Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Feb 1, 2016	2016_337581_0001	036306-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Weston Terrace Care Community
2005 LAWRENCE AVENUE WEST TORONTO ON M9N 3V4

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): January 18, 19, 20, 21 and 22, 2016.

This inspection was done concurrently with Critical Incident System Inspection (CIS), Log #’s 010504-15, 018004-15, 019829-15 related to falls management and follow up #013275-15.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSW), Food Service Manager (FSM), Registered Dietitian (RD), Dietary staff, Director of Recreation Programs, Environmental Service Manager (ESM), Private Duty Care Giver, families and residents.

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.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

11 WN(s)
6 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2015_163109_0002	528

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (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.

On January 18, 2016, during lunch service, resident #086 was observed being served multiple courses. Review of the resident's plan of care did not indicate they were to receive multiple courses during meals. PSW #122 reported that at times, the resident did not want to have meals served course by course. Interview with RPN #111 stated the resident was assessed and identified as having a preference to have courses served together; however, confirmed it was not included in their written plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

In July 2015, resident #001 fell from their tilt wheelchair. According to the post fall progress note, their chair was not tilted. Review of the restraint and PASD assessment completed in June 2015, noted the resident was at high risk of falls and their wheelchair was to be tilted when resident was positioned in their wheelchair. Review of the written plan of care for resident #001 indicated that they were positioned in a tilt wheelchair as a PASD for repositioning, comfort and safety but did not identify that the resident was to be tilted when up in their wheelchair. Review of the investigation notes post fall noted that the staff did not ensure that the resident was reclined in their wheelchair as per plan of care. Registered staff #100 confirmed that there was no clear direction to staff related to resident #001 being tilted when up in their wheelchair. [s. 6. (1) (c)]

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

A. From December 2014, the plan of care for resident #009 identified that the resident had an ongoing area of skin breakdown related to pressure. Wound assessments were documented weekly in Point Click Care (PCC), using the home's clinically appropriate assessment tool; however, the weekly assessments did not consistently include the size or measurement of the wound. From June 2015, to December 2015, eleven weekly assessments did not include wound measurement. Interview with registered staff #106 confirmed that for staff to complete the clinically appropriate assessment tool, wound measurements would be taken weekly; and that for resident #009, weekly wound assessments did not consistently include wound size. Since the weekly wound assessments as outlined above were not completed in full to include all aspects of the wound, the assessments did not complement or were not consistent with each other.

B. A review of the MDS assessments completed in November, August and May 2015, indicated resident #001 did not use bedrails. Review of the Physiotherapist quarterly assessment in November 2015, noted the resident required a bed rail for bed mobility. The resident's bed was observed during the course of this inspection with two half bed rails raised and interview with PSW #107 stated that the resident required bed rails for turning and positioning. Interview with registered staff #104 confirmed that the assessments were not consistent with each other related to the resident using bed rails

for bed mobility. [s. 6. (4) (a)]

4. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A. In July 2015, resident #001 fell from their wheelchair and sustained a head injury. Review of the written plan of care indicated they were to have a chair alarm on when up in their tilt wheelchair. Review of the post fall progress note identified that the chair alarm was not in place. Interview with registered staff #100 confirmed that the chair alarm was not applied when the resident was up in their wheelchair and staff did not provide care as directed in their plan of care.

B. The plan of care for resident #060 identified the resident to be a high risk for falls related to gait, imbalance, and history of falls. Falls prevention interventions were to be in place. In May 2015, the resident had a fall. Review of the post falls assessment revealed the resident lost their balance and all their falls interventions were not in place. The resident required admission to hospital and was diagnosed with an injury, resulting in a significant change in condition. Interview with the registered staff #126 confirmed that the intervention was not provided as specified in the plan of care, related to fall prevention interventions.

C. Resident #006's plan of care stated they were at high nutritional risk related to swallowing and choking risk and was to receive a texture modified diet and an adaptive eating device, as confirmed by the registered dietitian (RD). On January 20, 2016, during lunch, the resident did not receive their texture modified diet and adaptive eating device as confirmed by dietary staff #116. (585) [s. 6. (7)]

5. 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.

Review of resident #001's current written plan of care indicated they were transferred with a hoyer lift for all transfers. Interview with PSW #107 stated the resident was transferred on and off the toilet with the sabina sit to stand lift. Interview with registered staff #110 stated the resident was transferred on and off the toilet with the sabina lift and confirmed the written plan of care was not updated when their transferring needs changed. [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 plan of care set out clear directions to staff and others who provide direct care to the resident and ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. Resident #001’s bed was observed during the course of this inspection with two assist rails raised, one in the guard position and one in the transfer position. A review of the resident’s plan of care did not include an assessment of the bed rails being used. Interview with registered staff #110 and PSW #107 stated the resident had both bed rails raised when in bed to assist with turning and positioning. Registered staff #100 confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B. Resident #006’s bed was observed with one assist rail raised in the transfer position and one raised in the guard position during the course of this inspection. Review of the plan of care identified that no bed rail assessment was completed. Interview with registered staff #103 and PSW #121 stated the resident’s bed rails were raised when in bed and required the bed rails to help with turning and positioning. Registered staff #100 confirmed that there was no formalized assessment completed for resident #006 related to the use of bed rails.

C. On January 18 and 20, 2016, resident #003's bed system contained two assist rails which were raised in the guard and transfer positions. PSW #124 and PSW #125 reported the resident used the rails for bed mobility and positioning. RPN #123 stated the bed rails were used for positioning; however, confirmed the resident's bed system was not evaluated in accordance with evidence-based practices or in accordance with prevailing practices, to minimize risk to the resident. (585) [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 were none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: 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 has 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 may 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.

A. Resident's #001’s bed was observed with one assist rail raised in the transfer position and one bed rail raised in the guard position throughout the course of this inspection. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for its use. Registered staff #110 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.

B. Resident #003’s bed was observed with one assist rail raised in the transfer position and one bed rail raised in the guard position throughout the course of this inspection. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for its use. Registered staff #123 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. (585)

C. Resident #006’s bed was observed with one assist rail raised in the transfer position and one bed rail raised in the guard position throughout the course of this inspection. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for its use. Registered staff #103 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.

D. Resident #006 was observed positioned in a tilted wheelchair during the course of

this inspection. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the tilt wheelchair. Interview with PSW #121 stated the resident was tilted and repositioned in their wheelchair every two hours. Registered staff #103 confirmed that the resident's tilt wheelchair was not assessed as a PASD and they did not have documented consent or approvals for the PASD. [s. 33. (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 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 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, to be implemented voluntarily.

WN #4: 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 foods were prepared, stored and served using methods to preserve appearance and food quality.

On January 18, 2016, during lunch service, puree coleslaw and puree tossed salad were on the planned menu. Both salads appeared runny when served to residents. Dietary staff #114 reported puree foods were to be served at a pudding thick consistency and stated the items appeared runny. Interview with the FSM confirmed puree items should of been served at a pudding thick consistency. [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 foods are prepared, stored and served using methods to preserve appearance and food quality, 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:
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).

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

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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. 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.

On January 18, 2016, during lunch service, resident #080, resident #082, resident #083, resident #084, resident #085 and resident #087 were observed being served multiple courses. PSW #113 reported meals were to be served course by course and the identified residents were not to receive multiple courses and this was confirmed by the RD. [s. 73. (1) 8.]

2. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

On January 20, 2016, during lunch service, resident #089 was observed seated in a reclined position in a tilt wheelchair, receiving total assistance with eating by private duty care giver #117. The private duty care giver was observed standing while assisting the resident and reported they were unaware of how the resident was to be positioned. Registered staff #104 reported the resident was to be in an upright position while eating and confirmed they were not seated in a safe position. [s. 73. (1) 10.]

3. The licensee failed to ensure there was appropriate furnishings and equipment in resident dining areas, including appropriate seating for staff that were assisting residents to eat.

On January 20, 2016, during lunch service, recreation staff #118 was observed standing while assisting resident #088 to eat. Private duty care giver #117 was observed standing while assisting resident #089, resident #090 and resident #091. Both reported there was insufficient seating in the dining room for them to assist the residents appropriately. Observation of the dining room revealed there was no additional appropriate seating for the staff. [s. 73. (1) 11.]

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 proper techniques are used to assist residents with eating, includes safe positioning of residents who require assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs stored in a medication cart were kept secure and locked.

On January 19, 2016, at 1015 hours, a medication cart on an identified area was found unlocked and unsupervised for approximately five minutes. Multiple residents were in close proximity to the cart and the inspector was able to open the cart drawers which contained resident medications without staff being aware. RPN #109 confirmed the cart was unlocked and unsupervised. [s. 129. (1) (a) (ii)]

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 drugs stored in a medication cart are kept secure and locked, to be implemented voluntarily.

WN #7: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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 stairways that precluded exit by a resident were kept closed and locked.

On January 18, 2016, during an initial tour of the home, the south stairwell door on the third floor was found unlocked and the door access control pad indicated it was locked. Interview with the ESM confirmed the magnetic lock was not working properly and the door was not kept locked. [s. 9. (1) 1. i.]

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

A. On January 18, 2016, during the initial tour of the home, the following doors leading to non-resident areas were noted to be unlocked and unsupervised by staff:

i) The garbage room on the first floor was noted to be unlocked, no staff were noted to be in or around the garbage room and the room was not equipped with a resident-staff communication system. Interview with the RAI Coordinator confirmed that the room was a non-resident area and should be kept locked at all times.
ii) In the basement, a large storage room was observed to be propped open with a piece of wood, the housekeeping and laundry rooms were noted to be unlocked. Interview with registered staff #100 confirmed that the basement was accessible to residents.
iii) The soiled utility room in Harris Trail.
iv) Dietary utility room on Varley Boulevard, which contained chemical detergent and degreaser.
v) Linen closet on Lismer Lane
vi) Soiled utility room on Lismer Lane.

On January 21, 2016, the soiled utility room on Harris Trail was found unlocked.

Interview with the ESM confirmed the identified rooms were to remain locked as they were non-residential areas and did not contain communication response systems. The ESM also confirmed the dietary utility room contained chemical hazards and the soiled utility rooms contained infection control hazards. [s. 9. (1) 2.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's furnishings were maintained in a safe condition and in a good state of repair.

On January 18 and 20, 2016, in the Harris Trail dining room, table #1 was noted having a loose top and was slanted. PSW #122 reported the table was in poor repair and required maintenance servicing. The ESM confirmed a work order was submitted on January 20, 2016, to repair the table and it was not appropriately maintained. [s. 15. (2) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On January 18, 2016, during an initial tour of the home, the front lobby, cafe area and the corresponding outdoor area did not have a resident to staff communication response system. During the course of the inspection, residents, staff and visitors were observed spending time in the front lobby. The door leading to the outdoor area was also noted to be unlocked. Interview with the ESM confirmed that there were no call bells available in the home's front lobby and the outdoor area off the lobby. [s. 17. (1) (e)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a response in writing was provided within 10 days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council Meeting Minutes from January 21, 2015 to December 1, 2015, identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes from February 4, 2015, included a concern from families that the lights in the plant room needed to be replaced and that there were overdue payments from residents due to the hair salon and these concerns were not responded to in writing.

Meeting minutes from April 7, 2015, included a concern about the receptionist line of vision to the front door and that they cannot see who was coming or going, how the name Weston Terrace Care Community was chosen and could they have input into the name and recommended the laundry procedure be posted on the laundry room door for those families who are not aware of the process. These concerns and recommendations were not addressed in writing until May 5, 2015.

Meeting minutes from November 3, 2015, included a recommendation to have a larger bulletin board for family council on display, whether the home would provide decaffeinated coffee and if window coverings for privacy for the first floor residents would be provided by the home. These concerns were not responded to in writing.

Interview with the Director of Program Services confirmed the above concerns and recommendations were not responded to in writing to the Family Council within ten days. [s. 60. (2)]

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

Specifically failed to comply with the following:

s. 71. (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 at meals.

On January 21, 2016, during lunch service, juice, water and milk was listed on the planned menu. PSW #112 was observed distributing drinks and did not offer milk to resident #084. Resident #084 stated they were not offered a choice of fluids and the fluids were just placed at their table setting. Interview with PSW #112 reported they did not offer the resident choice. Interview with the FSM confirmed milk was on the planned menu and should have been offered to the resident. [s. 71. (4)]

Issued on this 10th day of February, 2016

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

Original report signed by the inspector.