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
Aug 7, 2014	2014_235507_0013	T-015-14	Resident Quality Inspection

Licensee/Titulaire de permis

BROADVIEW FOUNDATION
3555 DANFORTH AVENUE, TORONTO, ON, M1L-1E3

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

CHESTER VILLAGE
3555 DANFORTH AVENUE, TORONTO, ON, M1L-1E3

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

STELLA NG (507), ARIEL JONES (566), JULIENNE NGONLOGA (502), SOFIA DASILVA (567)

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): June 26, 27 and 30, July 2, 3, 4, 7, 8 and 9, 2014.

Critical incident Log # T-158-14 was also inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the chief executive officer (CEO), director of care (DOC), assistant director of care (ADOC), nurse manager, resident assessment instrument (RAI) coordinator, environmental services manager (ESM), resident support services manager (RSSM), dietary manager (DM), food services supervisor (FSS), physiotherapist (PT), registered dietitian (RD), registered nursing staff, personal support workers (PSWs), housekeeping aides (HKAs), dietary aides (DAs), financial coordinator, residents, family members and substitute decision makers (SDMs).

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of resident care, staff-resident interactions, reviewed the home's records, policies and procedures, Resident Council and Family Council minutes, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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. 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and

respects his/her dignity.

Interview with an identified resident revealed that on an identified date, an identified registered staff said to the resident “I heard that you reported me to the ministry” and “No one wants to come in here to look after you”. In addition, approximately a year prior, an identified PSW said to the same resident that “I ain’t got time for you”.

An interview with the registered staff confirmed that he/she did make the above comments to the identified resident and the way of speaking to the resident was not appropriate.

An interview with the director of care (DOC) confirmed that an identified direct care staff said to the above resident that “I ain’t got time”. As a result, all staff were provided coaching during a training session in 2013. The identified PSW confirmed that he/she received training in 2013 related to the Residents' Bill of Rights. [s. 3. (1) 1.]

2. The licensee failed to ensure that the right of the resident to live in a safe and clean environment is fully respected and promoted.

On an identified date, a resident who resides in an identified unit used a second identified resident’s private bathroom and made a mess. The second identified resident felt that his/her bathroom was too dirty to use and requested to have his/her bathroom cleaned at around 8:45 a.m.

Interview with an identified housekeeping aide (HKA) confirmed that he/she received the request from a staff member in the morning of the same day while he/she was cleaning the residents’ rooms on the other side of the unit. The identified HKA cleaned the identified resident’s bathroom only after cleaning all the rooms on the side of the unit. As a result, the identified resident did not have a clean bathroom until 12 p.m.

Interview with the environmental services manager (ESM) confirmed that the request from the identified resident to clean the bathroom was not attended to in a timely fashion. [s. 3. (1) 5.]

3. The licensee failed to ensure that the resident's right to have his or her participation in decision-making is fully respected and promoted.

Record review revealed that an identified resident experienced severe and excruciating pain for a period of four weeks. The resident was placed on regular pain medication to manage the pain. On an identified date during the four-week period, the resident requested to be sent to the hospital because he/she continued to experience severe pain and discomfort but the request was denied. Record review confirmed that the registered staff told the resident that the home would continue to monitor and manage the pain. The identified resident requested to be sent to the hospital again 16 days later; the resident was sent and a fracture was confirmed.

An interview with the identified resident revealed that he/she made a number of requests to the staff and the physician to be sent to the hospital during the identified four-week period because of the unmanageable pain.

An interview with the DOC confirmed that he/she was aware of the resident’s unmanageable pain and the requests to be sent to the hospital. The home did not incorporate the resident’s input into his/her plan of care. [s. 3. (1) 9.]

4. The licensee failed to ensure that the resident's right to have his or her personal health information within the meaning of the Personal Health Promotion Protection Act, 2004 kept confidential in accordance with that Act is fully respected and promoted.

On an identified date, the inspector observed the computer on top of the medication cart in the hallway next to the nursing station on the Diamond unit displaying an identified resident’s personal health information (PHI). The medication cart was left unattended.

Interview with an identified registered staff confirmed that the computer should be logged off when he/she left the medication cart unattended and the PHI of the resident was easily accessible to anyone passing by. [s. 3. (1) 11. iv.]

5. On three occasions, the inspector observed the residents' personal health information on display on the computer screen and the computer unattended:

1. On June 26, 2014, at approximately 10:00 a.m., on the Rubies unit,
2. On June 26, 2014, at approximately 12:30 p.m., on the Sapphire’s unit, and
3. On June 27, 2014, at approximately 09:45 a.m., on the Sapphire’s unit.

Interviews with registered staff confirmed that these were issues of privacy and the computer should be logged off while left unattended. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following resident's rights are fully respected and promoted:
1. to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity,
2. to live in a safe and clean environment,
3. to have his or her participation in decision-making, and
4. to have his or her personal health information within the meaning of the Personal Health Promotion Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (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).

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 the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Record review of an identified resident's written plan of care dated an identified date, confirmed that the plan of care is not based on an assessment of the resident and the needs and preferences of that resident; it does not include a reference in relation to the resident's sleep preference.

Interview with the registered staff confirmed that the plan of care does not reflect the identified resident's sleep preference. [s. 6. (2)]

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

of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are consistent with and complement each other.

Interview with an identified resident revealed that the resident has pain and has taken pain medication in the past without relief. The pain is worse when he/she sits for long periods of time.

Interview with registered staff revealed that the weekly pain assessment and pain medication were discontinued because the resident had not complained of any discomfort or pain for an identified period of two months.

Interview with an identified PSW confirmed that identified resident had complained of pain during the same identified two-month period. In particular, the resident complained of pain at least twice each shift for a period of five days and that information was reported to the nurse in charge.

This information related to the resident's ongoing pain was not included in the development and implementation of the resident's plan of care. [s. 6. (4) (a)]

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

An identified resident ambulates independently with a mobility aide and is identified at risk of falls.

Interview with the resident revealed that he/she does not like bothering the staff and using the call bell. The resident also indicated that he/she experienced falls in the past few months.

Record review revealed that interventions to prevent falls for the identified resident include call bell pinned to gown when in bed, hourly safety check, ensure environment is free of clutter, encourage resident to use handrails or assistive device properly, reinforce need to call for assistance, remind resident to wear proper and non slip footwear, and transfer and change positions slowly.

Interview with an identified PSW confirmed that interventions to prevent falls for the identified resident are reminding resident to wear proper and non slip footwear and

ensuring the environment is free of clutter. The PSW further stated he/she was aware of the interventions because these are common sense. The identified PSW demonstrated to the inspector in accessing the resident's care plan through point of care, and confirmed that he/she was not aware of other interventions to prevent falls for the identified resident as indicated in the resident's written plan of care. [s. 6. (8)]

4. The licensee failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

On an identified date, an identified resident had a fall and was sent to the hospital on the same day. The resident was diagnosed with fracture and returned to the home from the hospital 10 days later.

Record reviewed revealed and staff interviews confirmed that the identified resident stayed in bed for most of the day for a few weeks after returning to the home. However, it is unsafe for the resident to stay in bed during the day because of his/her attempt to get out of bed. The resident had been staying in the lounge from morning before breakfast until after supper daily for the past few months. However, the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) for this resident for the past seven months indicate the resident stays in bed for most of the day.

Interview with an identified registered staff confirmed that the resident's plan of care was not reviewed and revised when his/her care needs changed. [s. 6. (10) (b)]

5. A review of the health records for an identified resident revealed that the resident was assessed with a stage 2 pressure ulcer on an identified date. A review of the resident's written plan of care for a period of six months, includes the identified date, confirmed that the plan of care was not revised to reflect the change in the resident's care needs.

An interview with the registered staff confirmed that changes were not made to the identified resident's plan of care at the time the resident was assessed with a stage 2 pressure ulcer. [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 following with respect to the plan of care are complied with:
1. a written plan of care for each resident that sets out clear directions to staff who provide direct care to the resident,
2. the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
3. staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are consistent with and complement each other,
4. staff and others who provide direct care to a resident are kept aware of the contents of the plan of care, and
5. 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

On an identified date, an identified resident had a fall and was sent to the hospital the next day because of pain. The resident returned to the home the day after.

Record review revealed and interview with an identified registered staff confirmed that a skin assessment was not conducted for the identified resident upon his/her return from the hospital. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and any changes made

to the resident’s plan of care relating to nutrition and hydration are implemented.

Record review of the health records for an identified resident for a period of six months revealed that the resident had a stage 2 pressure ulcer and the resident had not been assessed by a registered dietitian (RD) during that period.

Interview with the registered staff confirmed that the resident was neither referred nor seen by a dietitian after he/she was diagnosed with a stage 2 pressure ulcer. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff.

Review of the progress notes for an identified resident revealed that the resident had a stage 4 pressure ulcer on admission to the home. A review of the resident’s progress notes revealed that weekly wound assessments were not conducted consistently for the resident for a period of six months.

Interviews with the registered staff and the DOC confirmed that weekly wound assessments were not conducted consistently for the identified resident for a period of six months.

A review of the health records for another identified resident revealed that the resident had a stage 2 pressure ulcer that was discovered on an identified date, and weekly wound assessments were not conducted since then.

Interviews with the registered staff, the assistant director of care (ADOC) and the DOC confirmed that weekly wound assessments were not conducted for the identified resident since the stage 2 pressure ulcer was discovered.[s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following with respect to skin and wound care program are complied with:
1. a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital,
2. a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital, and
3. a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record in relation to the written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is kept in the home that includes,
(a) The nature of each verbal or written complaint;
(b) The date the complaint was received;
(c) The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) The final resolution, if any;
(e) Every date on which any response was provided to the complaint and a description of the response; and
(f) Any response made by the complaint.

Interview with an identified resident revealed that the resident made a verbal complaint to the management of the home regarding a comment made by a staff member to him/her. The home conducted the internal investigation and responded to the resident regarding the resolution. The identified resident was satisfied with the home’s handling of the above verbal complaint.

Record review revealed and interview with the DOC confirmed that the identified resident’s received complaint and investigation were not documented. [s. 101. (2)]

2. Interview with the DOC revealed that another identified resident made a few complaints to the DOC about his/her care. The DOC confirmed that the home did not respond in writing to the resident regarding his/her complaints or concerns. In addition, the DOC failed to provide any documentation relating to this resident's received complaints. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record in relation to the written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is kept in the home that includes,
(a) The nature of each verbal or written complaint;
(b) The date the complaint was received;
(c) The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) The final resolution, if any;
(e) Every date on which any response was provided to the complaint and a description of the response; and
(f) Any response made by the complaint, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Drug Inventory Management policy that the licensee is required by the Regulation to put in place is complied with.

On an identified date, the inspector observed two prescribed medications in the room of an identified resident. The inspector confirmed that one of the prescribed medications for the resident was discontinued six months prior. Further, an interview with the registered staff confirmed that the resident was given this medication to administer him/herself while in the home and when on a leave of absence.

Review of the home's policy titled, Drug Inventory Management, index number 05-02-20, reviewed on December 13, 2013, states that monthly, medications that are no longer required due to being discontinued, will be identified, destroyed and disposed of. [s. 8. (1)]

2. The licensee failed to ensure that the home's Distribution of Nourishment policy that the licensee is required by the Regulation to put in place is complied with.

On an identified date during the morning beverage service, the inspector observed on an identiifed unit, an identified PSW serving a resident a cranberry juice without referring to the beverage list.

Review of the home's policy titled Distribution of Nourishment, revised April 2013, states each nourishment cart has a list of residents and their diets, as well as the current copy of the nourishment menu including therapeutics. PSW must refer to these lists when distributing nourishment.

Interview with the identified PSW confirmed that he/she did not refer to the beverage list prior to serving the cranberry juice to the resident because he/she knows the resident's diet as she works full time.

On another identified date during the morning beverage service, the inspector observed another identified PSW pouring and offering a glass of orange juice to a resident in the lounge of an identified unit without referring to the beverage list.

Interview with the identified PSW confirmed that he/she should refer to the diet list and ask the resident what beverage the resident would like prior to serving the orange juice, and he/she did not do so.

Interview with the dietary manager (DM) confirmed that staff should refer to the nourishment binder for the resident's diet and the snack cycle for the day when serving beverages. [s. 8. (1) (b)]

3. Review of the home's policy #NFS-IV-17 titled Food Temperatures revised in March 2014, indicates that staff should sanitize the thermometers after each use by dipping the thermometer probe in the D4 sanitization solution for approximately ten seconds before and after each use, starting from vegetables to the last protein.

On an identified date, the inspector observed an identified dietary aide (DA), probing food temperature from one food item to the next without sanitizing the thermometer as specified in the policy.

Interviews with the identified DA and the DM confirmed that the home's Food Temperature policy is not being followed. [s. 8. (1) (b)]

4. Review of the home's policy titled Meal Service In Dining Room revised September 19, 2013, requires to properly position resident on the chair. Interview with the DM indicated that residents are to be seated upright at a 90-degree angle while being fed.

On an identified date, the inspector observed an identified volunteer assisting an identified resident and an identified nursing student assisting another identified resident during the lunch meal service on an identified dining room.

The first identified resident was observed sitting at a 60-degree angle with his/her chin elevated, while being fed. Record review revealed that the resident’s written plan of care indicated that he/she has difficulty chewing and swallowing due to poor oral motor control.

The volunteer feeding the resident indicated that he/she was not aware of the safe feeding position for the resident.

The second identified resident was observed sitting at a 45-degree angle, the chin was elevated, and his/her eyes were oriented towards the ceiling.

Record review revealed that the resident’s written plan of care indicated that he/she is at high nutritional risk and has difficulty chewing and swallowing.

On interview, the identified nursing student feeding the second identified resident acknowledged that the resident was not at a safe feeding position, but he/she was not aware of how to position the resident’s chair upright at a 90-degree angle.

In both situations, PSWs repositioned the residents upright at a 90-degree angle after the inspector's intervention. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On an identified date, at approximately 10:15 a.m, the inspector observed a storage room on an identified unit was open.

An interview with an identified housekeeping aide confirmed that the storage room should be closed and locked when not in use.

On the same day at approximately 9:50am, on another identified unit, the inspector observed that the treatment room was unlocked and accessible. The treatment room housed a treatment cart, which contained prescribed residents' treatment creams. The room also stored iodine, disinfectant spray and supplies such as scissors and tweezers.

Interview with an identified registered staff confirmed that the treatment room should be closed and locked when unattended. [s. 9. (1) 2.]

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 home, furnishings and equipment are maintained in safe condition and in a good state of repair.

On three identified dates, inspectors #502 and #566 observed holes in the corridor wall outside of room 4-113, and between rooms 4-105 and 4-107, 4-18 and 4-20, 4-34 and 4-36, 4-38 and 4-40.

Record review revealed and interview with the ESM confirmed that the above noted areas, as well as other resident home areas, required repair following the removal of hand sanitizer units from the resident corridors and the repair was not completed to date. Furthermore, the ESM was unable to provide a repair schedule or plans for the above repair. [s. 15. (2) (c)]

WN #8: 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 where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On an identified date, the inspector observed one half side rail in the up position in an identified resident's bed and the resident was not in bed.

Interview with an identified PSW confirmed that two bed rails are used when the identified resident is in bed for safety as recommended by the PT as needed for mobility. The resident has history of rolling and falling to the floor during sleep. Interview with an identified registered staff indicated one bed rail is used for the resident for safety.

Record review revealed that bed system has been evaluated by Medicalmart.

Record review revealed that the identified resident was not assessed for the use of bed rails.

Interview with the ADOC revealed that the assessment for the use of bed rails was completed by the PT. Interview with the PT confirmed that the assessment for the use of bed rails for the identified resident was not completed. [s. 15. (1) (a)]

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

On an identified date, inspectors #502 and #507 observed the call bells in all three cubicles in the public washroom on the main floor next to the reception wrapped around the grab bar, and not functioning.

Interview with the DOC confirmed that the public washroom on the main floor is used by residents and correction actions are required immediately.

On the next day, the inspectors observed the above mentioned call bells functioning. [s. 17. (1) (e)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident's SDM, if payment is required.

Record review revealed that an identified resident was not offered an annual dental assessment or other preventive dental services in the last 12 months.

Interview with the resident's SDM confirmed that the home did not inform or call to offer an annual dental assessment for the resident.

Interview with an identified registered staff revealed that the annual dental assessment is offered only to residents with dental discomfort or problems. The DOC failed to provide the record of offering the annual dental assessment to the identified resident. [s. 34. (1) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review revealed and interview with staff confirmed that concerns raised during the Residents' Council meetings on November 22, 2013, and April 17, 2014, were not forwarded to the appropriate department heads for response in a timely manner.

An interview with the chief executive officer (CEO) confirmed that the Residents' Council was not provided with a response within 10 days for the concerns raised during the above mentioned meetings. [s. 57. (2)]

WN #12: 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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids are stored using methods which prevent adulteration, contamination and food borne illness.

Record review indicated that safe temperature for refrigerator to hold perishable cold food is between zero to four degrees Celsius.

On numerous occasions, the inspector observed refrigerator #3, which is located in the servery on the first floor, functioning at an unsafe temperature. Milk, cream, cheese, juice, bread, and sandwiches were stored in the refrigerator.

The inspector observed the readings of the thermometer located in the refrigerator ranged from 7 to 13 degrees Celsius on three identified dates at four different times ranging from 10:01 a.m. to 3:01 p.m.

Interview with the DM confirmed that refrigerator #3 was not functioning at a safe temperature to hold perishable cold food. [s. 72. (3) (b)]

WN #13: 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. (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 residents who require assistance with eating or drinking were only served a meal when someone was available to provide them assistance.

On an identified date, the inspector observed an identified resident during lunch meal service in an identified dining room. The resident's soup was served and a staff member was not available to assist the resident.

Review of the resident's written plan of care indicated that staff should provide total assistance with eating and drinking, and the resident needs to be redirected each time when he/she loses focus with the task at hand.

An identified nursing staff confirmed that the identified resident requires total assistance with eating and drinking. The resident received assistance 15 minutes after the soup was served.

On another identified date, the inspector observed another identified resident sitting in another identified dining room with no staff member in the dining room. The resident's breakfast was served.

Review of the resident's written plan of care indicated that the resident requires extensive assistance with eating, and that staff should provide total assistance with eating and drinking, constant encouragement and remain with the resident during meals.

An identified PSW entered the dining room 10 minutes later, and indicated that the resident was served 40 minutes prior and was provided assistance with eating. The PSW left the dining room 15 minutes later to assist another resident with his/her breakfast in bed because the identified resident was not eating despite encouragement. The identified resident's breakfast remained on the table untouched.

The PSW confirmed that this resident requires assistance with meals. The resident received assistance at 9:45 a.m., 45 minutes after his/her breakfast was served. [s. 73. (2) (b)]

WN #14: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented for the cleaning of common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

On an identified date, the inspector observed three chairs in the conference room in an identified unit were stained.

Record review revealed and interview with the ESM confirmed that the home does not have a deep cleaning schedule in place for the cleaning of common areas. Chairs are cleaned upon request by the staff. [s. 87. (2) (a) (ii)]

WN #15: 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 are stored in an area or a medication cart that is secure and locked.

On an identified date, during the medication administration, the inspector observed the medication cart was unlocked on an identified unit and the medication cart was left unattended.

Interview with the registered staff confirmed that the medication cart should be locked between medication administrations when it is left unattended. [s. 129. (1) (a)]

WN #16: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Record review revealed and interview with the DOC confirmed that the home has a standard medical directive in place, and all residents are assessed for the use of the medical directive on admission and every three months.

On an identified date, an identified resident complained of pain and requested the registered staff to give him/her something. The registered staff gave the resident pain medication as per the home's standing medical directive despite the fact that the resident was not assessed for the use of the standard medical directive.

Record review revealed and interviews with registered staff and the DOC confirmed that the identified resident did not have a medical directive or order for the administration of pain medication on the identified date. [s. 131. (1)]

2. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On another identified date, the inspector observed a prescribed medication in the room of an identified resident. An interview with the resident confirmed that he/she administers the drug to himself/herself.

A review of the health records for the identified resident and staff interview confirmed that self-administration had not been approved by the prescriber in consultation with the resident. [s. 131. (5)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff are provided training in falls prevention and management.

Review of the training records revealed and staff interview confirmed that 93 per cent of direct care staff have completed the training in falls prevention and management in 2013. [s. 221. (1) 1.]

2. The licensee failed to ensure that all direct care staff are provided training in skin and wound care.

Review of the home's training records and staff interview confirmed that 97 per cent of direct care staff received training in skin and wound care in 2013. [s. 221. (1) 2.]

3. The licensee failed to ensure that all direct care staff are provided training in pain management, including recognition of specific and non-specific signs of pain.

Review of the home's training records and staff interview confirmed that 91 per cent of direct care staff have completed the training in pain management in 2013. [s. 221. (1) 4.]

Issued on this 27th day of August, 2014

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