 10 servings on recipes (production sheets indicate 35 portions)
pureed - 15 portions on recipes - drained or baked fruit (production sheets indicate 29 portions)
Waffles - 65 portions on recipes (production sheets indicate 36 portions)
minced - 5 portions on recipes (production sheets indicate 19 portions)
pureed - 5 portions on recipes (production sheets indicate 17 portions)
canned fruit - 60 servings on recipes (production sheets indicate fruit salad - apples were served - 34 portions required)
minced - 10 servings on recipe (production sheets indicate 19 portions)
pureed fruit - 15 portions on recipes (production sheets indicate 17 portions)

B) Direction is not provided to staff regarding advance preparation of menu items or tempering. Staff stated they prepared some menu items day in advance but not others; however, direction was not provided on recipes or production sheets for advance preparation. During interview, staff stated that full time staff were aware of which items to prepare in advance; however, not all replacement staff would have clear direction for advance preparation/tempering. The FSM confirmed that advance preparation and tempering direction was not included in the information provided to staff preparing meals. [s. 72. (2) (c)]

2. The licensee has failed to ensure that substitutions were documented on the production sheet at the lunch meal August 25, 2014. The home ran out of waffles (on the planned menu) and substituted pancakes. The substitution was not documented on the production sheets. During interview, staff stated that menu substitutions were not consistently recorded on the production sheets and one would not be able to identify when substitutions were made to the menu due to shortages. Several concerns related to food shortages were voiced to the inspector during this inspection; however, a record of substitutions and shortages was not available for review. [s. 72. (2) (g)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours. Based on a licensed bed capacity of 160 Long-Term Care residents, the home required 504 hours per week for Food Service Workers. The home was providing 495 hours per week for Food Service Workers, resulting in a shortage of nine hours per week. The Nutrition Manager reviewed the calculations and confirmed the minimum number of hours for Food Service Workers was not currently being provided. [s. 77. (1)]

WN #16: 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).

Findings/Faits saillants :

1. The licensee did not ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff applied the physical device in accordance with any manufacturer's instructions.

In August 2014 two residents were observed to have a specific intervention applied improperly and not according to manufacturer's instructions. [s. 110. (1) 1.]

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. 19. (1)	CO #001	2013_105130_0019	146
O.Reg 79/10 s. 36.	CO #001	2013_105130_0020	146
O.Reg 79/10 s. 50. (2)	CO #002	2013_105130_0020	146

Issued on this 19th day of September, 2014

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