Ontario

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) :	JENNIFER LAURICELLA (542), DIANA STENLUND (163), KELLY-JEAN SCHIENBEIN (158)
Inspection No. / No de l'inspection :	2014_281542_0005
Log No. / Registre no:	S-000012-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 28, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Johanne Messier-Mann

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007,S.O.2007.c8,s.229(4) to ensure that all staff participate in the implementation of the Infection Prevention and Control program.
The plan shall be submitted to Jennifer Lauricella, Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury ON P3E 6A5 by April 28, 2014 (Fax # 705 564 -3133).

Grounds / Motifs :

1. During the initial tour on February 10, 2014, Inspector 158 randomly checked the wall mounted hand sanitizers and found that 4/5 hand sanitizers were empty. The Inspector observed that isolation precautions were posted on the door of resident # 43212 however, the hand sanitizer dispenser in the resident's room was empty from February 10, 2014 to February 19, 2014. Also during this time period, signage for isolation precautions was posted on resident # 43269's door, however, there was no Personal Protective Equipment (PPE) readily available and the hand sanitizer dispenser in the resident's room was empty.

On Feb 13, 14, 2014 Inspector # 163 made the following observations regarding the home's implementation of the infection prevention and control program: The hand sanitizer dispensers located in the room of two residents (residents #43177 and #43212) on isolation precautions were observed to be empty and the nearest hand sanitizer dispenser located outside of resident #43212's room was jammed and not operable. Additionally, there were no resident care carts containing PPEs readily available to staff providing care to these residents.

Inspector # 158 interviewed Assistant Director of Care on February 19, 2014

and was informed that the PPE is to be stored in plastic bins outside the resident's room or in the locked compartment of the resident lockable care carts. On February 19, 2014, Inspector 158 reviewed the home's policy related to isolation precautions. It was identified that plastic care bins are to be stored outside the resident's room with the PPE supplies and that a hands free hand sanitizer and a garbage receptacle is to be placed inside the resident's room. The policy indicates that resident care plans include the reason for the isolation precautions. On February 19, 2014, Inspector 158 observed that the plastic bins were located in resident # 43177 and # 43212 bedrooms near their beds and not outside or near the door entrance. On the same day the plastic bins were not observed in or outside resident # 43230 and resident # 43269 rooms. Inspector # 158 observed that the PPE supplies were not supplied in 2/2 plastic bins, or in 4/4 of the lockable resident care carts. The Inspector observed that a separate hands free garbage receptacle was not placed inside any of the four residents' rooms. The Inspector reviewed the four residents' health care records (# 43177, # 43212, #43230 and # 43269) and noted that the reason for the isolation precautions was only documented in 1/4 residents' care plans.

On February 18, 2014 Inspector #542 observed registered nursing staff # 106 clearing soiled dishes from resident's tables then proceed to set-up resident's plated food without performing any hand hygiene. Registered nursing staff #106 was observed doing this several times throughout the meal service. Inspector # 542 observed registered nursing staff # 106 complete a blood glucose test on a resident without performing any hand hygiene after the task. Staff member # 107 was observed to be wearing a surgical mask that was only secured at the top of the mask and was touching the mask repeatedly, lifting it away from their mouth all the while feeding a resident. No hand hygiene was observed by this Inspector.

Inspector #158 interviewed Assistant Director of Care (ADOC) with regards to the staff training on Infection Prevention and Control. Inspector was provided with the Hand Hygiene in-services attendance sheets for April 2013 and August 2013 in-services. As per documentation on attendance sheets, 19.5% (41/210) of staff currently employed in the home (excluding staff who are no longer employed, those who are on leave and 11 staff not reviewed) were not in attendance at the April or August, 2013 Hand Hygiene in-services.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)] (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

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.

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 28th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : Lauricella

Name of Inspector / Nom de l'inspecteur : Jennifer Lauricella

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 28, 2014	2014_281542_0005	S-000012-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue, SAULT STE. MARIE, ON, P6B-4J3

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

JENNIFER LAURICELLA (542), DIANA STENLUND (163), KELLY-JEAN SCHIENBEIN (158)

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): February 10, 11, 12, 13, 14, 18, 19, 20, 21, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care(s)(ADOC), Dietary Manager,Food Service Supervisor (FSS), Registered Dietitian (RD), Registered Staff, Physiotherapist, Personal Support Workers (PSWs),President of Family Council, President of Resident Council, Residents, and Family members.

During the course of the inspection, the inspector(s) - made direct observations of the delivery of care and services to residents
- conducted daily walk-through of the home
- reviewed resident health care records
- reviewed policies and procedures
- reviewed home's programs in regards to skin and wound care and continence care
- reviewed home's medication management systems, quality improvement, infection prevention and control program, admission process

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 Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
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 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).

Findings/Faits saillants :

1. During the initial tour on February 10, 2014, Inspector 158 randomly checked the wall mounted hand sanitizers and found that 4/5 hand sanitizers were empty. The Inspector observed that isolation precautions were posted on the door of resident # 43212 however, the hand sanitizer dispenser in the resident's room was empty from February 10, 2014 to February 19, 2014. Also during this time period, signage for isolation precautions was posted on resident # 43269's door, however, there was no

Personal Protective Equipment (PPE) readily available and the hand sanitizer dispenser in the resident's room was empty.

On Feb 13, 14, 2014 Inspector # 163 made the following observations regarding the home's implementation of the infection prevention and control program: The hand sanitizer dispensers located in the room of two residents (residents #43177 and #43212) on isolation precautions were observed to be empty and the nearest hand sanitizer dispenser located outside of resident #43212's room was jammed and not operable. Additionally, there were no resident care carts containing PPEs readily available to staff providing care to these residents.

Inspector # 158 interviewed Assistant Director of Care on February 19, 2014 and was informed that the PPE is to be stored in plastic bins outside the resident's room or in the locked compartment of the resident lockable care carts. On February 19, 2014, Inspector 158 reviewed the home's policy related to isolation precautions. It was identified that plastic care bins are to be stored outside the resident's room with the PPE supplies and that a hands free hand sanitizer and a garbage receptacle is to be placed inside the resident's room. The policy indicates that resident care plans include the reason for the isolation precautions. On February 19, 2014, Inspector 158 observed that the plastic bins were located in resident # 43177 and # 43212 bedrooms near their beds and not outside or near the door entrance. On the same day the plastic bins were not observed in or outside resident # 43230 and resident # 43269 rooms. Inspector # 158 observed that the PPE supplies were not supplied in 2/2 plastic bins, or in 4/4 of the lockable resident care carts. The Inspector observed that a separate hands free garbage receptacle was not placed inside any of the four residents' rooms. The Inspector reviewed the four residents' health care records (# 43177, # 43212, #43230 and # 43269) and noted that the reason for the isolation precautions was only documented in 1/4 residents' care plans.

On February 18, 2014 Inspector #542 observed registered nursing staff # 106 clearing soiled dishes from resident's tables then proceed to set-up resident's plated food without performing any hand hygiene. Registered nursing staff #106 was observed doing this several times throughout the meal service.
Inspector # 542 observed registered nursing staff # 106 complete a blood glucose test on a resident without performing any hand hygiene after the task. Staff member # 107 was observed to be wearing a surgical mask that was only secured at the top of the mask and was touching the mask repeatedly, lifting it away from their mouth all the while feeding a resident. No hand hygiene was observed by this Inspector.

Inspector #158 interviewed Assistant Director of Care (ADOC) with regards to the staff training on Infection Prevention and Control. Inspector was provided with the Hand Hygiene in-services attendance sheets for April 2013 and August 2013 in-services. As per documentation on attendance sheets, 19.5% (41/210) of staff currently employed in the home (excluding staff who are no longer employed, those who are on leave and 11 staff not reviewed) were not in attendance at the April or August, 2013 Hand Hygiene in-services.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

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. 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. (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. On February 12, 14, 18, 2014, the Inspector observed resident #43221 to remove their seat belt alarm and the table top. It was confirmed by staff #109 that this resident has the above behaviors daily. The Inspector reviewed resident #43221's health care record, including the progress notes and plan of care. The progress notes identified that the resident removed the seat belt alarm and attempted to self transfer several times during the month of February, however the care plan did not identify interventions to deter the resident of self transferring. [s. 6. (1) (c)]

2. Inspector reviewed the Care Plan document and Diet Sheet for resident #43308 regarding nutrition and hydration. The Care Plan document (ADL - Eating section) identifies that resident #43308 has difficulty with swallowing and is to be provided with thickened fluids. Conversely, the Nutritional Status section of the Care Plan document and the diet listed on the Diet Sheet indicate that this resident is on a regular diet, regular texture and regular fluids. The inspector reviewed the Med Review document dated Jan 7, 2014 identifying that this resident is to receive 90mls Med Plus 2.0 with med pass however upon review of the supplement with Registered staff # 110 it was reported that this supplement was discontinued in July 2013.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The Inspector reviewed the progress notes for resident # 43228 which identified that the resident fell but did not sustain injury. The Inspector reviewed the resident's plan of care, which identified that the resident is a high risk to fall. The plan of care also identified that a raised toilet seat is to be in place, enabling the resident to toilet easily. Inspector # 158 did not observe that a raised toilet seat was in place or accessible on Feb 12,14,18,19, 2014.

The licensee did not ensure that the care set out in the plan of care was provided to resident # 43228, as specified in the plan. [s. 6. (7)]

4. Inspector reviewed the most recent Care Plan document located in the PSWs binder and the most recent Care Plan located in Point Click Care (PCC) regarding pressure ulcer risk for resident #43212. The Care Plan documents reviewed indicate that the resident has several pressure ulcers. Inspector interviewed Registered staff # 110 on the unit who reported that the resident has more pressure ulcers than what the

Care Plan documents indicate. This staff member confirmed that the current Care Plan document reviewed has not been revised as needed as the resident's pressure ulcers areas have changed, and some areas, no longer exist. Inspector also reviewed in PCC the EO Weekly Skin Assessment dated Feb 9, 2014. Inspector noted that the assessment only indicates that there are two pressure ulcer areas. The Registered staff # 110 confirmed to the inspector that the weekly EO Skin Assessment did not indicate all pressure ulcer areas which currently exist. Inspector observed resident in bed on Feb 14, 2014 and noted the use of a positioning device under the resident's one heel. Inspector interviewed staff member # 110 about this device and it was confirmed that the resident does use this device on either heel as needed to relieve pressure, however the care plan document does not identify this positioning device is to be used to relieve pressure on the resident's heels. [s. 6. (10) (b)]

5. Inspector reviewed the current plan of care contained in the PSWs binder for resident #43177 who has a history of falls. The inspector noted that the Care Plan document identifies that the resident is to receive physio daily to improve their gait and balance. Inspector interviewed staff member # 115 (physiotherapy) who reported that resident #43177 does not receive physiotherapy and that the current care plan is out of date. [s. 6. (10) (b)]

6. Inspector reviewed the plan of care for resident #43184 regarding dental and oral hygiene. Inspector noted that resident #43184 does not have any teeth and does not wear dentures or any other dental appliances. The current Care Plan document contained in the PSWs binder and in PCC identifies that PSWs are to report to registered nursing staff if resident is refusing to brush their teeth. Inspector interviewed the resident who reported that they do not have any teeth and have not had dentures for about a year.

The licensee has not ensured that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary. [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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to resident, as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. During the initial tour on February 10, 2014, Inspector observed 17 residents resting in bed that did not have call bells that were accessible to them. The call bells were observed in a variety of locations; on the floor, buried in sheets, in between the bed rails, positioned at the head of the bed and clipped to the cord on the wall.

The licensee did not ensure that the home's resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (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 the home's resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. Inspector reviewed resident #43177's weight history over a period of two months. The first month indicated that the resident's weight was 91.89 kg and the second month was 83.2 kg. This weight change represented a 8.69kg weight loss. The inspector reviewed the home's Weight Change Program Policy #RESI-05-02-07. This policy indicates that when there is a weight difference of 2.5 kg or more from the previous month, the resident is to be re-weighed and registered staff are to ensure both the current weight and re-weigh are recorded by the 10th day of the month. Inspector interviewed the Dietary Manager and the Registered Dietitian about the process of recording re-weighs. They indicated that residents who have a 2.5 kg weight change are to be re-weighed and both the current weight and re-weigh are to be recorded in PCC. Although resident #43177 had a weight loss greater than 2.5 kg between the two months a re-weigh was not recorded as per the home's policy. [s. 68. (2) (a)]

2. Inspector reviewed resident #43308's weight history over a period of two months. It was recorded in PCC for the first month a weight of 69.4kg and the second month as 76.7kg. This weight change represented a 7.3kg weight gain. Although resident #43308 had a weight change greater than 2.5 kg between the two months a re-weigh was not recorded as per the home's policy. [s. 68. (2) (a)]

3. Inspector reviewed resident # 43216's weight history over a period of two months. It was noted for the first month a weight of 63.8 kg and the second month was 57.4 kg indicating a 6.4 kg weight loss. Inspector 542 reviewed the resident's health care record, and was unable to locate a re-weigh as per the home's policy. Assistant Director of Care was interviewed and confirmed that all re-weighs are to be entered in PCC.

The licensee has not ensured that the programs include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration. [s. 68. (2) (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 the programs include, the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration, specifically related to the home's policy of re-weighing residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On February 14, 2014, Inspector observed lunch meal service in one of the dining rooms. The inspector obtained food temperatures at point of service. Temperatures were recorded as follows: regular cold vegetable salad 63F, regular pizza 135F, and pudding 70F. On Feb 20, 2014 the inspector observed lunch meal service in another dining room. The following temperature were obtained at point of service: minced mixed winter vegetable 120F, minced turkey pot pie 133F, and chocolate pudding 60F. The inspector interviewed the Food Service Supervisor (FSS) about the home's policy on point of service food temperatures. The FSS provided a copy of the Point of Service Food Temperature policy. It identifies that in order to promote comfort and safety, staff are to ensure hot foods are served to residents at a minimum of 60C/140F and cold foods at a maximum of 5C/41F, however during the lunch meal service on Feb 14 and 20, 2014 temperatures taken of certain foods did not meet the required temperature for foods to be safe and palatable.
Additionally, the same policy indicates that to support acceptable food temperatures, pans of food in the steam table must be covered with appropriate lids, however the inspector noted during both meal service observations that pans of food items in the steam table were not covered with appropriate lids. [s. 73. (1) 6.]

2. Resident # 43228 stated to the Inspector on February 12 and February 18, 2014 that the food served at some meals were cold. On February 20, 2014 Inspector observed an evening meal service. The Inspector obtained food temperatures at point of service. Temperatures were recorded as follows: pork 93.2F, veal 111.1F and vegetables 116.9F. The Inspector also observed that the food items in the pans in the steam cart were not covered throughout the meal service as indicated in the home's policy.

The licensee has not ensured that the home has a dining and snack service that includes, at a minimum, the following elements: Food and fluids being served at a temperature that is both safe and palatable to the residents. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Foods and fluids being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #6: 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. On February 18, 2014 Inspector observed registered staff #106 on a unit leave the medication cart unattended and out of view. Registered nursing staff left the room and went behind a closed door. Inspector then proceeded to check the drawers, cart was not locked. This staff member left the medication cart unattended, unlocked several times during the duration of the observation. On February 19, 2014, Inspector observed a medication cart in the middle of the hallway on another unit with a drawer partially opened and no registered nursing staff present. Registered staff # 105 was noted to be in a resident's room completely out of view of the open medication cart.

The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use. [s. 130. 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 areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #7: 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. Inspector reviewed the health care record of resident #43212 with regards to bladder continence. Inspector reviewed the home's documents contained in the "Continence" binder located on the unit where the resident resides. The Continence binder contains a document that outlines the Continence Program Team Goals. This document identifies that Quarterly Bowel and Bladder assessments are to be completed by registered staff one week prior to RAI assessments being completed. Inspector reviewed the home's most recent MDS EO Bladder Continence Assessment in Point Click Care (PCC) for resident # 43212 and noted it was incomplete. The assessment only identified the registered staff names who completed the assessment, however the assessment was not completed. Inspector also reviewed the most recent quarterly MDS RAI assessment section - Continence in last 14 Days, section H3 which is to be reviewed if the resident uses any appliances. This section of the MDS RAI assessment was not completed for resident # 43212. Inspector interviewed Registered staff # 110 who confirmed that quarterly continence assessments are to be completed by registered staff and that the two documents reviewed by the inspector were not completed as per the home's procedure for bladder continence assessments.

The licensee failed to ensure that 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 (b) is complied with. [s. 8. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Inspector reviewed the most recent MDS assessment for resident # 43177. Section D of the MDS assessment identifies this resident has impaired vision and does not use any visual appliances. Inspector reviewed the Care Plan document located in PCC and in the PSWs Care Plan binder. The inspector was unable to locate a plan of care, that identifies resident #43177's vision care needs.

The licensee has failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 4. Vision. [s. 26. (3) 4.]

2. The Inspector reviewed resident # 43185's health record, including the progress notes and assessments. On two occasions, Registered staff #108 documented that resident # 43185 was frequently sliding out their wheelchair (w/c). The inspector interviewed the Physiotherapist on February 13, 2014 and the following recommendations were identified; use of roho cushion, the addition of a slight dump to the w/c seat so that the resident is seated further back in the chair were identified. Resident # 43185's plan of care was reviewed by the Inspector on February 18, 2014 and there was no mention of the resident's sliding out of the wheel chair nor the Physiotherapists recommendations included in the plan of care.

The licensee did not ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident safety risks. [s. 26. (3) 19.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. On February 13, 2014 Inspector observed resident # 43216 in a tilt recline position in wheel chair with a seat belt applied. Inspector reviewed resident's health record, however was unable to locate any information regarding the "tilt recline wheelchair." A consent and an order for the use of the seat belt was obtained, however no mention of the tilt recline wheelchair. Inspector interviewed Assistant Director of Care (ADOC) on Feb 18 and 19, 2014, Inspector was informed that the tilt recline wheel chair was considered a restraint for this resident and should be documented in the care plan and progress notes, also that a consent and order should be obtained.
Inspector # 542 reviewed resident's restraint record for a one month period in 2014, several missing signatures were noted. This was also confirmed by registered staff # 116 who stated that the staff must have missed documenting. Policy # RESI-10-01-01 Physical Restraints was reviewed by Inspector and identifies that a tilt feature, when engaged on a wheelchair is an approved physical restraint.
The home's Policy # RESI-10-01-01 regarding Physical Restraints also identifies the following: the registered staff are to obtain a physician's order, and resident/SDM consent, develop care plan with the goal of restraint reduction, restraints must be clearly detailed in the residents care plan, care staff are to ensure that a restraint record is completed with hourly safety checks and position changes every 2 hours are to be documented on the restraint record. Inspector reviewed resident's health care record and noted there was no order, consent, care plan or documentation from the care staff as indicated in the home's policy.

The licensee failed to ensure that their written policy on physical restraints was complied with. [s. 29. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. On February 12, 2014 at 0955h and February 14, 2014 at 01135h after breakfast Inspector observed that food debris from breakfast remained on resident # 43185's face. Breakfast is served at 0815h on this unit. Under resident # 43185's plan of care; Personal Hygiene Physical Limitation, it is identified that extensive assistance of one staff is to be provided when assisting with resident # 43185's personal hygiene. [s. 32.]

2. On February 20, 2014, the Inspector observed resident # 43228 at 1645h sitting in their room listening to music. It was observed at 1700h, that the resident appearance remained disheveled when brought to the dining room for supper. The resident was unshaven and hair was uncombed. The Inspector had previously observed that the resident was not shaved on February 18 and 19, 2014.
The resident's plan of care was reviewed and it was documented that the resident has severe osteoarthritis and requires extensive assistance of one staff with personal hygiene.

The licensee did not ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. [s. 32.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. It was documented in resident # 43221's plan of care that the resident's nails are cut and trimmed once a week on bath days. The bath records indicate that the resident received a bath on February 7 and 11, 2014. The Inspector observed that resident # 43221's fingernails were long and untrimmed on February 11, 12 and 13, 2014. It was also noted that the resident nails were split and blood was present around nails. [s. 35. (2)]

2. On February 12, 14, 18, 2014, the Inspector observed that a build up of dirt was present behind resident # 43185's painted fingernails.
Under the section of resident # 43185's plan of care; Bathing related to, it was identified that the resident requires total assistance and that the resident's fingernails and toenails are cleaned, trimmed, and filed once a week.
It was documented on the PSW flow sheets, that the resident received a tub bath, including cleaning of fingernails on February 5, 9, and February 12, 2014.

The licensee did not ensure that the resident 's finger nails were clean and trimmed. [s. 35. (2)]

WN #12: 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 Inspector reviewed resident # 43221's health care record. In resident # 43221's progress notes it was documented by staff during a five month period (2013-2014) that the resident had multiple falls. Inspector reviewed the post falls assessment record for the above mentioned falls and noted that they did not contain all of the possible medication triggers for this resident.

The licensee did not ensure that when resident # 43221 fell, a post-fall assessment was fully completed, using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The Inspector reviewed resident # 43185's progress notes, which identified specific interventions related to incontinence were initiated during the month of March, 2013 to aid in the healing of resident's wound. The progress notes further identified, that prior to the use of this intervention, the resident was incontinent of urine which interfered with healing of the wound on their buttocks. On February 12, 2014, it was confirmed by Registered staff # 109 that the resident continues to require the use of this intervention. Bladder continence assessments were completed in May, July, October 2013 and January 2014. Inspector reviewed these assessments and noted that other than the May 2013 assessment, the intervention was not identified nor were the causal factors or type of incontinence. It was further identified in all of the assessments that the resident was assessed as being continent. The MDS assessment completed by a Registered staff member in January 2014 identified the resident as being incontinent, which contradicts the above bladder assessments. The use of these specific interventions were not identified in this assessment. The Inspector reviewed the resident's plan care on February 18, 2014, which identified the use of these specific interventions are being utilized to prevent incontinence and further skin break down.

The licensee did not ensure that the assessments completed regarding resident # 43185's incontinence contained the use of specific interventions, identification of causal factors or the type of incontinence. The licensee did not ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

WN #14: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. Inspector interviewed the Chair of the Family Council about the Resident Satisfaction Survey. It was reported that the Family Council was not involved in developing and carrying out the survey, and in acting on its results. The inspector interviewed the Administrator about the Resident Satisfaction Survey. It was reported that the most recent survey was conducted in July 2013 however the Family Council was not involved in developing and carrying out the survey, and in acting on its results.

The licensee has failed to seek the advice of the Family Council in developing and carrying out the survey, and in acting on its results. [s. 85. (3)]

2. Inspector interviewed the Chair of the Family Council about the Resident Satisfaction Survey. It was reported that the Family Council was not made aware of the results of the survey. The inspector interviewed the Administrator about the Resident Satisfaction Survey conducted in July 2013. It was reported that the home did not share the results of the 2013 survey with the Family Council.

The licensee failed to ensure that, (a) the results of the survey are documented and made available to the Family Council. [s. 85. (4) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On February 10, 2014 at 1440h and on February 11, 2014 at 1540h Inspector # 158 noted that an odor was present and lingering in the hallway by a tub room. The Inspector observed the tub room on the above dates and noted that the toilet was filled with dried fecal material. The Inspector spoke with housekeeping staff on February 12, 2014 who identified that the cleaning of the toilet in the tub room occurs daily. The staff member also identified that the tub room has an odor at times when it is warm. The Inspector did note that a lingering odor was again present in this tub room on February 18, 19, 2014.

The licensee did not ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors. [s. 87. (2) (d)]

Issued on this 4th day of April, 2014

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

Jennifer Lauricella