Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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
Jul 18, 2014	2014_267528_0024	H-000811-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF NORFOLK COUNTY
50 Colborne Street South, SIMCOE, ON, N3Y-3H3

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

NORVIEW LODGE
44 ROB BLAKE WAY, P. O. BOX 604, SIMCOE, ON, N3Y-4L8

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

CYNTHIA DITOMASSO (528), CATHY FEDIASH (214), JENNIFER ROBERTS (582), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 2, 3, 4, 8, 9, 10, 11, 2014

This inspection was done concurrently with Critical Incident Inspection log #'s H-000404-14, H-000241-14, H-000830-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care(DON), Resident Care Coordinators(RCC), Programs/Volunteer Supervisor, Nutritional Services Supervisor, Facilities Supervisor Supervisor, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian(RD), Dietary Aides, registered nurses (RN), personal support workers(PSW), housekeeping, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, reviewed documents limited but not included to menus and production sheets, staffing schedules, policies and procedures, clinical health records, and meeting minutes.

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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 that every residents' 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.

Throughout the course of the inspection, observed registered staff throw medication packages in the general garbage. Registered staff confirmed that medication packages, which contained residents' names and medication regimes, were discarded with the general garbage and not disposed of in a manner which would protect the residents' personal health information. [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 that every residents' 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A. Resident #12 was noted to require assistance with activities of daily living. The

document the home refers to as the care plan indicated that the resident required extensive assistance of one staff member throughout the day and night with toileting. The monthly PSW Resident Information Sheet indicated that the resident required two staff members for extensive assistance with toileting and possible a lift as needed. In July 2014, the resident was observed to toilet themself after lunch, no staff assistance was provided. Interview with regular direct care staff confirmed that the resident sometimes self toilets and will call for assistance as necessary. Interview with registered staff confirmed that the plan of care for the resident did not provide clear direction to staff related to the level of assistance required with toileting. [s. 6. (1) (c)]

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

A. In November 2013, resident #12 presented with increasing cough and shortness of breath and, as a result, was diagnosed with an upper respiratory infection. The Resident Assessment Protocol (RAP) related to infection from December 2013, indicated that the resident was responding to ongoing care plan interventions related to the existing respiratory infection from the previous quarter. Review of the plan of care did not include a respiratory infection in both quarters. Interview with the Resident Assessment Instrument(RAI) Coordinator confirmed that the upper respiratory infection from November 2013 was not an existing issue from the previous quarter, and therefore, the RAPS was not consistent with the assessment and diagnosis by the physician. [s. 6. (4) (a)]

B. Resident #13 was noted to be occasionally continent of bladder, requiring incontinent products provided by the home as well as extensive assistance. The documents the home refers to as the care plan indicated that the resident was aware of appropriate place and time to void, however required extensive assistance with toileting including two staff members present with lift. The care plan also identified that the resident wore pull up type incontinent products in the day and a liner type product at night. The RAPS from January 2014 to present indicated that the resident wore pull up products 24 hours a day and that the resident was being toileted on a routine. Interview with registered staff confirmed that the care plan was consistent with the residents assessed needs, however the RAPS from January 2014 was not consistent with the care plan. [s. 6. (4) (a)]

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

The plan of care for resident #70 from April 2014, indicated that the resident had high risk behaviours, related to chronic pain. As a result, the document the home refers to as the care plan instructed staff to observe the resident swallowing all narcotic medications. In June 2014, registered staff found two medications cups filled with microspheres from narcotic capsules. It was noted in the clinical record that according to the pharmacist, the microspheres found in the resident's room equaled to approximately seven to nine dosages of the prescribed medication, potentially lethal if injected. Interview with the Director of Nursing (DON) and Resident Care Coordinator (RCC) confirmed that the resident was pocketing the medication in their mouth upon administration and later emptied the contents of the capsules into medication cups. The RCC confirmed that at the time of the incident the care plan directed staff to ensure that the resident had swallowed all narcotics upon administration. The registered staff did not ensure that the resident swallowed the medication as outlined in the plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A. According to the plan of care and observations, residents #11 and #12 required two half bed rails in the raised position when in bed for security and to aid positioning. Review of the clinical health record did not include an assessment of the bed rails being used. Interview with the Director of Care confirmed that no formalized assessment was completed for the bed rails. (582) [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize the risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

A. During a tour of the home in July 2014, it was identified in one home area's spa room that individual plastic blue caddy's with white lids, which the home refers to as tub caddy's, contained resident's fingernail and toe nail clippers, nail files, orange sticks and personal grooming items such as hair combs and hair brushes. It was observed on three dates in July 2014, that resident's #50, #51 and #52's tub caddy contained nail clippings located on the bottom of their tub caddy. An interview with registered staff confirmed that the resident's tub caddy should not contain nail clippings and that the tub caddy was to be cleaned weekly as per the cleaning schedule that is followed for assisstive devices cleaning and any other time the caddy requires cleaning. An interview with the Resident Care Coordinator, who also monitors the Infection Prevention and Control Program, indicated that nail clippings should not be in the resident's tub caddy and that the resident's tub caddy was to be cleaned on the resident's bath day.

B. During a tour of the home in July 2014, it was identified in four out of eight of the home area's spa rooms that several containers of petroleum jelly, Vitarub and Infazinc were located on the counter of each of these spa rooms. The containers were not labeled with resident names, however opened and used. An interview conducted with the Resident Care Coordinator confirmed that as per the home's expectations, the containers of petroleum jelly, Vitarub and Infazinc were to be labeled with the resident's name and used for individual use only. [s. 229. (4)]

2. The licensee did not ensure that the staff participated in the implementation of the

infection prevention and control program.

The home's Policy "HSS/NVL: Infection Control - Hand Hygiene Program", indicated that staff are to complete hand hygiene before initial resident or resident environment contact, before aseptic procedures, after body fluid exposure risk, and after resident or resident environment contact.

In July 2014, Inspector observed medication administration on one home area from 7:30 to 8:01 hours. Registered staff administered medications to nine different residents, including oral medications and two subcutaneous injections, as well as, assisted residents to the dining room for breakfast. Hand hygiene was not completed by staff at any time during the observation. [s. 229. (4)]

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

A. A review of the clinical record for resident #32 revealed that the resident's tuberculosis screening was initiated 28 days after admission to the home and no previous documented results of immunization records were available to the home. An interview conducted with registered staff confirmed that the resident was not screened for tuberculosis within 14 days of admission. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infections and prevention and control program, related to hand hygiene, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. A review of the home's policy, Skin and Wound Care Program (NSS/NVL and dated May 18, 2013) identified responsibilities of the registered staff when a resident was identified with altered skin integrity or with a pressure ulcer. The responsibilities however, did not include the requirement listed in the Ontario Regulation 79/10 s. 50 (2)(b)(iii), that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home. An interview conducted with the DON and the RCC, confirmed that home's policy was not in compliance with the applicable requirements under the Regulations. [s. 8. (1) (a)]

2. The licensee did not ensure that any plan, policy protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home's policy, Responsive Behaviour Management Through Gentle Persuasive Approaches (HSS/NVL, and dated May 23, 2013) indicated that incidents of responsive behaviour were to be documented on an Internal Incident Report and the resident's notes in Goldcare.

A review of resident #10's clinical record indicated that the resident demonstrated responsive behaviours that included repeatedly pulling the call bell, yelling, scratching, swearing, and name calling toward staff during personal care in June 2014. An interview with the Director of Care and Resident Care Coordinator, confirmed that an Internal Incident Report had not been completed for the above incidents of responsive behaviour and that the home's policy had not been complied with.

B. The home's policy, Food Temperature (HSS/NVL NSE 1.9), indicated that the temperature of foods shall be taken just before serving (holding temperature) to ensure hot foods are served to residents at a minimum of 60 degrees Celsius/140 degrees Fahrenheit and cold foods at a maximum of 4 degrees Celsius/39 degrees Fahrenheit.

The home has four dining rooms in which the lunch meal service commenced at 12:00 hours and four dining rooms in which the lunch meal service commences at 12:15 hours. In July 2014, it was observed in four dining rooms, that the 1215 hour lunch meal service had commenced and no temperatures had been taken of the foods, just before serving. Interview conducted with the dietary aides on all four units confirmed that temperatures of the foods are taken just prior to serving at the 12:00 hour lunch meal service, but that temperatures of foods are not taken just prior to serving at the 12:15 hour lunch meal service. An interview with the Nutritional Services Supervisor confirmed that the temperatures of the foods are not obtained just before the 1215 hour lunch service as the temperature log sheet is designed to only record the first lunch meal service; that the temperatures of the food should be obtained just prior to serving at all lunch meal services and that the home did not comply with their policy.

C. The home's policy, Fall Prevention and Management Program (HSS/NVL, and dated June 17, 2013) indicated that residents identified as a high falls risk would be offered hip protectors as one of the interventions/strategies to minimize injury.

Resident #53 sustained a fall in January 2014, and a fall risk assessment completed at this time, identified the resident as a high falls risk. A review of this resident's clinical record and confirmed with the Resident Care Coordinator identified that the offer to implement hip protectors had not been done as required by the home's policy.

D. The home's policy, Pain Management Program (HSS/NVL and dated April 25, 2014) indicated the following:
- A Comprehensive Pain Assessment Tool is completed on admission, quarterly, annually and with any significant change during the 7 day observation period and when pain is indicated or observed with the Comprehensive Pain Assessment, a Pain Treatment Flow Sheet will be initiated.
- For routine analgesia administration a numerical rating scale of 0-10 or a facial expression scale of A-F, will be used to describe the level of pain. A corresponding number or letter will be noted with each routine administration of pain medication in

the electronic medication administration record (eMAR) notes. If the residents pain is greater than a three, or greater than a B at routine administration times a follow up pain assessment note is required in the eMAR notes.

i. MDS coding under Section J: Health Conditions from April 2014, indicated that resident #10 exhibited pain less than daily and that their pain intensity was moderate. A review of the resident's Comprehensive Pain Assessment completed in April 2014, identified that the resident had experienced pain in the last seven days and also indicated a "no" response to the question, "Was Pain Flow sheet initiated if: pain is indicated now or in the last seven days"? A review of this resident's eMAR notes indicated that in June 2014 a pain level of C was documented and in July 2014 a pain level of D was documented. A review of the resident's follow up pain assessment notes indicated that no follow up notes were completed. An interview with the RAI Coordinator and the Resident Care Coordinator confirmed that the resident had experienced pain during the observation period as indicated by the Comprehensive Pain Assessment and that no Pain Treatment Flow Sheet had been initiated and that no follow up pain assessment notes were completed when the resident's pain level was identified as greater than a B with their routine administration of pain medication, as required by the home's policy.

ii. MDS coding under Section J: Health Conditions from July, 2013 to present, indicated that resident #13 was noted to be receiving routine analgesia for daily moderate pain. The eMAR from May 2014 to present indicated that the resident rated pain greater than four out of ten prior to routine analgesia administration, approximately 26 times. The eMAR notes did not include documentation of the resident's response and effectiveness of the medication approximately 50 percent of the time. Interview with the RAI Coordinator confirmed that the residents response and effectiveness of the medications was not documented regularly. [s. 8. (1) (b)]

WN #6: 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 that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

A. Observations conducted in July 2014, revealed that three out of eight bath/tub lift chairs in the home had worn surfaces and discolouration in the area of the lift where residents would be seated. In July 2014, two staff members, on behalf of facilities services, confirmed that one bath/tub lift was quite worn and in need of replacement. The Administrator of the home indicated that there was a plan to replace the lift this year. [s. 15. (2) (c)]

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 did not ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who is a member of the staff of the home.

A review of resident #19's clinical record indicated the following incidents of alteration in their skin integrity:

A. On February 2, 2014, the resident sustained three skin tears to their left elbow. A review of their Skin Integrity Issues/Non Pressure Wounds Documentation Sheet identified that the section inquiring if the dietitian was notified, was blank and not completed.

B. On May 5, 2014, the resident sustained a skin tear to their right arm. A review of their Skin Integrity Issues/Non Pressure Wounds Documentation Sheet identified that the section inquiring if the dietitian was notified, was blank and not completed.

C. On May 21, 2014, the resident sustained a skin tear to their left arm, near their elbow. A review of their Skin Integrity Issues/Non Pressure Wounds Documentation Sheet identified that the section inquiring if the dietitian was notified, was blank and not completed.

D. On May 24, 2014, the resident sustained a skin tear to the top of their left hand. A review of their Skin Integrity Issues/Non Pressure Wounds Documentation Sheet identified that the section inquiring if the dietitian was notified, was blank and not completed.

An interview with the Nutritional Services Supervisor and the Registered Dietitian indicated that referrals to the dietitian were completed through electronic mail and that no referrals had been received for the incidents of altered skin integrity listed above and as a result, the resident was not assessed by a Registered Dietitian. [s. 50. (2) (b) (iii)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of resident #10's clinical record indicated that the resident demonstrated known responsive behaviours that included yelling, screaming, swearing, crying, striking out at staff and resistance to care.

A. According to the resident's progress notes, in June 2014, the resident demonstrated responsive behaviours of speaking very loudly, scratching, swearing and name calling toward staff during personal care. Registered staff documented that they would continue to monitor the resident, however, no documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

B. According to the resident's progress notes, in June 2014, the resident began yelling loudly and requested to be repositioned. Registered staff documented that the resident was repositioned, had continence care provided and that their bowel routine was initiated, however, no documentation was included regarding the resident's responses to the interventions provided.

C. According to the resident's progress notes, in June 2014, the resident rang their call bell, for approximately one hour, with requests to be repositioned and asking for their personal items and that the resident appeared to be sleeping when checked on the hourly safety rounds, however, no documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

An interview with the Director of Care and Resident Care Coordinator confirmed that documentation was not completed regarding actions taken to respond to the needs of the resident or the resident's response to any interventions that were implemented, for the incident's noted above. [s. 53. (4) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Findings/Faits saillants :

1. The licensee did not ensure the Ontario Menu Spring/Summer 2014 provided a variety of foods, including fresh and seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time.

A review of the Ontario Spring/Summer 2014 menu, 21 day cycle revealed the same type of potato side dish was offered first and second choice at dinner 13 times. For example, parsley potatoes were the side dish at dinner, Friday week one, for both entrées and paprika potatoes were the side dish at dinner, Thursday week 2 for both entrees. In total a form of potatoes was the available side dish on the dinner menu 35 times out of a possible 42 choices . An interview with the Registered Dietitian confirmed the dinner entrees did not provide a variety of foods in the 21 day cycle. [s. 71. (2) (b)]

Issued on this 7th day of August, 2014

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