Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 21, 2014	2014_369153_0001	T-093-14	Resident Quality Inspection

Licensee/Titulaire de permis

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

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

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

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

LYNN PARSONS (153), ARIEL JONES (566), BARBARA PARISOTTO (558), ERIC TANG (529)

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): April 29, 30, May 1, 2, 5, 6, 7, 8, 9, 12, 2014.

During the course of the inspection, the inspector(s) spoke with executive director (ED), director of care (DOC), assistant directors of care (ADOC), director of life enrichment, food service manager (FSM), environmental services manager (ESM), resident assessment instrument minimum data set (RAI MDS) coordinator, registered dietitian (RD), physiotherapist (PT), occupational therapist (OT), pharmacist, wound care coordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), social

worker (SW), staffing clerk, life enrichment aide, dietary aide (DA), housekeeper, family and residents.

During the course of the inspection, the inspector(s) reviewed clinical health records, nursing staff schedules, equipment and housekeeping cleaning schedules, Resident and Family Council minutes, food committee minutes, complaint log, pest control records, drug destruction records, resident administration file, activity participation records, environmental services log records, physician communication log, staff training records and home policies related infection control, complaints, medication management, food and nutrition, pain management, restraint, fall prevention, continence care, skin and wound care, responsive behaviours, care planning, restorative care, pest control, maintenance, and documentation;
completed observations of staff to resident interactions, resident to resident interactions, meal service, provision of care, drug destruction process and administration of medications;
conducted tour of the home.

The following critical incident logs were inspected: T-520-13, T-268-14.
The following complaints were inspected: T-518-13, T-602-13, T-336-14, T-439-14, T-522-14.

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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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. 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

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

In this home, a care plan kardex is a summarized version of the electronic plan of care for each resident. This care plan kardex is printed and filed in the flow sheet binders for PSWs to access direction regarding resident care requirements.

a) The written plan of care for resident #4485 did not set out clear directions related to communication and physical aggression.
The communication resident assessment protocol (RAP) was triggered on the

quarterly MDS assessment completed in December 2013, for resident #4485 who has a limited vocabulary, difficulty in expressing needs and will become verbally abusive with unfamiliar staff.
A review of the written plan of care filed in the flow sheet binder on May 7, 2014, at 2:58p.m. did not contain a section related to communication.
Interviews with staff confirmed the written plan of care did not contain a section for communication.
A review of the written plan of care filed in the flow sheet binder on May 8, 2014, revealed a revised plan of care which included a section related to communication.
During an interview with a PSW it was identified that the resident demonstrates physical aggression with some staff during the provision of care.
A review of the written plan of care also did not contain clear direction for staff related to physical aggression.
When interviewed the DOC confirmed the written plan of care filed in the flow sheet binder should contain directions related to communication and physical aggression.

b) The written plan of care for resident #4563 did not set out clear directions related to ambulation, communication and the use of side rails.
A record review of resident #4563's care plan revealed that the resident is to be supervised during ambulation. The PT recommended in March 2014, to provide one-on-one assist with all ambulation. The written care plan kardex used by PSWs for resident #4563 did not include a section for mobility and ambulation.
On May 2, 2014, the resident was observed ambulating on the unit independently without staff assistance. On May 6, 2014, the resident was observed ambulating with assistance of one PSW to the dining room.

A record review of resident #4563's plan of care revealed that the use of bed rails was not an identified intervention. Further review of the resident's flow sheets completed by the PSWs revealed five shifts between May 3 - 5, 2014, where the resident was recorded as having one full bed rail in use.
Observations of the resident's room on May 2, 5, and 9, 2014, revealed one full bed rail in the "up" position next to the wall when the resident was not in bed. The rail was observed to be in the "down" position on May 6, 2014, during provision of care for the resident by two staff members.
An interview with a PSW revealed that the resident is unable to get out of bed independently, requires assistance of two people for bed mobility, and does not require bed rails. Interviews with two registered staff indicated that the resident requires one full bed rail for assisted repositioning, while a third registered staff

member stated the resident does not require bed rails and is independent with bed mobility.
Staff interviews revealed inconsistent interpretation of the level of staff assistance required for the resident's ambulation and the use of bed rails. An interview with the DOC confirmed that the resident required assistance of one staff member for ambulation and that resident #4563 does not use a restraint, and that if in use, bed rails are an intervention that should be included in the resident's plan of care.
The licensee failed to ensure that resident #4563's plan of care set out clear directions to staff and others who provide direct care to the resident regarding the use of bed rails. (566)

A review of the MDS assessment completed in October 2013, for resident #4563 revealed the following related to communication:
- speech is a mode of expression
- rarely or never makes self understood
- unclear speech
- sometimes understands others.
Resident #4563 is cognitively impaired and uses limited speech. During an interview, a PSW was able to identify that resident #4563 has a communication problem related to a language barrier and cognitive impairment, but was unable to identify communication interventions for the resident. The PSW referenced the care plan kardex for resident #4563 and identified there were no communication interventions. An interview with the ADOC confirmed there were no clear directions related to communication on the resident's care plan kardex.(558)

c) The written plan of care for resident #4494 did not set out clear directions related to communication.
A review of the MDS assessment completed in October 2013, for resident #4494 under the communication section indicated:
- no speech, absence of words
- unable to understand others.
The communication RAP was triggered which indicated the resident was at risk for unmet needs because of the lack of speech and the resident's reliance on others to discern and meet the resident's needs.
A review of the written care plan kardex failed to reveal any directions for direct care staff related to interventions to communicate with resident #4494 to ascertain the resident's level of well being or care needs.
An interview with a registered staff confirmed interventions for communicating with the

resident should have been incorporated into the kardex to assist the direct care providers in discerning the resident's needs.
The DOC also confirmed interventions related to communication should be included in the care plan kardex.

d) The written plan of care for resident #4591 did not set out clear directions related to communication and oral care.
The quarterly MDS assessment for resident #4591 completed in November 2013, identified the following information related to cognitive loss, communication and oral care.
Cognitive Loss
- short and long term memory loss
- moderately impaired, decisions poor, cues or supervision required
- mental function varies over the course of the day, not of recent onset
Communication:
- speech is the mode of expression
- usually makes self understood, difficulty finding words or finishing thoughts
- clear speech
- understands others
Oral Care:
- daily cleaning of teeth or dentures or daily mouth care by resident or staff.

A review of the written plan of care for resident #4591 failed to reveal any direction for the staff who provide direct care related to communication and oral care.
Interviews with front line staff provided conflicting information related to the process for completing the resident's oral care needs.
An interview with a registered staff confirmed the written plan of care did not contain directions for staff related to communication or oral care.
When interviewed the DOC also confirmed the written plan of care did not contain clear directions for staff related to communication and oral care.

e) The written plan of care for residents' #0001 and #0003 did not set out clear directions related to continence care.
On May 12, 2014, during interviews with an identified RPN and ADOC, it was revealed that the following information should be made available on the residents' written plan of care related to incontinence:
- that the resident requires a brief and the type of brief
- number of staff required to perform care

- frequency of monitoring/changes required.
A review of the care plan kardex for resident #0001 and #0003 revealed the type of brief and the frequency of monitoring was not indicated. The ADOC confirmed that the written plan of care does not provide clear direction related to the resident's continence care needs. (558)

f) The written plan of care for resident #4597 did not set out clear direction related to fall prevention. On May 2, 2014, resident #4597 was observed seated in a recliner chair, on a sensor pad alarm, however the pad was not connected to an alarm unit. A record review revealed that the resident required a personal alarm in bed and wheelchair for safety.
A review of fall incident reports for resident #4597 revealed a recent incident where the resident experienced a fall.
An interview with the DOC confirmed that resident #4597 requires a functional sensor pad alarm for safety. (566) [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 collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

a) A record review of resident #4485's plan of care in October 2013, and March 2014, indicated the use of a continence device. The use this continence device was not coded in the resident's MDS assessments for December 2013, and March 2014. Observations completed throughout the inspection confirmed that resident #4485 has a continence device in place. An interview with the DOC confirmed that the above mentioned MDS assessments were incorrectly coded in relation to the use of the continence device.

b) A record review revealed that resident #4563 sustained multiple falls between January 2014 and April 30, 2014. The PT's post-fall assessment from March 2014, included the recommendation for one-on-one assist with all ambulation due to a significant decline in gait and balance. The resident's current plan of care updated in April 2014, directed staff to provide supervision during ambulation.
On May 2, 2014, resident #4563 was observed to ambulate independently on the unit. Staff interviews revealed inconsistencies within the staff's understanding of the resident's mobility status. An interview with a PSW revealed that the resident walked well with one staff, whereas the registered staff stated that the resident self transferred

and ambulated independently.
The assessment of the resident's mobility status was not collaborative. Resident #4563's nursing assessment was inconsistent with the recommendations made in the PT's post-fall assessment. (566)

c) A review of the daily food and fluid intake records dated September and October 2013 for resident #4589 indicated the following:
- September 8-11, 2013, the resident consumed 3.5-7 – 125ml glasses of fluids
- September 22-26, 2013, the resident consumed 4.5-8.5 – 125ml glasses of fluids
- October 1-8, 2013, the resident consumed 3-7 – 125ml glasses of fluids and
- October 17-22, 2013, the resident consumed 2-6 – 125ml glasses of fluids.

An interview with an RPN revealed a referral for decreased fluid intake is made to the RD when a resident consumes less than the daily target of 12.5 glasses of fluids over three days. An interview with the RD revealed a referral is generated if a resident is consuming less than 75% of the suggested fluid intake (1500ml) or 1100ml per day. A record review and staff interviews confirmed referrals were not made to the RD during the time periods mentioned above.
The licensee failed to ensure that the staff collaborated with each other in the assessment of resident #4589's hydration status.

d) Resident #0024's MDS assessments completed in January 2014, and April 2014, indicate the use of a wheelchair as the primary mode of locomotion. The plan of care dated April 16, 2014, states the resident ambulates independently on and off the unit. Resident #0024 was observed to mobilize on the unit using a wheelchair on May 6, 7, 8, and 12, 2014. An interview with the PT confirmed resident #0024 uses a wheelchair on and off the unit for locomotion. Additional interviews with a RPN and the DOC confirmed the resident's plan of care for locomotion on and off unit was not based on the assessment of the resident. [s. 6. (4) (a)]

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

a) A record review revealed that resident #4597 sustained two falls in April, 2014. The resident's care plan as of May 2014, outlined the need to ensure that the personal alarm is clipped to the resident's clothing at all times when in the wheelchair.
On May 5, 2014, at 9:45a.m. and May 6, 2014, at 7:45a.m. the resident was observed seated in a wheelchair in the lounge without the chair alarm attached to the wheelchair or to the resident.

Staff interviews confirmed that the resident is at risk for falls and requires a personal alarm in both the bed and wheelchair. Interview with the DOC confirmed if a resident requires a personal chair alarm, then it should be clipped to the resident at all times when he/she is seated in a wheelchair.
The licensee failed to ensure that the resident's personal alarm was in use as outlined in the resident's plan of care. [s. 6. (7)]

4. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

a) A record review of resident #0023's plan of care completed in June 2013, indicated the use of an identified medication when the resident is anxious. A review of the resident's medication orders revealed that the identified medication was discontinued in August 2012. Interviews with a RPN and the DOC confirmed that the resident's June 2013 plan of care was not revised to reflect the discontinuation of the identified medication.

b) A record review of resident #4625's plan of care dated March 12, 2014, indicated that the resident requires a safety device for falls prevention to be on at night time when the resident is sleeping. On May 2, 5, and 6, 2014, the safety device was not observed in the resident's room. Staff and family interviews confirmed the safety device was discontinued several months ago when the resident's ability to mobilize declined. The DOC confirmed that this intervention should be removed from the resident's care plan as it was no longer required.

A record review revealed that resident #4625's most current care plan was reviewed and signed by the nursing department on March 12, 2014. The previous care plan was reviewed and signed by the nursing department staff on August 11, 2013, approximately 7 months prior. Interviews with a RPN, ADOC and DOC revealed that all residents' care plans should be updated quarterly or at any time related to a resident's change in condition. An interview with a RPN confirmed that resident #4625's care plan should have been reassessed between August, 2013, and March, 2014. The ADOC confirmed that resident #4625's care plan review schedule was not consistent with the home's policy for quarterly care plan reviews. (566)

c) A review of the MDS assessments and care plan revisions for resident #4591 revealed the plan of care had not been reviewed or revised since July 2013.

Quarterly MDS assessments were completed in July, October 2013, January and April 2014 but the care plans were not reviewed or revised.
Interviews with the DOC and RAI MDS coordinator confirmed the care plans had not been reviewed and revised. (153)

d) A record review revealed that resident #4589's most current care plan was reviewed and signed by the nursing department on April 24, 2014. The previous care plan was reviewed and signed by the nursing department staff on July 23, 2013, approximately 9 months prior. Interviews with a RPN, ADOC and DOC revealed that all residents' care plans should be updated quarterly or at any time related to a resident's change in condition. Staff interview with the unit RPN confirmed that resident #4589's care plan should have been reviewed and revised between July, 2013, and April, 2014. The ADOC confirmed that resident #4589's observed care plan review schedule was not consistent with the home's policy for quarterly care plan reviews. (566) [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that;
- the written plan of care sets out clear directions to staff and others who provide direct care to the residents
-the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and compliment each other
- the care set out in the plan of care is provided to the resident as specified in the plan
- the resident is 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 change or the care set in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any policy and procedure put in place is complied with.

a) The home's policy and procedure titled preventative skin care #03-03 dated June 2010, under step three of the procedure states the care staff are to observe all areas of a resident's skin during the first bath/shower of the week and record findings on the weekly skin observation form. A record review of resident #4485's weekly skin observation form revealed that weekly skin observation was not recorded on the following days in 2014: January 29, February 26, March 19, 26, April 2, 9, 23, and 30. Interviews with a RPN and the DOC confirmed the weekly skin observation was not recorded on the above mentioned dates as per the home's preventative skin care policy and procedure.

A record review of resident #4532's skin observation form reveals that it has not been completed weekly between February 16, 2014, and April 22, 2014. An interview with the director of care has confirmed resident #4532's skin observation form has not been completed weekly for the above mentioned time period.

b) The home's policy and procedure titled daily care records #05-06-01 dated June 2013, under procedure #2 indicates that staff are to record day of the month, all levels of care provided and all observations made.

A review of resident #4485's daily care record for April and May 2014, revealed missing documentation of bladder and bowel continence on the following dates and shifts:
April 2014:
- day - 13
- evening - 5, 18

- night - 28, 30

May 2014:
- day - 2.

On record review of resident #4560's daily care record indicates missing documentation of elimination and/or bladder and bowel continence on the following dates and shifts:
January 2014:
- day - 23, 27
- night - 21, 26

February 2014:
- day - 4, 5, 6, 10, 24
- evening - 1. 6. 10. 22
- night - 9, 27, 2

March 2014:
- night - 8.

A review of resident #4591's daily care record indicated missing documentation of bladder and bowel continence for the following dates and shifts:
February 2014:
- evening - 28

March 2014:
- evening - 9

April 2014:
- evening - 19

May 2014:
- evening - 5.

Interviews with RPNs and the DOC confirmed that the home did not follow the above mentioned policy on the identified dates.

c) The home's policy titled self-administration of medications #5-5 dated January

2014, states the following:
1) prescriber and nursing team assesses the resident for their capacity to self-administer their own medication and complete a "self-administration assessment" form. File form with MAR.
2) prescriber writes the medication order including in the directions "may self-administer".
3) prescriber indicates the amount of medication allowed to be securely stored at the bedside, if other than the standard size package.
6) resident signs "resident self-administration agreement" and files signed form in resident's chart.
7) monitor the resident's ability to self-administer medications and notify the physician of any change in the resident's chart
8) complete the "self-administration assessment" form quarterly or with any change in resident's status.
12) document in progress notes weekly that monitoring has been done and the extent to which the resident is compliant with self-administration. Report any concerns to the physician.
A review of the physician order form for resident #0037 revealed an order dated June 10, 2013, that indicated may have an identified medication in the resident room.
A review of the subsequent quarterly medication reviews revealed the same order which was renewed by the physician.
When requested to view the self-administration assessment form for resident #0037, the registered staff was unable to locate the forms.
An interview with a RN confirmed the resident does self-administer the identified medication, which is kept in resident #0037's room.
A review of the progress notes failed to reveal any documentation to indicate that monitoring had been done nor the extent to which the resident is compliant with self-administration as per home policy.
An interview with the DOC confirmed the order to self-administer medication was not consistent with the home's policy and the required procedures had not been completed. (153)

d) The home's policy titled expiry and dating of medications #5-1 dated January 2014, indicates the following:
Policy:
- a system is in place to ensure that an adequate and unexpired supply of medication is maintained for each resident.
Procedure:

1) examine the expiry date of all medications on a regular basis.
2) remove any expired medications from stock and order replacement if necessary.
4) treat expired prescription medications as surplus medications.
On May 5, 2014, at 10:15a.m. the following expired medications were observed in the 4 east medication cart:
- multivitamin - expiry date April 2014
- docosate sodium 100mg. - expiry date April 2014
- epinephrine 1:1000 injectable - expiry date April 2014.
The expired medication was given to the RN who placed them in the discontinued drugs for destruction container in the medication room.
When interviewed the DOC confirmed the expired medications are to be removed on a regular basis. (153) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the home is required 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, is complied with related to the following areas;
- wound care
- documentation on clinical health records
- medication management system, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident-staff communication response system can be easily seen, accessed and used by residents, staff and visitors at all times.
On May 1, 2014, at 11:05a.m. the green call bell cord in the bathroom of room #2247 was observed to be wrapped around the grab bar preventing it from being activated.
Two PSWs came to the room and demonstrated that the call bell would activate if you removed the call bell cord from the grab bar and pulled the clear tubing at the call station. When asked to use the green call bell cord to activate the call bell, the green connector pulled apart and prevented the call bell from activating.
During a demonstration with the ESM of the call bells in the resident bathrooms, it was identified that the green connectors pulled apart when the call bell cord was pulled which prevented the call bell from being activated.
The ESM indicated an audit would be completed of the call bells in the resident bathrooms to identify which call bell cords needed to be replaced. [s. 17. (1) (a)]

2. The licensee failed to ensure the resident-staff communication and response system is on at all times.
On April 30, 2014, at 9:25a.m. and at 2:10p.m. in resident room #2214, the inspector attempted to activate the call bell at the bedside. This resulted in no audible sound or light activated in the hallway outside the resident's room.
A PSW came to the room and confirmed the call bell was inoperable, as no audible sound or light activated in the hallway outside the resident's room.
The PSW reported the inoperable call bell to the RPN who informed maintenance.

On April 30, 2014, at 10:35a.m. in resident room #4204 washroom, the call bell cord was broken at the call bell station and could not be activated when pulled. A RPN was alerted to the situation and confirmed the call bell was not able to be activated. The RPN indicated maintenance would be notified.
Observations completed on May 1, 2014, indicated both call bells were operational. [s. 17. (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 ensure that the resident-staff communication and response system can be;
- accessed and used by residents, staff and visitors at all times
- is on at all times, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, was reassessed at least weekly by a member of the registered nursing staff.

A review of resident #4485's wound consultation note in February 2014, indicated the presence of pressure ulcers. As per the resident's plan of care in October 2013, a registered staff is to assess and record dimensions of wound, stage, odor, exudate and any other relevant characteristics of the wound every week on the wound assessment record. A record review and interviews with the wound care coordinator and the DOC confirmed the wound assessment record was not completed weekly.

On review of resident #4532's wound consultation note in December 2013, indicated the presence of two pressure ulcers. In April 2014, the wound consultation note indicated one pressure ulcer was healed and the other pressure ulcer continued to require treatment. A record review revealed wound assessments were not completed on a weekly basis between December 4, 2013, and April 15, 2014. An interview with the wound care coordinator and the DOC confirmed the wound assessment record for resident #4532 was not completed on a weekly basis. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: 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 failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A record review indicated that the last written response from the DOC, to the Residents' Council, was undated and attached to the February 26, 2014, Residents' Council minutes. Interviews with the DOC and the FSM regarding complaints raised during Residents' Council and food committee meetings, confirmed a verbal response is provided during the meeting. For situations that required follow-up, a response would be attached to the meeting minutes and be discussed at the next scheduled meeting. A review of the meeting minutes from December 2013 to April 2014, revealed that minutes indicated that a follow-up was required and did not include a written response to the identified concerns.
A review of terms of reference for Residents' Council and the resident food committee policy indicates suggestions and complaints raised during these meetings will be responded to in writing within 10 days.
An interview with the ED confirmed that the practice of recording complaints in the Council minutes and following up with a verbal response at the next meeting is not consistent with the LTCHA, 2007. [s. 57. (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 concerns or recommendations received from the Residents' Council are responded to in writing within 10 days, to be implemented voluntarily.

WN #6: 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that food is served at a temperature that is both safe and palatable to the residents.

On May 5, 2014, between 5:00-5:25p.m., five residents were interviewed about their dinner meal. Residents #0004, #0005 and #0006 identified the potatoes as cold and residents #4570, #0006 and #0007 identified the vegetables as cold. Residents #0005, #0006 and #0007 stated it is common for the food to be served cold. Resident #0005 asked that the meal be microwaved as it was cold.
At 5:25p.m. the inspector requested a sample plate and took the temperature of the food items prior to sampling them. The Caribbean chicken breast was 47.9C, the farmer's sausage link was 58.3C, the oven browned potatoes were 34.0C and the Scandinavian vegetables were 40.4C. The potatoes tasted under cooked and cold.

A review of the temperature sheets identified temperatures are taken for entree #1, entree #2, vegetable #1, vegetable #2, minced entree #1, minced entree #2, minced vegetable #1, minced vegetable #2, pureed entree #1, pureed entree #2, pureed vegetable #1, pureed vegetable #2, dessert, minced dessert and pureed dessert.
An interview with an identified DA confirmed the temperature of potatoes is not taken.
A record review of policy #DIET-07-01-03 version June 2013 identifies hot foods are served to residents at a minimum of 60C/140F.

A record review of the food committee minutes dated March 28, 2013, identified items, especially mashed potatoes, as cold when received. On June 27, 2013, fourth floor identified issues with temperatures mainly at dinner.
An interview with the FSM and FSS revealed there was monitoring of temperatures on fourth floor after receiving complaints from residents.
Following the interview, the FSM updated the temperature sheets to include starch (rice, potato, noodles). [s. 73. (1) 6.]

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 food is served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure there are measures in place to prevent the transmission of infections.

On April 30, 2014, the following wall-mounted hand sanitizers were observed to have an expiry date of October 2011:
- residents' room #4204, #4211, and #4233.
An interview with an ADOC confirmed that expired hand sanitizers are not to be used in the home.
The ESM confirmed it is the responsibility of housekeeping staff to review the hand sanitizer products for expiration dates. The identified expired products were replaced once the home was made aware. [s. 86. (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 ensure that all hand sanitizers used in the home do not exceed expiration date, 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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On May 5, 2014, at 10:15a.m. an inspection of the 4 east medication cart revealed the presence of the following items:
- 1 pair of scissors
- several band-aids
- tape for dressings
- hearing aide batteries.
The registered staff indicated when interviewed that the above noted items would be removed. [s. 129. (1) (a)]

2. The licensee failed to ensure controlled substances are stored in a separate, double-locked area within a stationary cupboard in the locked area.

In January 2014, a significant supply of controlled drugs were found missing by the ADOC and pharmacist during the completion of the drug destruction process.
The licensee notified the police and ministry of health and long term care (MOHLTC) immediately of the missing controlled drugs.
An internal investigation was commenced immediately.
Controlled drugs waiting for drug destruction are placed in a locked wooden safe located in a medication/treatment room.
During the course of the inspection, interviews with staff revealed a practice on the night shift whereby registered staff leave the medication/treatment door open and staff are not in attendance.
The outcome of the police investigation was inconclusive.
An interview with the DOC confirmed the medication/treatment door is to be locked and secure when registered staff are not in attendance. [s. 129. (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 ensure controlled substances are stored in a separate, double-locked area within a stationary cupboard in a locked area, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

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

a) Resident #0037 was prescribed an identified medication.
A review of the MAR and progress notes for April 2014, failed to reveal documentation as to the resident's response or the effectiveness of the identified medication on the following dates and times:
- April 5, at 11:40a.m.
- April 14, at 10:41a.m.
- April 15, at 11:12p.m.
- April 24, at 2:48p.m.

Interviews with registered staff confirmed documentation of the effectiveness of the medication is to be completed in the MAR and the progress notes.
An interview with the DOC confirmed the documentation had not been completed on the above dates in regards to the effectiveness of the medication in the MAR and the progress notes.

b) A record review of resident #0024's MARs indicates that the resident received an identified medication for pain with no documentation to identify the effectiveness of the medication on January 5 and 12, February 16 and 21, March 6 and 31, and April 13, 2014. Interviews with a RPN and the DOC confirmed the effectiveness of the identified pain medication was not documented as per home policy for resident #0024. (529) [s. 134. (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 when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs, to be implemented voluntarily.

WN #10: 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 failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

a) On April 29, 2014, at 3:12p.m. resident #4532's wheelchair was observed to be soiled with dried food down the right side of the chair, along the side cushions and the seat of the chair. The chair remained soiled on May 2, 5, 6, 7, and 9, 2014. A review of the resident equipment cleaning schedule/audit for May 2014, identified that the chair was cleaned on Thursday, May 1, 2014, and Thursday, May 8, 2014. An interview with a PSW on May 7, 2014, confirmed the wheelchair was dirty. An interview with the ADOC on May 9, 2014, confirmed the wheelchair was dirty and should have been cleaned on Thursday, May 8, 2014.

b) On April 29, 2014, at 2:37p.m. the carpet in resident room #3137 was observed to have two white stains. The carpet remained stained on May 2 and 5, 2014. An interview with a housekeeper on May 8, 2014, revealed a full cleaning of a resident's room includes spot cleaning the carpet at the end of the shift otherwise it is marked in a book for another time. A review of the full clean schedule identified the resident's room would have been cleaned on Sunday, May 4, 2014. A review of the staff member's book confirmed full cleaning of scheduled rooms for the above mentioned date was completed. The book did not include notes identifying the carpet in room #3137 required cleaning. An observation on May 9, 2014, at 9:17a.m. revealed the carpet stains were removed. An interview with the ESM confirmed carpets should be spot cleaned daily and if a carpet requires a shampoo, it should be documented in the housekeeping book and the manager should be notified. The manager had been notified of the stained carpet in room #3137 and the janitor shampooed it the night of May 8, 2014. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment are

maintained in a safe and in a good state of repair.

The following observations were completed on April 29 and May 2, 2014:
2 west:
- extensive black marks and chipped drywall on the wall across from the bottom of the bed in resident room #2214.
3 west:
- chipped ceramic wall tile and grout missing between ceramic tile in shower room.
3 east:
- scraped drywall with black scuff marks, crack in the wall under the window sill and stains on the top of the vanity in the bathroom in resident room #3137.
4 east:
- chipped drywall on the wall across from the bottom of the bed in resident room #4113.

A review of the maintenance logs failed to reveal that the above areas requiring repair had been recorded in the maintenance log book for the individual resident units.
The ESM confirmed the above noted areas required repair. [s. 15. (2) (c)]

WN #11: 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).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. Interviews conducted with the Family Council president and the ED confirmed that the Family Council was not involved in the development or carrying out of the satisfaction survey in 2013. The results of the satisfaction survey were reviewed at the Family Council meeting on April 24, 2014. During an interview with the Family Council president it was confirmed the licensee did not seek the advice of the Family Council on acting on the results of the satisfaction survey. [s. 85. (3)]

WN #12: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A staff interview with the ADOC confirmed that the home did not evaluate their infection prevention and control program for 2013. [s. 229. (2) (d)]

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

On May 5, 2014, at 8:50a.m. a PSW was observed clearing dirty cereal bowls followed by serving the main entree without performing hand hygiene. The same PSW removed used clothing protectors, placed them in the soiled linen bag and proceeded to clear dirty dishes and serve meals without performing hand hygiene. An interview with the PSW confirmed hand hygiene should have been performed between clearing dirty items and serving the entree. [s. 229. (4)]

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

Issued on this 23rd day of May, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs			
L. Parsons.	For Ariel Jones	E. Jang	B Pawotta