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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2015	2015_337581_0021	032471-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
99 Wayne Gretzky Parkway BRANTFORD ON N3S 6T6

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

ST JOSEPH'S LIFECARE CENTRE
99 WAYNE GRETZKY PARKWAY BRANTFORD ON N3S 6T6

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585)

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 25, 26, 27, 30, December 1, 2, 3 and 4, 2015.

This inspection was done concurrently with Complaint Inspection Log #’s 028928-15 and 021506-15 related to responsive behaviours and personal support services and Critical Incident System (CIS) Log #'s 008013-14, 017393-15, related to falls management and CIS Log # 026469-15, related to responsive behaviours.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes and clinical health records.

During the course of the inspection, the inspector(s) spoke with the President, Directors of Care (DOC), Director of Finance and Business Services, Registered Nurse (RN), Regular Practical Nurse (RPN), RAI Coordinator, Personal Support Worker (PSW), Program Manager, Registered Dietitian (RD), Manager of Nutrition and Support Services, Dietary staff, Maintenance Staff, Laundry Staff, Restorative Coaches, Receptionist, residents and families.

The following Inspection Protocols were used during this inspection:

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
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **17 WN(s)**
- **8 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

During the course of the inspection, resident #009 was observed sitting in their wheelchair with a front fastening seat belt, which the resident could release independently. Interview with PSW #106 identified that the resident wanted to wear the seat belt daily and was able to physically release the belt. Review of the plan of care did not include any documentation for the application of the front fastening seat belt. Interview with registered staff #121 confirmed that the resident wore the belt daily and therefore should be included in the plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the staff and others involved in the different aspects

of care of the resident collaborated with each other, in the assessment of the resident so their assessments were integrated and were consistent and complemented each other.

A. Review of the MDS assessment in August 2015, indicated resident #012 was frequently incontinent of bladder, the MDS assessment in November 2015, revealed they were incontinent of bladder and there was no change in their urinary continence. Review of the written plan of care indicated the resident was frequently incontinent of bladder. Interview with the RAI Coordinator confirmed the resident was incontinent of urine, there was a change in their urinary continence between quarterly assessments and their assessments and written plan of care did not collaborate or complement each other.

B. Review of MDS assessment in November 2015, indicated resident #012's vision was moderately impaired with limited vision, not able to see newspaper headlines but could identify objects and did not wear glasses. Review of the Resident Assessment Protocol (RAPS) in November 2015, indicated the resident's vision was moderately impaired and object identification was in question, but their eyes appeared to follow objects. The written plan of care revealed their vision was highly impaired; their ability to identify objects was in question but their eyes appeared to follow objects. Interview with registered staff #103 stated the resident had impaired vision and the MDS assessment and the written plan of care did not complement each other as well as the RAPS indicated they were moderately impaired but included the definition of being highly impaired. Registered staff #103 confirmed that both assessments and the written plan of care did not collaborate with each other related to the resident's vision. [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident was assessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

A. Review of resident #004's written plan of care indicated they were transferred in and out of bed and toileted with a tempo lift and two staff assistance. Interview with PSW #104 stated they were transferred in and out of bed with a ceiling lift and were transferred on and off the toilet with the sit and stand lift. Interview with registered staff #125 confirmed that the resident was no longer using the tempo lift for transfers and that the care plan was not revised when their transferring needs changed.

B. Review of resident #005's written plan of care indicated they wore a medium brief. Interview with PSW #114 and review of the Resident Profile Worksheet indicated the resident wore a liner on days and evenings shifts and a medium brief at night.

Registered staff confirmed that the resident wore a liner on days and evenings and the written plan of care was not updated to include the continence care product the resident required on all shifts.

C. Review of resident #005's written plan of care indicated under sleep and rest pattern they preferred to get up at 0800 hours. During the course of this inspection the resident was observed in bed until after 0930 hours. Interview with PSW #114 stated the resident liked to sleep in and did not get up until approximately 0930 hours. Registered staff #127 confirmed that the resident preferred to sleep in, received breakfast mid morning and the written plan of care was not updated related to the resident's sleep preference in the morning. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so their assessments are integrated and are consistent and complemented each other and the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 was complied with.

A. On November 25, 2015, at 0940 hours, in the Hummingbird dining room, an unlabeled plastic container was observed in the nourishment refrigerator. The container contained white semi-solid food item with black spots that appeared to be mold. A sign on the fridge stated residents' items were to be labeled. At 1500 hours, PSW #141 confirmed the presence of the unlabeled food item and that it appeared spoiled. The Food Services Supervisor confirmed the home's procedure for the storage of residents' food items included labeling and dating to ensure that food items remained safe.

B. A review of the "Head Injury Routine, Policy No: 5-RS-270, revised on June 2015, directed registered staff to complete a Head Injury Routine (HIR) for all residents with evidence of a head injury and the HIR would be monitored every hour for the first four hours and then every four hours for the next twenty hours post fall.

On November 14, 2015, resident #010 sustained an unwitnessed fall in their room and reported to registered staff they hit their head. Review of the plan of care indicated that a HIR was initiated on November 14, 2015, but was not completed. Interview with registered staff #102 confirmed the HIR was not completed post fall according to the home's policy.(581)

C. On August 17, and June 25, 2015, resident #004 sustained two un-witnessed falls and hit their head according to the progress notes. Review of the plan of care indicated that a HIR on August 17, 2015 was initiated post fall but was not completed and there was no HIR documented on the Glasgow Coma Scale (GSC) form post fall on June 25, 2015. Interview with registered staff #125 confirmed that the HIR was not completed according to the home's policy after the resident fell on August 17, 2015 and there was no HIR documented on the GCS form post fall on June 25, 2015. (581) [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, 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 failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A. On December 1 and 2, 2015, resident #005 was observed in bed with two half bed rails raised. Review of the written plan of care, interviews with registered staff #120 and PSW #114 revealed the resident required two half bed rails raised when in bed for positioning and bed mobility. A review of the resident's plan of care did not include an assessment of the bed rails being used. Registered staff #102 and registered staff #120 confirmed that the home did not have a formalized assessment for the use of bed rails in place when the bed rails were smaller than three quarters in length.

B. On November 30, 2015, resident #002 was observed laying in bed with two half bed rails raised. Interview with registered staff #100 confirmed that the resident used half rails daily when in bed. Review of the plan of care did not include an assessment of the resident's use of the bed rails. Interview with registered staff #102 confirmed that bed rail assessments were not completed for half bed rails. (528) [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 when bed rails are used, 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living would be included in a resident's plan of care only if all of the following were satisfied:

1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #005 was observed in bed on December 1 and 2, 2015, with two half bed rails raised. Review of the clinical record indicated that there was no assessment completed to determine the reason for the use of the bed rails, nor any documented consent or approvals for its use. Registered staff #120 confirmed that the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint nor did they have documented consent or approval for the bed rails in place. [s. 33. (4)]

2. The licensee failed to ensure that the use of a PASD under subsection (3) that assisted a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A. On November 25, 2015, resident #002 was observed sitting in a tilted wheelchair. The written care plan identified that the tilt wheelchair was used to increase the resident's ability to engage in activities of daily living. A progress note from January 2015, documented that a message was left for the substitute decision-maker (SDM) notifying them that their consent was needed to be signed for the use of the tilt wheelchair; however, there was no consent noted at the time of the inspection. Interview with staff #100 confirmed that the consent was not included in the plan of care. [s. 33. (4) 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 the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living is included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD has been considered and tried where appropriate.
3. The use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #5: 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 a resident had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument.

A review of the "Elder Care Fall Prevention and Management, Policy No: 5-RS-281", revised on August 2015, directed registered staff to complete a Post Fall Assessment and a Fall Risk Assessment after every fall in Point Click Care (PCC).

A. In August 2015, resident #004 sustained an unwitnessed fall in their room. Review of the plan of care indicated that the Post Fall Assessment and Fall Risk Assessment were not completed post fall. Interview with registered staff #126 confirmed that both falls assessments were not completed after the resident fell using a clinically appropriate assessment.

B. In November 2015, resident #010 sustained an unwitnessed fall in their room. Review of the plan of care indicated that the Post Fall Assessment and Fall Risk Assessment were not completed post fall. Interview with registered staff #125 confirmed that the falls assessments were to be documented in PCC post falls and were not completed using the home's clinically appropriate assessment. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and a post-fall assessment is conducted using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.

Over the course of the inspection, puree food items were observed runny.

i. On November 25, 2015, during lunch on Bluebird Terrace, puree tomato and chicken balls appeared runny, pooling out on divided plates, as well as puree sunrise vegetables which had fluid separating from the portioned served. The items also poured off of the serving scoop. Dietary staff #143 confirmed the chicken appeared runny.

ii. On December 1, 2015, during lunch on Lilac Lane, puree sandwich, bean salad and mixed hot vegetable appeared runny, pooling out on divided plates. The sandwich was noted to pour off a spoon. Dietary aide #143 reported puree foods were to be served at a mousse consistency.

iii. In the kitchen, dietary staff #144 and dietary staff #145 reported in interviews that puree items were prepared a day in advance and not always thickened to the mousse consistency as their texture would change overnight, in addition to chilling and heating, affecting the food quality and appearance. Both reported they did not follow the recipes provided as they did not support them in achieving a desired consistency.

iv. During meal service, puree meals were observed served in divided plates. Dietary staff #146 reported divided plates were used to prevent food from running together; at times, puree items required texture modification before meals to adjust the consistency after heating; and there was no written direction on how achieve an appropriate consistency.

The Manager of Nutrition and Support Services confirmed that dietary aides had to assess and thicken puree items at meals as required, that puree food should not be runny, and confirmed the home had challenges achieving appropriate puree consistencies as food was prepared in advance. [s. 72. (3) (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 all food and fluids in the food production system are prepared, stored and served using methods to, preserve taste, nutritive value, appearance and food quality, 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: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

A. On November 25, 2015, during lunch service resident #061 and resident #062 were observed with their main course and dessert served together. PSW #130 assisting resident #061 and PSW #131 assisting resident #062 reported they were unsure why the residents were served courses together.

B. On December 2, 2015, during lunch in the dining room, resident #061, resident #063, resident #064 and resident #065 were observed with their main courses and desserts served together. PSW #132 distributing desserts stated the residents were not served by course as they did not have enough time to wait for them to finish their main dish. The Registered Dietitian reported meals should be served course by course and confirmed the identified residents were not assessed to receive their courses together. [s. 73. (1) 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 meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act was applied by staff in accordance with any manufacturer's instructions.

On November 25, 2015 at 1040 hours, resident #066 was observed with a front fastening seat belt applied, four to five finger widths from their torso. The resident was unable to unfasten the belt when asked by the inspector. PSW #140 stated the belt appeared loose but did not know how it was to be applied. Registered staff #106 reported the belt was used for positioning and did not know how it was to be applied. Registered staff #135 reported their was no specific manufacturer's instructions for the belt; however, based on the description, confirmed it was too loose. [s. 111. (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 a PASD used under section 33 of the Act is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #9: 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 that the rights of residents to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act, were fully respected and promoted.

A. During a medication administration observation on December 3, 2015, registered staff #127 discarded medication packages into the medication cart waste bin. The medication packages contained personal health information including residents' names, medications, dosages and times of medication administration. Interviews with registered staff #125 and registered staff #127 identified that they tried to tear packages open by removing the names of the residents; however, confirmed that this was not done every time. Registered staff #127 confirmed that the waste bin was emptied by housekeeping and added to the general garbage. [s. 3. (1) 11. iv.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas would be equipped with locks to restrict unsupervised access to those areas by residents, and those doors would be kept closed and locked when they were not being supervised by staff.

During an initial tour of the home on November 25, 2015, the following doors to non-resident areas were observed to be unlocked:

i. The staff washroom, room N240 was unlocked and was not equipped with a resident to staff communication system. Interview with PSW #122 confirmed the bathroom was for staff use only, was unlocked and should have been kept locked when not in use.

ii. The staff washroom, room S342 was unlocked and was not equipped with a resident to staff communication system. Interview with support services staff #123 confirmed that the bathroom was for staff use only, was unlocked and should have been kept locked when not in use.

Additionally, on November 30, 2015, the staff washroom on Oriole Ave was unlocked and was not equipped with a resident to staff communication system. Interview with PSW #124 confirmed that the bathroom was for staff use only, was unlocked and should have been kept locked when not in use. [s. 9. (1) 2.]

WN #11: 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 failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #008 had a respiratory condition and had an order to receive an identified treatment on an unspecified day in June 2015 and to monitor the effects of the treatment. At the time of this inspection, the resident's plan of care indicated staff were to document their treatment. Review of the resident's monitoring sheets revealed there was no documentation that recorded the treatment since an unspecified day in July 2015. Interview with registered staff #137 reported staff monitored each shift but did not document. [s. 30. (2)]

WN #12: 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 that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In January 2015, resident #009 was admitted to the home with an area of skin breakdown. Progress notes identified that in November 2015, registered staff documented the wound was improving. Review of the plan of care did not include an assessment of the wound at least weekly, as follows:

i. In January 2015, one weekly assessment was not completed.
ii. In February 2015, three weekly assessments were not completed.
iii. In March 2015, two weekly assessments were not completed.
iv. In May 2015, two weekly assessments were not completed.
v. In June 2015, three weekly assessments were not completed.

Interview with registered staff #131 confirmed that the above weekly skin assessments were not completed as required. [s. 50. (2) (b) (iv)]

WN #13: 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 failed to ensure that for each resident who demonstrated responsive behaviours, 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. As a result of increased responsive behaviours displayed by resident #024 to staff and co-residents, dementia observation system (DOS) assessment was initiated to monitor the resident every 15 minutes in October 20, 2015. Upon review of the documentation, the DOS assessment was not consistently documented every 15 minutes on the following dates:

i. On October 29, 2015, for twenty one hours.
ii. On October 30, 2015, for fourteen hours.
iii. On October 31, 2015, for six hours.
iv. On November 1, 2015, for seventeen hours.
v. On November 2, 2015, for fourteen hours.
vi. On November 3, 2015, for six hours.
vii. On November 4, 2015, for fifteen hours.
viii. On November 6, 2015, for fourteen hours.
xi. On November 9, 2015, for eight hours.
x. On November 28, 2015, for fifteen hours.
xi. On November 30, 2015, for three hours.
xii. On December 1, 2015, for nine hours.

Interview with registered staff #135 confirmed that staff were not documenting the resident's behaviours every 15 minutes, as required. Interview with registered staff #108 confirmed DOS charting continues.

B. In September 2014, DOS charting was initiated for resident #021. The plan of care for the resident identified that the resident had ongoing responsive behaviours that were unpredictable and was followed by the Geriatric Outreach team. For approximately one month, staff documented the residents behaviour using DOS; however, behaviours were not documented on the following dates;

i. On October 10, 2015 for 10 hours
ii. On October 14, 2014 for 10 hours.
iii. On October 17, 2014 for sixteen hours.

Interview with registered staff #102 and staff #105 confirmed that the DOS observations were not consistently documented by staff. [s. 53. (4) (c)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The plan of care for resident #024 identified that the resident displayed responsive behaviours. Interventions included, but were not limited to, redirection or distraction of the resident, to set limits of behaviours and ongoing medication changes. Review of the progress notes indicated that between June to November 2015, the resident displayed identified behaviours towards co-residents and staff.

Interview with RPN #108 confirmed that the residents behaviours continued in June, October and November 2015, despite interventions in place. Therefore, co-residents risk of altercations from resident #024 remained and further interventions were not developed to minimize the ongoing risk between and among residents. [s. 55. (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On December 2, 2015, during lunch service, pudding and apple sauce were on the planned menu for dessert. At the end of lunch, resident #060 was observed still eating their main course. When the resident finished, PSW #128 removed their plate and began to porter them away from the table. PSW #128 confirmed the resident was not offered dessert and proceeded to locate dessert. The PSW returned with pudding, which was not on the planned menu. Dietary aide #129 confirmed they did not offer the two planned dessert items. [s. 71. (4)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council and Family Council in developing and carrying out the satisfaction survey.

A. Review of the Residents' Council minutes from January 2 to November 13, 2015 and interview with the Resident Council President revealed that the residents' council did not have input in developing and carrying out the satisfaction survey. This was confirmed by the Program Manager.

B. Review of the Family Council minutes from January 14 to November 17, 2015 and interview with the Family Council President revealed that the family council did not have input in developing and carrying out the satisfaction survey. This was confirmed by the Program Manager. [s. 85. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On November 25, 2015, at approximately 1015 hours, a door adjacent to the entrance of the Magnolia home area was found unlocked with drain cleaner, air freshener, and sealant paint present. Labels on the items indicated they contained hazardous substances. Maintenance staff #138 confirmed the door was to be locked at all times. [s. 91.]

Issued on this 30th day of December, 2015

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

Original report signed by the inspector.