Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Dec 6, 2013	2013_105130_0039	H-000771-13	Resident Quality Inspection

Licensee/Titulaire de permis

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street, St. Catharines, ON, L2N-4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street, St. Catharines, ON, L2N-4J4

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

GILLIAN TRACEY (130), CAROL POLCZ (156), CATHIE ROBITAILLE (536), CATHY FEDIASH (214), LISA VINK (168), ROBIN MACKIE (511)

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): November 20, 21, 22, 25, 26 and 27, 2013

Please Note: This inspection was conducted simultaneously with the following inspection: H-000805-13.

During the course of the inspection, the inspector(s) spoke with Administrator, Controller, Admissions Manager, Pharmacist, Registered Staff, Resident Assessment Protocol (RAI) Coordinator, Personal Support Workers (PSW), Food Services Manager, dietary staff, activation staff, maintenance staff, residents and families.

During the course of the inspection, the inspector(s) Interviewed staff, residents and families, reviewed clinical records, business files, relevant policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident was restrained by a physical device that the device was used in accordance with any requirement provided for in the regulations.

a) The Manufacturer's Specifications for Seatbelt Applications, provided by the home, indicated the following; "for the use of belt application for proper positioning to be effective, any belt must be: not too loose to allow client to slide under belt, nor too tight to irritate bony prominences or soft tissue. (Just enough space for two fingers to fit between the belt and pelvic crest)." Although the Manufacturer's Specifications for Seatbelt Applications were not included in the home's policy for minimizing of restraints, the Administrator advised it was the expectation for staff to follow this directive. In 2013, residents #001, #002 and #003 were observed with loose seatbelts applied. All three residents were identified to be at risk for falls. Staff observed the belts and confirmed they were too loose. [s. 31. (3) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 did not ensure the residents' personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

a) During this inspection staff were observed disposing of empty medication pouches, which contained residents' personal health information, into the garbage bag attached to the medication cart. Staff confirmed this bag was then disposed of in the regular garbage. [s. 3. (1) 11. 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 the residents' personal health information within the meaning of the Personal Health Information Protection Act, 2004 is kept confidential in accordance with the Act, to be implemented voluntarily.

WN #3: 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 did not ensure that there was a written plan of care for each resident that set out, the planned care for the resident; the goals the care was intended to achieve; and clear direction to staff and others who provided direct care to the resident.

a) The plan of care for resident #580 did not include the use of bed rails. Interviews with the resident and front line staff confirmed that two bed rails were used as a Personal Assistance Services Device (PASD) for bed mobility. The plan of care did

not include a focus statement, goals or interventions for their use.

b) The kardex for resident #527 noted the behaviour of resistance to care, however, the plan of care did not include a focus statement of this identified need, goals nor directions for the provision of care. Registered staff confirmed on interview the resident demonstrated resistance to care and there was no plan of care in place.

c) The plan of care for resident #461 did not include all of the planned care, goals, nor directions to staff who provided direct care. The resident was continent of bowel functioning and had the presence of pain, which was well controlled with the intervention of routine analgesic. The plan of care did not include a focus statement for bowel functioning or pain management, which was confirmed during an interview with the RAI coordinator, who revised the plan on a specific date in 2013, to include these needs.

d) The plan of care for resident #567 did not include all of the planned care, goals, nor directions to staff who provided direct care in relation to bowel management. This information was confirmed by staff. [s. 6. (1)]

2. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

a) A review of continence assessments completed over a three month period in 2013 for resident #589 stated on one assessment they had occasional incontinence and another assessment stated they were continent. Interviews conducted with front line and registered staff confirmed that the resident was continent and that the assessments conflicted. [s. 6. (4) (a)]

3. The licensee did not ensure that the care set out in the plan was provided to the resident as specified in the plan.

a) The plan of care for resident #100 indicated the resident "required total assistance for dressing; staff to move limbs gently; do not rush; resident stiff and frail." On an identified date in 2013, the resident sustained an injury, while receiving care. According to the clinical record staff were adjusting clothing when the resident voiced complaints of discomfort. On another date in 2013, the resident sustained another minor injury while staff were removing their sweater. During the removal of the

sweater the resident stated "ouch", staff noted the area was bleeding. On a third occasion in 2013, the record indicated that staff "inadvertently scratched resident with fingernail". Resident had two centimeter (cm) linear scratch on left side of forehead. The record and staff interviewed confirmed the resident did not receive "gentle" care on these occasions. [s. 6. (7)]

4. The licensee did not ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

a) Resident #462 returned from hospital in 2013, with a specific care requirement. Staff confirmed bathing requirements, mobility status, transferring abilities and toileting requirements had changed, however, the plan was not revised to reflect these changes.

b) Resident #462 had skin breakdown during a specific time period in 2013. Staff interviewed confirmed the plan of care was not revised to reflect the affected areas until later in 2013.

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 there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care was intended to achieve; and clear direction to staff and others who provide direct care to the resident and that care is provided as specified in the plan of care, to be implemented voluntarily.

WN #4: 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 did not ensure the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

a) In 2013, the resident and staff communication response system was not easily used in rooms 323, 121 and 131. Inspectors were unable to activate the call bells at the bedside using the cord designed for this purpose and were only able to activate bells by pushing the wall panel. Discussion was held with the Administrator on November 20, 2013. On November 21, 2013, the necessary call bell cords were replaced. On November 25, 2013, the identified call bells were tested and found to be fully functional. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) Resident # 567 had identified open areas during a specific time period in 2013, registered staff confirmed the resident's skin was not assessed using a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

2. The licensee did not ensure that the resident who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds was reassessed weekly by a member of the registered nursing staff.

a) Resident #100 sustained a number of skin tears in 2013. Record review and staff interviewed confirmed that weekly skin assessments were not consistently completed during this period of time. [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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 wounds, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

a) According to the Residents' Council Minutes reviewed, the Administrator reviewed and signed the minutes, however, there was no record to indicate that advice related to concerns and recommendations made by the council were responded to in writing within 10 days. The Administrator confirmed this information was accurate. [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 the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns and recommendations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee did not ensure that all residents were monitored during meals, including residents eating in locations other than dining areas.

a) Resident #103 was served a tray in their room on a specific date in 2013. The resident was observed eating in their room without supervision; when the inspector spoke to the resident, they indicated that staff just drop the food off and do not stay. The plan of care for this resident indicated that supervision with eating was required related to a specific diagnosis.

b) On a specific date in 2013, resident #105 was observed with a tray in their room and was not monitored during the meal. The resident did not receive assistance for at

least seven minutes after the meal was delivered. The plan of care indicated constant encouragement and physical assistance remaining with resident during meals (extensive assistance) with eating. [s. 73. (1) 4.]

2. The licensee did not ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

a) During the observed lunch meal on November 22, 2013, cold food temperatures were found to be in the unsafe temperature zone at point of service. Coleslaw was on the counter in the servery and was probed at 55 degrees (Farenheight), minced coleslaw at 60F, and puree coleslaw at 62F.

b) On another specific date in 2013, resident #002 was in their room being fed by a family member who indicated that the food was cold. The family member indicated that the meal was cold upon arrival and was not palatable.

c) On another specific date in 2013, resident #104 received a tray in their room, however, had to wait for assistance until the staff member had finished feeding the roommate. The resident's meal was on the bedside table and when the staff member attempted to feed, the resident refused the meal. The inspector took the temperatures of the food and found the mashed potatoes to be proved at 117.5 degrees Fahrenheit (F), puree steak at 103 degrees F, puree vegetable at 95 degrees F and puree coleslaw was probed at 84 degrees F.

d) Residents' Council minutes indicated complaints about food temperatures. On February 7, 2013, residents indicated that they wanted a microwave in the dining room to reheat their food and drinks. The issue was brought up again the following month. On May 23, 2013, residents felt that the food was not coming out to the tables warm enough. The minutes also indicated that residents were inquiring about having two servers at meal times to help speed up service and keep food warm. [s. 73. (1) 6.]

3. The licensee did not ensure that residents were provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

a) The plan of care for resident #100 indicated staff were to ensure resident drinks their juice at snack time (family request). On a specific date in 2013, from approximately 1030-1200 hours, the resident had a glass of cranberry juice at the

bedside. Staff did not stay with the resident to ensure they had consumed all of the juice from the morning snack pass. Later that day, at the afternoon snack pass, the resident was observed in their room with the glass of juice still at the bedside. The staff entered the room but did not leave nourishment, nor did they assist or wake the resident to ensure that they had consumed the beverage. Staff were not in the room long enough to assist the resident.

b) On a specific date in 2013, at approximately 1040 hours, resident #205 was observed lying in bed. A plastic glass that contained apple juice with an enclosed lid and a straw was sitting on an over bed table which was approximately three feet away from the resident and not within reach. At approximately 1055 hours, the inspector confirmed two front line staff entered the room and provided care including changing of bed linens, for this resident. Immediately following staff exiting the room, the resident was observed with the glass of apple juice in their right hand. The resident was lying flat on their back in the bed, coughing and the straw inserted in the drink was resting on their cheek. The residents' chin and right side of the neck were wet with a sticky liquid substance. At approximately 1105 hours, the inspector asked a PSW to provide care to the resident immediately left resident's room and stopped and spoke with a PSW. The inspector asked the PSW to provide care to the resident. The PSW confirmed the resident was unable to consume fluids on their own. The resident did not receive assistance to consume the fluids. The plan of care for the resident indicated that the resident required total feeding assistance.

c) On a specific date in 2013, the morning beverage pass was observed on second floor. Resident #002 was observed with a full glass of fluid at the bedside at 1035 hours. The resident was not provided assistance in drinking as the glass was observed untouched at 1205 hours, by the inspector. The plan of care for this resident indicated they required total feeding assistance. Resident #701 was observed with a full glass of fluid at the bedside at 1035 hours. The resident was not provided assistance in drinking as the glass was observed untouched at 1205 hours by the inspector. The plan of care indicated they required supervision with minimal set up or assistance. [s. 73. (1) 9.]

4. The licensee did not ensure that residents who required assistance with eating or drinking were served a meal only when someone was available to provide the assistance.

a) On a specific date in 2013, resident #105 was observed with a tray in their room at

approximately 1215 hours. The resident did not receive assistance for approximately seven minutes with meal in front of the resident. The care plan for this resident indicated that the resident required constant encouragement and physical assistance remaining with resident during meals (extensive assistance) in eating.

b) On a specific date in 2013, resident #003 received a tray in the room, however, had to wait at least ten minutes for assistance until the staff member had finished feeding the resident's roommate. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum: monitoring of all residents during meals, food and fluids being served at a temperature that is both safe and palatable to residents and providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #8: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

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 did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, as per the home's policy.

a) Resident #589 was admitted in 2013, and did not receive their first step tuberculosis screening testing until sometime later in 2013.

b) Resident #201 was admitted in 2013, and did not receive their first step tuberculosis screening testing until sometime later in 2013.

2. The licensee did not ensure that residents were offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

a) According to the clinical records, residents #580, #561, #489 and #204 were not offered immunization against tetanus and diptheria. The Administrator confirmed that the home does not have a program in place to offer these immunizations.

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 each resident admitted to the home is screened for tuberculosis within 14 days of admission, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) According to the clinical record, resident #912 passed away in 2103. Registered staff interviewed in 2013, confirmed that not all assessments and interventions completed at the time of the resident's death, were documented.

b) In 2013, an incident occurred between a staff member and resident #580. Front line staff were aware the incident had upset the resident. Registered staff interviewed confirmed the situation was reported and that interventions were provided to support the resident. However, the Registered Practical Nurse (RPN) confirmed they failed to document the incident, including interventions and the resident's response to the interventions. [s. 30. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee did not ensure that they consulted regularly with the Residents' Council, at least every three months.

a) The Administrator did not attend any of the 2013 Residents' Council meetings. This information was confirmed by the minutes reviewed, the Administrator and current Council Chairperson. [s. 67.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks.

a) The plan of care for resident #513 identified a specific diet, however, the therapeutic menu did not include this therapeutic diet to provide clear direction for staff. Staff questioned in 2013, in the servery did not know which column to follow on the therapeutic menu for this resident. [s. 71. (1) (b)]

2. The licensee did not ensure that the menu cycle included alternate choices of entrees, vegetables and desserts at lunch and dinner for all diets.

a) On November 25, 2013, the menu for Week #3 Monday indicated a specific item was disallowed on a specific therapeutic diet. The cook confirmed that there was no alternative choice on the therapeutic menu and there was not a second choice of vegetable for this diet. On this date, the menu also indicated that another dessert item was disallowed but there was no alternative dessert choice indicated. [s. 71. (1) (c)]

3. The licensee did not ensure that the planned menu items were available and offered to the resident at each meal and snack.

a) The therapeutic menu indicated that a specific food item was to be provided for bedtime snack on Monday Week #3, for a specific therapeutic diet. Resident #513, was on this diet, however, a different food item was found at the bedside on November 26, 2013. It was confirmed with the Food Services Manager (FSM) that the resident did not receive the correct diet as per therapeutic menu for the snack the previous night. [s. 71. (4)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that menu items were prepared according to the planned menu.

a) Recipes were not always available or followed. A review of the therapeutic menu for Tuesday Week #3 revealed that the home did not have recipes for diluted chicken soup, pureed Spanish omelette, toast points, diet jello and buttered cabbage. This was confirmed by the FSM on November 27, 2013. The cook confirmed that production sheets were not always completed and recipes were not followed on Tuesday, November 26, 2013, for pork loin, beef, noodles, mashed potatoes, buttered cabbage, peas and gravy. Recipes did not always match the portion sizes listed on the therapeutic menu. For example, on Tuesday Week #3, the recipe indicated that a #8 scoop was to be used for minced pineapple, however, a #10 scoop was indicated on the therapeutic menu. The recipe indicated that a 5 ounce (oz) portion was to be provided for minced beef stroganoff, however, the therapeutic menu indicated a #10 scoop (3 oz) was to be used. [s. 72. (2) (d)]

WN #13: 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 did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

a) The Administrator confirmed the home has not sought the advice of Residents' Council in developing the satisfaction survey. [s. 85. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee did not ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

Staff confirmed the following stock observed in the storage room, exceeded their three month usage.
a) Acetaminophen 500mg, three cases of 12 units, b) Acetaminophen 325mg seven cases of 12 Units, c) fleet enema 58 containers d) 46 bottles of Sodium Cyclamate and e) 123 bottles of 350ml Almagel. [s. 124.]

WN #15: 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 did not ensure that drugs were stored in an area or a medication cart that was secure and locked

a) On observation the Registered staff on two occasions left the medication cart unattended and unlocked while distributing medication in the dining room. Registered staff confirmed the cart should be locked at all times.

b) On November 21, 2013, at 0910 hours, prescription creams, that were defined as a drug, were observed to be stored and left unattended in a woven basket on the care cart in the first floor hallway. Accessible creams included, Hydrocortisone ; Clotrimaderm ; Betaderm and Mometasone was left unattended. Registered staff confirmed that these drugs were to be secured and locked. [s. 129. (1) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

a) During this inspection it was observed a member of the maintenance team had a key and accessed the room where medication were stored. The Administrator confirmed the maintenance staff should not have access. [s. 130. 2.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee did not ensure that improvements made to accommodations, care, services, programs, and goods provided to the residents were communicated to the Residents' Council.

a) On November 22, 2013, the Administrator confirmed that improvements made to accommodations, care, services, programs, and goods provided to the residents were distributed to residents and families not directly to Residents' Council. [s. 228. 3.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee did not ensure that quarterly itemized statements were provided to the resident, or to a person acting on behalf of a resident with respect to money held by the licensee in trust for the resident.

a) Interview with the Controller confirmed that the home did not routinely provide quarterly itemized statements to residents or persons acting on their behalf, with respect to money held in trust by the licensee. Residents or persons acting on their behalf were able to request a balance or statement related to trust accounts and this information would be provided on request however statements were not provided on a quarterly basis. [s. 241. (7) (f)]

Issued on this 13th day of December, 2013

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN TRACEY (130), CAROL POLCZ (156), CATHIE ROBITAILLE (536), CATHY FEDIASH (214), LISA VINK (168), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2013_105130_0039
Log No. / Registre no:	H-000771-13
Type of Inspection / Genre d' inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 6, 2013
Licensee / Titulaire de permis :	BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED 600 Lake Street, St. Catharines, ON, L2N-4J4
LTC Home / Foyer de SLD :	HEIDEHOF LONG TERM CARE HOME 600 Lake Street, St. Catharines, ON, L2N-4J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ELENA CADDIS

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations;
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations;
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;
(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2);
(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):
(i) an alternative to restraining, or
(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; and
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Order / Ordre :

The licensee shall apply physical devices on all residents, including those observed on residents #001, #002, #003, in accordance with the manufacturers specifications.

Grounds / Motifs :

1. s. 31. (3) (a) The licensee did not ensure that when a resident was restrained by a physical device that the device was used in accordance with any requirement provided for in the regulations.

a) The Manufacturer's Specifications for Seatbelt Applications, provided by the home, indicated the following; for the use of belt application for proper positioning to be effective, any belt must be: not too loose to allow client to slide under belt, nor too tight to irritate bony prominences or soft tissue. (Just enough space for two fingers to fit between the belt and pelvic crest). Although the Manufacturer's Specifications for Seatbelt Applications were not included in the home's policy for minimizing of restraints, the Administrator advised it was the expectation for staff to follow this directive. In 2013, residents #001, #002 and #003 were observed with loose seatbelts applied. All three residents were identified to be at risk for falls. Staff observed the belts and confirmed they were too loose.

O (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu' il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of December, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : GILLIAN TRACEY

Service Area Office / Bureau régional de services : Hamilton Service Area Office