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
Jun 10, 2014	2014_157210_0007	T-111-14	Resident Quality Inspection

Licensee/Titulaire de permis

DRS PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET, TORONTO, ON, M5A-2S3

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

WELLESLEY CENTRAL PLACE
160 WELLESLEY STREET EAST, TORONTO, ON, M4Y-1J2

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

SLAVICA VUCKO (210), NITAL SHETH (500), TILDA HUI (512)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 19, 20, 21, 24, 25, 26, 27, 28, 31, 2014 and April 01, 02, 03, 2014.

Additional inspections related to the following log#'s were also completed during this inspection:
Log # T-217-14 related to the complaint #2959-000002-14
Log # T-632-13 related to the complaint #IL-30092-TO
Log # T-000445-14 related to the complaint # IL-30092-T0 and IL-31759-TO

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), director of nursing care (DONC), manager of environmental services, executive director, resident assessment instrument (RAI) coordinator, director of programs and volunteer services, resident and family services coordinator, dietary aids, food services manager (FSM), registered dietitian (RD), physiotherapist (PT), family members, president and representative of family council, president of resident council, private care givers, cook, residents, house keeping aid.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed resident and home records, observed the home's environment, meal service and food production, reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
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
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. (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).

Findings/Faits saillants :

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

A review of a plan of care of resident #095 indicated staff to discourage family from bringing inappropriate food items, and encourage compliance with therapeutic diet.

An interview with an identified staff confirmed that the above mentioned interventions do not provide clear directions to staff. There should be more specific examples of food items. [s. 6. (1) (c)] (500) [s. 6. (1) (c)]

2. A review of the recent written plan of care, did not indicate resident #002 was positive for an identified transmissible colonization and that staff had to follow Infection Prevention and Control(IPAC) practices for contact precautions according to Provincial Infectious Diseases Advisory Committee (PIDAC) guideline.

Interview with staff confirmed there was a sign for contact precautions on the door for approximately two weeks and it was removed. [s. 6. (1) (c)]

3. The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A review of the plan of care in relation to urinary and bowel incontinence for resident #135 indicated he\she had urinary incontinence. The interventions to be implemented are: resident is part of the incontinent program, containment, staff to check for wetness before and after meals, evening and on rounds during the night. For the bowel incontinence resident is part of the incontinent program, containment, using a brief, medium size.

Interview with an identified staff indicated resident #135 was incontinent of bladder and bowels. The staff has tried to assist the resident for toileting by offering the commode, and giving him\her 10 minutes time. The resident was not successful in his/her attempts. The same staff indicated the resident usually had a bowel movement when giving 15-20 minutes on the commode on shower days.

Interview with another identified staff indicated he\she was not aware about the bowel movement routine of the resident in order to update the plan of care. [s. 6. (4) (a)]

4. A review of the recent plan of care in relation to bladder continence for resident #221, indicated the resident to be checked for wetness before and after meals and before going to bed. A review of the plan of care in relation to bowel continence, indicated the resident had bowel incontinence, characterized by inability to control bowel movements related to impaired mobility. The intervention described was that the resident is part of the incontinent program, and to be toileted at established times, before and after meals and before bed time.

Interview with resident #221 indicated he\she is always continent of bowels, he\she receives assistance every two to three days to be transferred to the toilet, as requested. Further, the resident stated he\she was incontinent of bladder and she wanted his\her incontinent product to be changed at 9:00 a.m., and 9:00 p.m., not during the night.

Interview with an identified staff indicated staff changed the incontinent product at 9:30 a.m. and staff assists her/him with bowel continence/toileting every few days. A review of the flow sheets indicated in two occasions in March 2014, the resident was incontinent of bowels.

Interview with another identified staff, indicated he\she was not aware of the resident's toileting routines (the times of changing the incontinent product and the bowel continence) in order to update the plan of care for managing the bladder continence and bowel incontinence. [s. 6. (4) (a)]

5. A review of the RAI assessment at admission indicated resident #231 was continent of bowels.

Interview with two identified staff indicated resident #231 was continent of bowels, he/she was using the toilet and he/she never had incidents of incontinence. He/she was wearing pull-ups with a pad during the day and underwear at night without a pad.

Observation of the note on the wall of the resident's washroom and interview with the private care giver confirmed that the resident never had bowel incontinent incidents.

A review of the quarterly assessments completed by the registered nursing staff indicated in the last three assessments, the resident was occasionally incontinent (once a week), frequently incontinent (two-three times a week) and occasionally incontinent of bowels.

An interview with an identified staff confirmed that the documentation for bowel incontinence was incorrect and he/she did not communicate with the private care giver or a family member who assisted the resident with toileting in order to complete consistent assessments and documentation. [s. 6. (4) (a)]

6. A review of the clinical record for resident #066 indicated he\she had a recurring Stage 3 pressure ulcer on the coccyx which healed at the end of 2013. Identified staff documented the skin assessments in the flow sheets performed on the days when resident had a bath. In January 2014, it was documented sixteen times that resident #066 had either red or open skin area.

A review of the clinical record indicated that registered nursing staff initiated a treatment at the end of January 2014, for Stage 2 pressure ulcer. Interview with an

identified staff indicated it was not reported to registered nursing staff the altered skin integrity for appropriate treatment to be initiated to prevent further worsening of pressure ulcers prior to the treatment initiation. [s. 6. (4) (a)]

7. A review of the recent plan of care, indicated resident #209 needed assistance with toileting, especially in the evening.

An interview with an identified staff indicated resident # 209 needed extensive assistance with toileting especially in the morning. The staff did not share the information with registered nursing staff in order to update the resident's plan of care. [s. 6. (4) (a)]

8. Interview with resident #209 indicated the resident was continent of bladder and bowels, and he/she did not wear any incontinent product.

A review of the recent written plan of care for urinary incontinence, indicated the goal was for the resident to remain continent of bladder. A review of the flow sheets indicated the resident was sometimes incontinent which was a sign of a worsening continence status. Interview with the nurse confirmed he/she did not communicate with the resident and the other staff about the worsening continence status in order to re-assess the resident. [s. 6. (4) (a)]

9. A review of the recent plan of care in relation to bowel continence, for resident #221 indicated the resident had bowel incontinence, characterized by inability to control bowel movements related to impaired mobility. The intervention described was that the resident is part of the incontinent program, and to be toileted at established times: before and after meals and before bed time.

Interview with resident #221 indicated he\she was never incontinent since the admission, he\she usually has constipation and has every two-three days bowel movement. Whenever he\she had the urge to go he\she would call the staff to assist him\her with sitting on the commode\toilet. [s. 6. (4) (a)]

10. The licensee failed to ensure the plan of care for resident #001 was provided as specified in the plan.

A review of the plan of care indicated resident #001 has inability to express emotions and share information. The resident finds it difficult to express his/her needs as he/she

is unable to find words or to finish his/her thoughts due to confusion. He/she is resistive to care and staff has to leave the resident and return in 5-10 minutes, inform resident of activity of daily living (ADL) that is required ahead of time and allow for flexibility in routines. The resident acts by ineffective coping, and has a history of verbal/physical aggression related to yelling and being "combative" during care. Staff not to express anger or impatience verbally or with physical movements (i.e. shaking head, pointing finger) because these responses are likely to increase confusion and agitation.

Interview with an identified staff confirmed that while giving personal care to resident #001 staff has to explain the procedure, be patient, repeat the sentence few times, and make sure that the resident consented.

On an identified date in the first quarter of 2014, the resident tried to refuse the personal care given by two PSWs, and sustained head bruises from the bed rail.

Interview with one of the staff, who was giving the morning care, indicated while the resident was assisted with changing the incontinent product he/she started being restless and agitated. The staff continued with changing the incontinent product while explaining the procedure. Staff left him for a while and approached again to continue with the care. This time, the resident was "combative", moved to the sides of the bed and hit his/her head on the bed rail that was in up position. The staff stated it has not happened the resident to behave like that in the last few years, but that morning the unit was short of staff and the job had to be finished.
The personal care of resident #001 was not provided as specified in the plan of care and he/she was not allowed for enough flexibility in routines. [s. 6. (7)]

11. The licensee failed to ensure staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it.

Interview with identified staff indicated they did not have access to the written plan of care but only to the Kardex that is a short form of the written plan of care.

Review of the plan of care indicated resident #135 to be provided diligent oral care after meals. Interview with evening identified staff confirmed the staff did not have access to the full care plan and she was not aware of the need to perform oral care after meals. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff, staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident, 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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with as follows.

The home's policy titled Medication Administration, Drug Destruction and Disposal F-35, revision date July 3, 2013, stated that "surplus drugs (drugs for destruction) will be removed from current medication system and will be destroyed and disposed in accordance with regulatory requirements. In the Procedure section 1.a, the policy stated that all drugs that have expired are included as "Surplus Drugs". The policy was not complied with in the following situation.

Observation conducted on March 26, 2014, at 10:45 a.m., on 4th floor unit revealed that two medications were expired one in December 2013, and another one in February 2014, and were observed in the medication cart and drug cupboard in the medication room.

An interview with an identified staff confirmed that expired medications are not to be

stored in medication cart and drug cupboard in the medication room but in a separate locked drawer in the medication room. [s. 8. (1)]

2. The licensee failed to ensure that the protocol for Skin and Wound Management, is complied with.
A review of the Skin and Wound Management program, treatment protocol, revised May 2013, stated if a resident is at medium and high risk of skin breakdown (incontinent, reddened excoriated skin, predisposing factors-diarrhea, medications, tube feeding) a preventative skin care devices are in place (pressure relief mattress, cushions, lifting devices).

A review of the clinical record and interview with a RN indicated resident #063 was identified at high risk for skin breakdowns in the last quarter of 2013, and the interventions such as turning and repositioning and protective dressing were planned. He/she received a pressure relief mattress in the middle of the first quarter of 2014, after the pressure ulcer worsened to Stage 3. [s. 8. (1) (b)]

3. The licensee failed to ensure that the policy "Found personal items" and "Missing resident laundry" is complied with.

Policies for missing resident laundry, found personal items and a "missing laundry" form, dated August 2013, were presented to the inspector by the DOC. Interview with resident #064, #095 and #104 indicated they lost different pieces of clothing/laundry in 2013.

Interviews with residents, identified staff, manager of environmental services, resident and family services coordinator, and staff from laundry indicated staff were not familiar with all of the steps in the policy for managing lost clothing, such as what to do when a resident or family member reports missing laundry, documenting and finalizing the search. [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 the protocol Skin and Wound Management, the policy Found Personal Items" and Missing Resident Laundry", are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are provided with food and fluids that are safe, and adequate in quantity.

Observation conducted on March 19, 2014, at 12:00 p.m., on the 4W dining room revealed that residents #023 and #024 were served thickened water with nectar consistency.

A review of the residents' plans of care revealed that residents should be provided thickened fluids with honey consistency.

Interview with the nursing staff confirmed that nectar consistency of fluids were not safe for these residents.

Observation conducted on March 19, 2014, at 12:00 p.m., on 4th floor dining room revealed that scoop #16 was used for sweet potato pureed instead of scoop #10, and scoop #2 for Italian vegetable pureed instead of #16. Standardized scoop size were not used which may alter the quantity and nutrient value of the foods [s. 11. (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 residents are provided with food and fluids that are safe, and adequate in quantity, to be implemented voluntarily.

WN #4: 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 that the communication and response system can be accessed and used by residents, staff and visitors at all times.

Observation conducted on March 19, 2014, at 10:30 a.m., revealed that one call bell on 2nd floor dining room was not operational.

An interview with an identified staff confirmed that if the call bell cord is pulled the call bell was not activated. [s. 17. (1) (a)]

2. The licensee failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

Observation made on March 19, 2014, at 10:30 a.m., confirmed that the balcony doors on second and third floors were accessible to residents. There were no call bell systems installed in these balconies.

An interview with staff confirmed that the doors to second and third floor balconies were programmed to stay open from 8 a.m. to 8 p.m. for residents to access unsupervised and that there were no call bell systems installed. [s. 17. (1) (e)]

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 communication and response system can be accessed and used by residents, staff and visitors at all times, the resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies are developed and implemented to meet the needs of resident #135 and #001 with compromised communication and verbalization skills, and cognitive impairment.

A review of the clinical chart for resident #135 indicated he\she was diagnosed with cerebral vascular accident (CVA) and had compromised communication-aphesia. A review of the written plan of care indicated resident to be asked short questions that required short answers, yes or no.

Interview with identified staff indicated the resident was able to understand when other people speak to him, he\she tries to respond, or express his\her opinion but he/she is not well understood. Interview with a family member and staff indicated that the resident would sometimes leave 50 % of the food in the plate and staff was not able to identify the reason. Staff confirmed that they were not always sure if the left food in the plate was because resident was not hungry anymore or he/she did not like the food, and that having some kind of a communication tool will improve the communication with the resident. [s. 43.]

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 strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, and cognitive impairment, to be implemented voluntarily.

WN #6: 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 failed to ensure that when residents #104, #226, and #231 had fallen, post-fall assessments were conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A record review for resident #104 revealed that the resident had a fall on an identified date in 2014 and post fall assessment was not conducted. Review of the plan of care indicated the resident was at a high risk for falls related to poor balance, decreased cognition, confusion, dementia, issues in decreased static and dynamic balance during standing, muscle weakness in lower extremities and decreased postural alignment. Resident was weak in legs and not able to sustain his/her standing posture for more than 3 seconds.

Interview with registered nursing staff confirmed that the resident had a fall on an identified date in 2014 and no post fall assessment was conducted. [s. 49. (2)]

2. A review of the plan of care for resident #226 indicated the resident was at risk for falls characterized by history of falls/ injury, multiple risk factors related to unsteady gait and weakness/frailty.

Record review indicated resident had an unwitnessed fall on an identified date in 2014, early in the morning, at end of his/her bed. The resident was found bleeding from the head. The resident was transferred to hospital and returned the same day. No suturing required for laceration. Resident was put on head injury routine but no fall assessment was recorded.

Interview with registered nursing staff confirmed that the resident had a fall on an identified date in 2014, and no post fall assessment was conducted. [s. 49. (2)]

3. A review of resident #231's plan of care indicated the resident was at risk for falls characterized by history of falls/ injury, multiple risk factors related to impaired balance, unsteady gait, visual deficit, dementia, and taking psychotropic drugs.

Review of progress notes revealed that the resident had a witnessed fall on an identified date in 2014, after lunch time in the dining room. The resident was walking with his/her spouse and felt sudden weakness in his/her legs.
The resident fell backwards and did not sustain visible injuries.

An interview with registered nursing staff confirmed that the resident had a fall on an identified date in 2014,and no post fall assessment was conducted. The identified registered nursing staff indicated that the post fall assessment including head injury routine was not initiated as it was a witnessed fall and there was no injury.

A review of the home's post fall assessment policy, procedure item 1, stated that "the resident will be assessed after each fall using the Risk Incident (RIM) assessment in point click care (PCC). [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 post-fall assessments has been conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #7: 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 failed to ensure resident #143 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to promote healing, and prevent infection, as required.

Interview with an identified staff indicated the resident had a venous ulcer that worsened since the last quarter of 2013. A review of the weekly wound assessments confirmed that the wound worsened. On an identified date in the the third quarter of 2013 the weekly skin assessment indicated there was odor, signs of infection and resident was not on antibiotics. Interview with an identified staff indicated whenever there are signs of infection a microbiology swab should be taken and the physician to be notified immediately. A review of the clinical chart and interview with the identified staff indicated the swab was not taken and the physician was not notified immediately. The physician was contacted and an order was received 12 days after the assessment was performed, for the resident to receive antibiotics.

Resident #143 presented with signs and symptoms of infection but was not treated for 12 days. [s. 50. (2) (b) (ii)]

2. The licensee failed to ensure resident #066 exhibiting altered skin integrity, including pressure ulcers, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the clinical record for resident #066 and interview with an identified staff indicated that the weekly skin assessment was not performed on three occasions in the period between January and March, 2014. [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 residents exhibiting altered skin integrity, including skin breakdown and pressure ulcers, received immediate treatment and interventions to promote healing, and prevent infection, as required; been assessed by a registered dietitian; has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #8: 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,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

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

A review of the recent plan of care in relation to bladder continence, for resident #221 indicated resident was on the incontinent program with the intervention containment, which meant staff to check the incontinent product for wetness before and after meals and before going to bed. He/she is cognitive and aware that he/she voids in his/her briefs at night and wants the night staff to be aware of this.

Interview with an identified staff and review of the clinical record for resident #221 indicated when the resident was admitted, he/she was wearing an incontinent product for the continence but an incontinence assessment was never performed. [s. 51. (2) (a)]

2. The licensee failed to ensure that continence care products are not used as an alternative to providing assistance to toilet for resident #135.

Interview with the resident indicated he/she is not happy with using the incontinent product, and that no other choice was offered. Interview with an identified staff indicated staff was changing the incontinent product in the morning, lunch, evening and on rounds during the night and the resident was never offered alternatives for toileting. [s. 51. (2) (e)]

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 who is incontinent received an assessment, the resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence; continence care products are not used as an alternative to providing assistance to toilet, to be implemented voluntarily.

WN #9: 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 ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), within 10 days of receiving the advice, responds to the Residents' Council in writing.

An interview with the president of Residents' Council confirmed that the home did not provide written response always within ten days for any concerns or recommendations advised by the Residents' Council.

A review of Residents' Council Concerns forms from January, 2013, to March 2014, revealed that the home did not provide a written response for the concerns or recommendations advised by the Residents' Council meetings conducted on January 30 and March 6, 2013 [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 that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #10: 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).

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

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

Observation conducted on March 19, 2014, at lunch time, revealed that the posted daily lunch menu contained coleslaw vinaigrette and grapes. The residents were served sweet potato puffs and mango instead. The posted daily menu was not changed until the middle of lunch time.

Interviews with residents and staff confirmed that not always posted food items on the menu are served to residents. [s. 71. (4)]

2. The licensee failed to ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle.

An interview with identified staff confirmed that there are no individualized menus developed for residents with food allergies or special dietary requirements. RD defined the lacto-ovo vegetarian diet as a diet containing egg and dairy products but not meat, chicken, fish and sea foods. He/she confirmed that the home did not have a therapeutic menu for lacto-ovo vegetarian diet, but the individual preferences are addressed in the resident' plan of care.

A review of the current vegetarian menu revealed that fish and sea food listed as one of the entrée choices could not meet the requirements of lacto-ovo vegetarian diet.

A review of plans of care for residents #025, #026, and #027 revealed that the special dietary requirements are not addressed. The individualized menus to consider residents dietary preferences are not developed for above mentioned residents. Current vegetarian menu provides choices of fish and sea food that is not suitable for residents with lacto-ovo vegetarian diet, based on their dietary preferences. [s. 71. (5)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure resident #001's SDM was immediately notified upon becoming aware of the alleged or suspected incident of abuse of the resident that resulted in a physical injury or pain to the resident or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Review of the clinical record and staff interview indicated on an identified date in 2014, there was an incident of suspected physical abuse while direct care staff was performing morning personal care and the resident sustained scratches on his/her forehead, and both hands.

Interview with an identified staff indicated resident #001's preference was to update an identified family member about health status change and updates were communicated by email. Interview with an identified staff and review of the clinical record indicated the family member was not contacted about the suspected physical abuse. [s. 97. (1) (a)]

2. The licensee failed to ensure that resident #001's SDM was notified of the results of the alleged abuse investigation immediately upon the completion.

Interview with identified staff indicated resident #001's SDM was not notified of the results of the alleged abuse investigation that happened on an identified date in 2014, immediately upon the completion. [s. 97. (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 resident's SDM specified by the resident was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or

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

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the

licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: the complaint is be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Interviews with family members of resident #075 and resident #076, confirmed that the home did not respond to their complaints.

A record review revealed that resident #075 was involved in an altercation with another resident in the first quarter of 2013. A family member noted that the resident had a swollen and bruised right thumb and raised a verbal concern to the identified staff. The family member never received a response to the complaint.

An interview with a family member of resident #076 revealed that the family member raised a concern to unit staff that cold water was sprayed to the resident during shower on one occasion. The family member never received a response to the complaint.

An interview with the identified staff, confirmed that no records were available about the investigation conducted for resident #075, and #076's incidents.

An interview with the ED confirmed that a response to complaints was not provided within ten business days. [s. 101. (1) 1.]

2. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: for those complaints that cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint is provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 is provided as soon as possible in the circumstances.

Interviews with family members of resident #075 and resident #076, confirmed that the home did not provide acknowledgment to their complaints within 10 business days.

A record review revealed that resident #075 was involved in an altercation with another resident at the beginning of 2013. A family member noted that the resident

had a swollen and bruised right thumb and raised a verbal concern to the identified staff. The family member never received an acknowledgment to the complaint within 10 business days.

An interview with a family member of resident #076 revealed that the family member raised a concern to unit staff that cold water was sprayed to the resident during shower on one occasion. The family member never received an acknowledgment to the complaint within 10 business days.

An interview with the identified staff, confirmed that no records were available about the investigation completed for residents #075 and #076's incidents.

An interview with the ED confirmed that acknowledgment of complaints were not provided to complainants within ten business days [s. 101. (1) 2.]

3. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: response is made to the person who made the complaint or the licensee believes the complaint to be unfounded will provide the reasons for the belief.

Interviews with the family members of resident #075 and resident #076, confirmed that the home did not provide responses indicating what the home have done to resolve their complaints.

A record review revealed that resident #075 was involved in an altercation with another resident in January, 2013. A family member noted that the resident had a swollen and bruised right thumb and raised a verbal concern to the DONC. The family member never received a response indicating what the home have done to resolve the complaints or the reasons why the home believed the complaint was unfounded.

An interview with a family member of resident #076 revealed that the family member raised a concern to unit staff that cold water was sprayed to the resident during shower on one occasion. The family member never received a response indicating what the home have done to resolve the complaints or the reasons why the home believed the complaint was unfounded.

An interview with the identified staff confirmed that no records were available about

the investigation investigations conducted for residents#075 and #076's complaints. [s. 101. (1) 3.]

4. The licensee failed to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

An interview with resident and family service coordinator confirmed that not all complaints that cannot be resolved in 24 hours were documented on the Client Service Response (CSR) form.
An interview with resident #209 confirmed that, in fall 2013 he/she complained about his/her missing parcel of new slippers delivered to the home. The resident's family ordered new slippers for the resident to be delivered to the home address. Home provided a record that the parcel was received by the home but it was never delivered to the resident.

A record review of the complaint log confirmed that there was no record of the resident's complaint. [s. 101. (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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with, to be implemented voluntarily.

WN #13: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the consent by the resident or if the resident is incapable, by the SDM for the use of the physical device to restrain is documented.

Interview with the private care giver and an identified staff confirmed that resident #0228 did use the bed side rails whenever resident is in bed for safety.
A record review confirmed that bed side rails were ordered by the physician in May, 2013. Interview with an identified staff confirmed that a consent given by the resident or the resident's SDM was not documented. [s. 110. (7) 4.]

2. On March 31, 2014 at 2:30 p.m. the inspector observed resident #012 was sitting in a wheelchair with a seat belt fastened.

Interview with the resident confirmed that the resident was not able to undo the fastened seat-belt.

Interview with an identified staff confirmed that the Fastex seat belt is applied to the resident whenever sitting in the wheelchair for his\her safety.
Record review confirmed that the Fastex seat belt was ordered by the physician in 2013. Staff interview and record review indicated that a consent from the resident or the resident's SDM was not documented. [s. 110. (7) 4.]

3. Interview with an identified staff indicated that two full size bed rails were applied for resident #001's safety.
Record review indicated that on May 2013 the physician ordered two full size bed rails to be applied for resident #001 when he\she is in bed. Staff interview and record review indicated the consent from the resident or resident's SDM was not documented. [s. 110. (7) 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 consent by the resident or if the resident is incapable, by the SDM for the use of the physical device to restrain is documented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure there is a designated staff member to co-ordinate the IPAC program with education and experience in infection prevention and control (IPAC) practices including cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

Interview with an identified staff indicated that the previous designated lead of the

IPAC program worked until December 2013. Until the role of lead of the IPAC program was assigned to a new employee, the role was shared between two identified staff. Interview with an identified staff indicated inability for a proof to be provided for the previous designated lead for the IPAC program in 2013 and the present staff who shared the role for the appropriate education in IPAC practices such as cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. [s. 229. (3)]

2. The licensee failed to ensure that the home's staff participates in the implementation of the infection prevention and control program.

Observation conducted on March 20, 2014, at 12:30 p.m., revealed that in the shared bathrooms for rooms # 2104, #2105, and #2074 the inspector found unlabeled personal care items (denture cup, tooth brush, shaving cream, and hair brush).

Observation conducted on March 24, 2014, at 11:30 a.m., on 3th floor unit revealed that an identified staff did not perform hand hygiene prior to administration of oral and subcutaneous medication, and did not use gloves when there was potential of coming in contact with bodily fluids (eye drops instillation). [s. 229. (4)]

3. Interview with identified nursing and environmental staff indicated that staff do not perform IPAC practices for contact precaution for resident #002 who is positive for an identified transmissible colonization.

Observation on 2nd floor unit revealed there were no practices in place for contact infection prevention precautions (IPP), such as sign on the door and personal protective equipment (PPE) accessible in place. [s. 229. (4)]

4. Observation conducted on March 24, 2014, indicated staff did not practice routine precautions before and after getting in contact with resident's environment according to PIDAC practices. It was observed that when a staff came in an identified room to offer a beverage to the resident, moved the table close to the resident, touched the newspaper, put the cup with the juice on the over-bed table and left the room without cleaning her hands. The hand sanitizer was located on the wall of the resident room.

Observation conducted on March 20, 2014, revealed in two shared washrooms non-labeled personal care items such as K-basin, pink basin, basket with personal care products, tooth paste and denture brush. [s. 229. (4)]

5. The licensee failed to ensure residents are offered immunizations against tetanus and diphtheria (TD) in accordance with the publicly funded immunization schedules posted on the Ministry website.

A record review revealed that resident #063 has signed a consent form at admission in 2011, for 2 step Mantoux test, influenza, pneumococcal vaccine and TD vaccine. She\he has not received the TD vaccine yet. Observation and interview with an identified satff confirmed that the tetanus and diphtheria vaccine is not available in the vaccination fridge and it is not offered to residents. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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 designated staff member who co-ordinates the infection prevention and control (IPAC) program has the education and experience in infection prevention and control (IPAC) practices, staff participate in the implementation of the infection prevention and control program, residents are offered immunizations against tetanus and diphtheria, to be implemented voluntarily.

WN #15: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Observation made on March 24, 2014, at 11:30 a.m. on an identified unit that an identified staff was observed administrating medications to resident #211. The staff took the medications into the resident's room and parked the medication cart along the opposite hallway outside the room. The computer was left on with residents' personal health information visible to anyone passing by.

Observation made on March 26, 2014, at 11:30 a.m. on an identified unit that another identified staff parked medication cart outside entrance to dining room and was not noted to be anywhere in the vicinity and the screen with residents' personal health information was visible to anyone passing by. [s. 3. (1) 11. iv.]

WN #16: 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 is maintained in a safe condition and in a good state of repair.

Observation conducted on March 20, 2014, at 12:10 p.m., revealed that the ceiling in one of the rooms, had a light panel, approximately four feet long, hanging down. Two of the brackets, holding the panel in place, were detached from the frame.

An interview with an identified staff confirmed that the panel should be secured within the frame and should not be hanging off the ceiling. [s. 15. (2) (c)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure resident #221 is bathed, at a minimum, twice a week by the method of his or her choice.

Interview with resident #221 indicated on an identified date in 2014, she\he was scheduled to have a bath but she\he was not offered one. Further, the resident stated that a staff told her because the home was short of staff they were not able to perform it and they would try the next day. The following day the bath was not offered again.

A review of the flow sheets and interview with identified staff confirmed the in an identified week in 2014, the resident did not have a bath, at a minimum, twice a week. [s. 33. (1)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure when the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), that within 10 days of receiving the advice, responds to the Family Council in writing.

An interview with a member of the Family Council confirmed that the home does not respond to the Family Council within ten days of receiving any concerns or recommendations advised by the Family Council.

An interview with the ED confirmed that home does not provide response in writing within ten days for any concern or recommendations advised by the Family Council. [s. 60. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

**s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).**

**s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).**

Findings/Faits saillants :

1. The licensee failed to ensure that standardized recipes as part of the planned menu are followed. A menu item was not prepared as planned and this can alter the flavour, nutrient value and the appearance of the planned menu.

In an interview with an identified staff confirmed that the standardized recipe for coleslaw vinaigrette was not followed. Mayonnaise was added in the recipe which is not listed in the ingredients.

A review of a standardized recipe for coleslaw vinaigrette revealed that mayonnaise is not listed in the ingredients list of the recipe.

Interview with an identified staff confirmed that the recipe has to be followed which is provided in the binder and changes in ingredients and in the preparation of the recipe are not allowed to be made. [s. 72. (2) (d)]

2. The licensee failed to ensure that the food production system, at a minimum, provides for, communication to residents and staff of any menu substitutions. Observation conducted on March 19, 2014, at lunch time, revealed that posted daily lunch menu indicated coleslaw vinaigrette and grapes but the residents were served sweet potato puffs and mango. The posted daily menu was changed after half of the lunch time was over.

Residents and staff interviews confirmed that usually posted food items on the menu board are not served at meal times and menu substitutions are not always communicated with the residents and staff. [s. 72. (2) (f)]

3. The licensee failed to ensure that the home has and that the staff of the home comply with, policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service.

A review of home's policy #LTCI005, titled Dish Machine Temperature, reviewed on May, 2012, revealed that dietary aide or designee has to measure dish washer wash cycle and final rinse temperatures in the morning and throughout the day and record on the dishwasher water temperature audit form. The unit manager has to review dish machine temperatures weekly and sign each document, if missing information is noted, corrective action needs to be completed immediately.

A review of the water temperature record for the kitchen dishwasher revealed that on March 2014, the temperature was recorded every day in the morning and throughout the day. The record was not reviewed or signed by FSM/Unit manager.

The Home's policy #LTCI028, titled Thermometer Calibration, reviewed on April, 2013, revealed that food thermometers are calibrated as necessary to ensure their accuracy. If the thermometer is not been able to calibrate at zero it must be discarded and replaced.

A review of the food temperature record, on March 19, 2014, at lunch time, indicated a documented temperature of four degrees for desserts. Interview with staff confirmed that the thermometer was not calibrated at 32 degrees Fahrenheit or zero degrees Celsius as per the policy prior to the measurement. [s. 72. (7) (a)]

WN #20: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.

An interview with the president of the Residents' Council confirmed that, home has not reviewed the meal and snack times with the Residents' Council.

An interview with an identified staff and review of Residents' Council meeting minutes confirmed that home has not reviewed meal and snack times with the Residents' Council in 2013 or 2012. [s. 73. (1) 2.]

2. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

An interview with an identified staff indicated that, residents on pureed texture should be fed with a tea spoon.

Observation made on March 19, 2014, at lunch time, revealed that resident #022 was fed pureed texture food with a big round table spoon.

An interview with an identified staff confirmed that tea spoons should be used for feeding residents who are on pureed texture and require feeding assistance to prevent the risk of aspiration. [s. 73. (1) 10.]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

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

8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79 (1), specifically failed to comply with the following: copies of the inspection reports from the past two years for the long-term care home.

Observation conducted on March 19, 2014, at 10:30 a.m., revealed that the bulletin board for posting MOHLTC inspection reports was located in the hallway of the main floor behind the front desk, in front of the administration offices. The bulletin board was observed to be inside locked glass cases with a note directing the public to go to reception desk to ask for a binder with inspection reports.

An interview with an identified staff revealed that the key for the bulletin board case was kept at reception which was opened from 7:30 a.m. to 7:30 p.m. every day. Beyond the reception's opening hours, the bulletin board case was not accessible to the public.

An interview with the receptionist confirmed that he\she did not have the key to open the cupboard where the binder with the inspection reports was kept. [s. 79. (1)]

2. Observation of the bulletin board indicated that not all inspection reports from the last two years were posted. [s. 79. (3) (k)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the home takes immediate action to deal with pests.

Interview with resident #221 on April 03, 2014, indicated that on an identified date in 2014 he/she observed flies around juice cups and food in the dining area. [s. 88. (2)]

2. The inspector observed fruit flies in the kitchen in the 4th floor dining room on three occasions in April 2014.

Interview with identified staff confirmed the presence of flies and that the environmental staff was not notified in order to initiate appropriate action. [s. 88. (2)]

WN #23: 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, and that is secure and locked.

Observation of the medication cart on March 26, 2014 at 10:45 a.m. on one of the units revealed that non-medication items including a cigarette lighter, one OHIP card, four hospital cards, and a wrist watch were found in the medication cart. Three access swipe cards, two visitor's identification cards, a resuscitation face mask and a pump were found in the narcotic box.

An interview with an identified staff confirmed that the above non-medication items should not be stored in
the medication cart or in the narcotic box. [s. 129. (1) (a)]

Issued on this 11th day of June, 2014

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