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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 1, 2014	2014_237500_0018	T-118-14	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE WOODHAVEN
380 Church Street, MARKHAM, ON, L6B-1E1

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

NITAL SHETH (500), GORDANA KRSTEVSKA (600), JULIENNE NGONLOGA (502), MATTHEW CHIU (565), TILDA HUI (512), VALERIE JOHNSTON (202)

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): August 26, 27, 28, 29, September 2, 3, 4, 5, 8, 9, 10, 2014.

Additional inspections related to the CI Log# T-804-14, T-744-13 and complaint Log #T-265-14 were also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), associate director of care (ADOC),food service manager (FSM), food service supervisor (FSS), environmental manager, resident's care coordinator (RCC), physiotherapist (PT), registered nurse (RNs), registered practical nurse (RPNs), registered dietitian (RD), personal care providers (PCPs), dietary aides, activity aide, house keeping staff, residents and family members .

During the course of the inspection, the inspector(s) observed residents' care areas, reviewed home records for policies and procedures and resident's records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

On August 26, 2014, resident #13 was observed during meal service on an identified floor dining room. Resident's meal was served on a regular china plate.

Review of the resident plan of care indicated that resident requires a special plate as eating assisting device.

Dietary aide confirmed that the resident was not served on a special plate. [s. 6. (7)]

2. A review of the written plan of care for resident #8 indicated that the resident was at high risk for falls and wandering. The written plan of care set out the following directions to staff:

1. Ensure that the resident has worn hip protector all the time and has posey alarm while in bed or wheelchair,
2. Ensure that the resident has a wander bracelet and assess daily and document on the sheet provided.

Observation performed on September 4, 2014, at 10:03 a.m., and on an identified floor revealed that the resident was sitting on a wheelchair near the nursing station without using a posey alarm and hip protector. The resident was wearing the wander bracelet on the right wrist.

Interview with the PCP and registered nursing staff confirmed that the hip protectors were not given to the resident because all the resident's hip protectors were sent to the laundry at that time. They also confirmed that they did not use the posey alarm for the resident on wheelchair because they were not aware of the use of posey alarm for the resident while in bed or wheelchair.

A review of the daily inspection log for the wander bracelet revealed that there was no record for the bracelet's assessment on two identified days.

Interview with the registered nursing staff confirmed that there was no documentation available for these two days. [s. 6. (7)]

3. The licensee has failed to ensure that he staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

A review of the written plan of care for resident #8 indicated that the resident was at high risk for falls and wandering. The written plan of care indicates for staff to

1. Ensure that the resident has worn hip protector all the time and has posey alarm while in bed or wheelchair,
2. Ensure that the resident has a wander bracelet and daily assessment and documentation is conducted on the sheet provided.

Observation performed on September 4, 2014, at 10:03 a.m., and on an identified floor revealed that the resident was sitting on a wheelchair near the nursing station without using a posey alarm and hip protector. Resident was wearing the wanders bracelet on the right wrist.

Interview with the PCP and the registered nursing staff confirmed that they were not aware that a posey alarm should be used for the resident while in bed or wheelchair neither a wander bracelet being in use for the resident or the need for the daily assessment and documentation for it. [s. 6. (8)]

4. A review of the current plan of care revealed that the resident #10, is having own teeth and lower partials, oral care given in the morning and in the evening, with one staff assistance and staff to clean dentures.

Interview with PCP confirmed that she was not aware of the resident's content of the plan of care. The PCP was a part-time employee and therefore was not sure about the resident, if the resident has own teeth or dentures. [s. 6. (8)]

5. Interview with an identified PCP confirmed that she does not read the care plan and doesn't know what is in resident #17's care plan. PCP confirmed that the home have provided them an access to the care plan and kardex, however he/she was not aware of the content of the resident's care plan.

Interview with the registered nursing staff confirmed that PCP have access to the care plan and they should read the care plan specially if they are not familiar with the resident's care and not working with the resident on a daily basis.

Interview with the RAI coordinator confirmed that all PCPs should be aware of the content of the plan of care prior to provide care to the resident. [s. 6. (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:
- care set out in the plan of care is provided to the resident as specified in the plan, and
- the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents are protected from verbal abuse.

An interview with resident #3 indicated that on an identified day, during the evening shift an identified RPN came into his/her room to administer medications. The resident indicated that he/she tried to warn the RPN that his/her floor was wet before he/she entered the room because he/she had just sprayed Febreeze. The resident requested that he/she leave the room, however, he/she entered the room and began to yell profanities at the resident. The resident indicated that the RPN yelled, indicated that he/she was not leaving the room and called him/her a "f...ing old man/woman" and slammed the door. The resident indicated that he/she reported the incident to the RN in charge that evening and later to his/her family member.

An interview with the identified RPN indicated that on August 15, 2014, during the evening shift, he/she entered resident #03's room to administer medications. The

resident was trying to tell him/her something, however, due to his/her hearing impairment the RPN bent down to the resident to listen closer. The RPN indicated that the resident began to yell at him/her, told he/she pays his/her wages and to leave. The RPN indicated that he/she responded to the resident by stating "you old man/woman, you are not paying my salary, the government does". The RPN indicated that he/she wrote a note in the resident's progress notes and reported the incident to the RN in charge.

The RN confirmed in an interview that the resident called him/her immediately after the incident by using the home's phone to report that an identified RPN was verbally abusive toward him/her and stated that he/she called him/her a "f...ing old man/woman", used foul language and slammed his/her door. The RN indicated that upon reciept of the phone call, went to speak to the RPN, requested that he/she apologize to the resident and wrote a note regarding the incident in the resident's progress notes. The RN indicated that the RPN refused to apologize to the resident, and stated that he/she was too busy. The RN indicated that he/she went to see the resident after the incident, however, the resident was sleeping and no further action was taken.

An interview with the administrator indicated that on August 19, 2014, the family member of resident #3 reported that an identified RPN was verbally abusive toward the resident, used foul language and slammed his/her bedroom door while giving him/her medications during the evening of August 15, 2014. The administrator indicated that upon receipt of the allegation, investigated and confirmed the above. The RPN was suspended for one day, reeducated on the home's abuse policy and apologized to the resident. [s. 19. (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 residents are protected from verbal abuse, to be implemented voluntarily.

WN #3: 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:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that sufficient time is provided for residents to eat at their own pace.

On August 29, 2014, resident #14, was observed during meal service in floor dining room. The resident was still eating when his/her private sitter removed his/her plate. The resident's private sitter then proceeds to remove the resident cloth's protector while telling him/her "can we go now to exercise?." When the sitter questioned stated that he/she was not employed by the home, the resident was under his/her care and he/she needs to take him/her to exercise.

The nursing staff confirmed that resident #14 was rushed during meal and he/she will address the concern with to the private sitter. [s. 73. (1) 7.]

2. The licensee failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

On August 27, 2014, at 3:50 pm., resident #12 was observed sitting in the family room, his/her snack was sitting on the table beside her.

Review of the resident #12's plan of care indicated that the resident requires assistance with meals and snacks.

Interview with an identified PCP indicated that the resident was served a snack by morning staff and confirmed that the resident is a total care and requires to be fed, she then proceed to fed the resident.

Interview with the RD indicated that nursing staff should supervise all meals and snacks, if PCPs are not able to complete the feeding prior the end of their shift, they should report that to the nursing staff for the continuity of care. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that sufficient time is provided for residents to eat at their own pace and residents, who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

A review resident #36's clinical records indicated that the resident is permitted to self-administer identified medications. On September 2, 2014, at 3:10 p.m., the identified medications were observed to be on top of the bedside table in resident #36's room.

Interview with the resident confirmed that he/she keeps the resident's medications on top of the bedside table all the time.

A review of resident #37's clinical records indicated that the resident is permitted to self-administer identified medications.

On September 03, 2014 at 10:00 a.m., the resident was observed to be taking out his/her above medications from a plastic organizer drawer located next to the resident's bedside table.

Interview with the resident confirmed that he/she keeps his/her medications in the plastic organizer drawer all the time.

An interview with the RCC indicated that resident #36 and #37 are permitted to self-administer the above medications and both residents keep the medications in their rooms. The RCC confirmed that both resident #36 and #37 do not have authorization by a physician, registered nurse in the extended class or other prescriber who attends the resident, to keep the drug on his or her person or in his or her room. [s. 131. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On observation made on August 26, 2014, at 10:15 a.m., during the initial tour, the inspector noted rusty and unclean nail clippers kept in cabinet in the shower rooms of the third and forth floors. Cut out nails were noted in two of the nail clipper storage

caddies in the third floor shower room.

Interview with PCPs confirmed that the used nail clippers were either rinsed with water and then padded dry or soaked in hot water and soap and dried before being stored away in the individually labelled caddies.

Interview with the ADOC who was the lead for the infection prevention and control program confirmed that staff were expected to use alcohol wipes, which were kept at the nursing station, to disinfect the used nail clippers before storage. [s. 229. (4)]

2. On August 28 and 29, 2014, the following observations were made:

- dietary aide #1 fed the dish machine with dirty pans and pots, went to the adjacent servery on the first floor, start the setting for dinner meal service, then came back in the kitchen to remove cleaned and sanitized pan and pots, without washing her hands.

- dietary aide #2 fed the dish machine with dirty dishes, then removing cleaned and sanitized dishes without washing his/her hands.

Interview with FSM confirmed that the dietary aides failed to wash their hands between tasks. [s. 229. (4)]

3. On August 28, 2014, at 10:46 a.m. in third floor, a PCP was observed to serve nourishment to residents in two resident's rooms. The PCP contacted the residents' environments but did not perform hand hygiene between residents.

Interview with the registered nursing staff and the identified PCP confirmed that hand hygiene should be performed between residents. [s. 229. (4)]

4. The licensee failed to ensure that the resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Record review indicated that resident #26 was not screened for tuberculosis (TB) until 56 days after admission.

Interview with the ADOC confirmed the above information. [s. 229. (10) 1.]

5. The licensee failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review indicated that resident #26 was not offered immunizations against tetanus and diphtheria.

Interview with the ADOC confirmed that immunizations against tetanus and diphtheria were not given to the resident and there was no record for why the immunizations were not given to the resident. [s. 229. (10) 3.]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's right to be treated with courtesy and respect is fully respected and promoted and in a way that fully recognizes his individuality and respects his dignity.

On August 26, 2014, resident #15 was observed during meal service. The resident was fed by an identified activity staff. The staff used a nosy cup to clean thickened fluid dripping and a spoon to clean food around the resident's mouth.

On August 28, 2014, the resident was observed during snack service. The resident had a paper napkin around the neck instead of a clothing protector.

Interview with the PCP indicated that staff do not use cloth's protector during snack service.

Interview with FSM indicated that staff using paper napkin as clothing protector or eating devices to clean the resident's mouth is not dignifying for the resident. [s. 3. (1) 1.]

WN #7: 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 resident's personal equipment are kept clean and sanitary.

Observation made on two identified days, revealed the following:

- armrest of resident #1's Geri-chair was soiled with food debris,
- cushion cover of resident #2's wheelchair was soiled with food debris and the wheelchair's frame was covered with dirt.

Interview with ADOC indicated that the residents' wheelchairs are cleaned twice a week and as needed by night shift PCP and a preventive maintenance is completed twice a year by Shoppers.

Interview with an identified PCP confirmed that those chairs were soiled with dried food debris, and proceed to clean the chairs. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Observation made on two identified days, revealed the following:

- Three dents on doors and paint peeled off from the wall across from resident #1's bed.
- Holes on the wall below the toilet paper holder in resident's #1 washroom.
- Scratched wall in resident #3's bathroom
- The paint on the left wall in resident #4's bedroom was chipped and dry wall damage at about one foot above the baseboard
- The power outlet cover in the shower room on the fourth floor was broken,
- The tile in the shower area is broken and water is infiltrating the floor,

Interview with environmental manager confirmed the inspector's observation and indicated that an action plan is in placed to repair the identified areas by October 15, 2014. [s. 15. (2) (c)]

WN #8: 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 home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

Observation on August 26, 2014, revealed and staff interview confirmed that the Tidy Cupboard room, was not equipped with a communication system, and the room is used to weigh the residents each month.

Interview with the environmental manager indicated that the room should be equipped with a communication system and the home will remove the balance to the spa room where a call bell is available. [s. 17. (1) (e)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's abuse policy, titled, Resident Abuse, RCA-LTCE-E-02 RCAM-IV-15, dated April 2013, contains an explanation of the duty under section 24 of the Act to make mandatory reports.

The home's abuse policy indicated above directs all staff members to report any abuse or allegations of abuse immediately to the Administrator/General Manager, Director of Care/Resident Services Manager or delegate. The person receiving the report is to report the allegation to the provincial Ministry of Health and Long Term Care.

An interview with the Administrator confirmed that the home's abuse policy does not provide a clear explanation of the duty under section 24 of the Act to make mandatory reports, however, the policy is currently under revision as he is aware that the above policy is misleading for staff. [s. 20. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred immediately reports the suspicion and the information upon which it is based to the Director.

An interview with an identified RN indicated in an interview that he/she received a phone call from resident #03 on the evening of an identified day, reporting that an identified RPN was verbally abusive toward him/her. The RN indicated that the resident was upset and reported that an identified RPN called him/her a "f...ing old man/woman", used foul language and slammed his door. The RN indicated that upon receipt of the phone call, went to speak to the RPN and, requested that the RPN apologize to the resident. The RN indicated that because he/she felt he/she settled the situation he/she decided to write a note about the incident in the resident's progress notes, assuming that the DOC or ADOC would see it on the next shift.

The administrator indicated in an interview that on an identified day, the family member of resident #03 reported that an identified RPN was verbally abusive toward the resident, used foul language and slammed his/her bedroom door while giving him/her medications. The administrator indicated that upon receipt of the allegation, he/she began the investigation and reported the allegation of verbal abuse to the Director at this time. The administrator confirmed that the initial reported allegation of verbal abuse received by the RN was not immediately reported to the Director. [s. 24. (1)]

WN #11: 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:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the dental and oral status, including oral hygiene with respect to the resident.

A review of a plan of care for resident #5 revealed that there is no planned care

developed for resident's dental care, the goals are not developed and does not provide clear direction to the staff about the dental status of the resident that resident is having natural teeth or dentures and how the staff should provide oral or dental care to the resident.

Interview with PCP confirmed that PCP was not aware that the resident is having natural teeth or dentures.

Interview with the registered nursing staff confirmed that there is no indication about the resident having natural teeth or dentures in the plan of care.

Interview with the RAI coordinator confirmed that, usually, the home have a plan of care developed for dental status under personal hygiene on their electronic charts, however it is missed out to develop goal and interventions for the resident's oral/dental care. [s. 26. (3) 12.]

2. A review of a plan of care for resident #5 revealed that there is not planned care developed for resident's dental care, the goals are not developed and does not provide clear direction to the staff about the dental status of the resident that resident is having natural teeth or dentures and how the staff should provide oral or dental care to the resident.

Interview with the PCP confirmed that they have a Kardex for resident's information however not sure if the resident is having natural teeth or dentures.

A review of Kardex for the resident revealed that it does not have any information about the resident's oral/dental care.

Interview with the registered nursing staff confirmed that there is no indication about the resident having natural teeth or dentures in the plan of care.

Interview with the RAI co-ordinator confirmed that, usually the home have a plan of care developed for dental status under personal hygiene on their electronic charts, however it is missed out to develop goal and interventions for the resident's oral/dental care. [s. 26. (3) 12.]

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 licensee failed to ensure that when the resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls if required.

Review of resident #6's plan of care revealed that the resident is at high risk for falls. On an identified day, the resident fell on the floor in the small family activity room with no injury. There was no post fall assessment completed for this resident after the fall.

Review of the Licensee's fall prevention and management policy #LTCE-CNS-G-10 and interview with the registered staff confirmed that the resident should be assessed using the post fall analysis tool but this was not completed for this resident. The registered staff initiated the post fall analysis for the resident after the interview on September 2, 2014, eight days after the fall.

Interview with registered nursing staff and the associate director of care confirmed that the post fall analysis should be started right away after the fall. [s. 49. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there is cleaning schedule for all the equipment related to the dining and snack areas.

Observation of the walk-in freezer on August 28, 2014, revealed food debris on the floor, dried frozen blueberry on the floor, also ice machine was observed with mold and covered with dust.

Interview with FSM indicated the freezer was schedule to be clean five days prior, and confirmed that the freezer was cleaned as per the schedule.

Record review and interview with the environmental manager and food supervisor indicated that the ice machine is not on the equipment's cleaning schedule in their respective department. [s. 72. (7) (b)]

2. On August 28, 2014, mold and other debris were observed inside the ice-cube machine; staff were observed retrieving ice cubes from that machine for the lunch meal service.

Interview with the FSS and ESM confirmed that the ice-cube machine was not included in the housekeeping or the food service cleaning schedule.

On August 29, 2014, the FSS indicated that he/she has defrosted the ice-machine and confirmed that the debris were from dust that had built inside the ice-machine, and he/she indicated that all ice cubes were removed from the machine before cleaning and sanitizing the machine. [s. 72. (7) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff have received annual retraining on infection prevention and control.

A review of the staff training records and interview with the ADOC revealed 10 out of 185 direct care staff did not receive training in infection prevention and control in 2013. [s. 76. (4)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

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Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79 (1), specifically, copies of the inspection reports from the past two years for the long-term care home.

The inspector observed on August 26, 2014, at 10.00 a.m., the Ministry of Health and Long-term Care home inspection reports in a binder placed besides the wall of reception desk. The inspector did not observed any sign directing residents and visitors to the location of the inspection reports.

Interview with the administrator confirmed that the inspection reports are left in a binder for the residents and visitors and not actually posted in the home. [s. 79.]

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

Issued on this 1st day of October, 2014

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