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
Jun 10, 2014	2014_157210_0008	T-0005-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO AGED MEN'S AND WOMEN'S HOMES
55 Belmont Street, TORONTO, ON, M5R-1R1

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

BELMONT HOUSE
55 BELMONT STREET, TORONTO, ON, M5R-1R1

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

SLAVICA VUCKO (210), NITAL SHETH (500), TILDA HUI (512)

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): April 15, 16, 17, 22, 23, 25, 28, 29, 30, 2014.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered nurses (RN), registered practical nurses (RPN), director of care (DOC), assistant director of care (ADOC), environmental services supervisor, food services supervisor, resident assessment instrument (RAI) manager, physiotherapist (PT), housekeeping aide, recreation coordinator, recreation director, representative and president of the Family Council, president of the Resident's Council, private care givers, residents, maintenance representative, dietary staff, cook, professional practice, quality and risk leader, director of support services.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed resident and home records, observed the home's environment, meal service and food production, reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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. (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. A review of the most recent Minimum Data Set (MDS) assessment for resident #555, indicated the resident had a a non-healing pressure ulcer since the end of 2012 and a pressure relieving device for the wheelchair.

Observation conducted on April 23, 2014, at 4:00 p.m., confirmed the presence of a pressure relieving device-cushion on the wheelchair. Hand pressure was applied on the pressure relieving device, and it was confirmed by interview with identified staff that the cushion was deflated. A PSW indicated there is a pump on the unit to inflate the cushion if necessary. Interview with identified RPN confirmed he/she was not able to locate the pump, explain what is the proper pressure for the cushion or who is responsible for checking the inflation cushion pressure.

A review of the plan of care dated March 23, 2014, indicated a pressure relief mattress to be used for the bed, a tilt wheelchair to provide comfort and prevent skin

breakdown, turn and reposition with skin care every two hours. The resident's plan of care did not provide clear direction to staff in relation to the pressure relieving device. [s. 6. (1) (c)]

2. The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A review of the plan of care indicated resident #550 required one person extensive assistance when toileted at 7:30 a.m., 12 p.m., and 5 p.m.

Interview with identified staff indicated during the day shift the resident was assisted with toileting in the morning, before breakfast, before and after lunch, and before 3 p.m. The resident was continent of bladder and bowel most of the time and used incontinent product "pull-ups" for security. The resident was able to use the toilet without assistance. It was documented in flow sheets by PSWs that the resident was incontinent all the time. The registered staff documented in the quarterly RAI MDS assessments for 2013, and 2014, that resident #550 was incontinent of bladder all the time, relying on the flowsheet documentation. [s. 6. (4) (a)]

3. A review of the written plan of care for resident #579 indicated the resident to be toileted at 7:30a.m., 9:30 a.m., 11:30a.m., 4 p.m., 6 p.m., 7:30 p.m., and when the resident asks. The resident uses pull-ups as continent product.

Interview with the private care giver and identified staff indicated the resident used medium size incontinent product for several months.
Interview with an identified PSW confirmed she was not informed about the change of the type of incontinent product.
Interview with staff indicated they did not communicate with the private care giver about the bladder toileting routine of resident #579 including assistance required with toileting according to the care plan, and if the resident was continent or incontinent of bladder. [s. 6. (4) (a)]

4. The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
A review of the written care plan for resident #579 indicated resident requires extensive assistance for morning and evening care (e.g. brushing teeth). Staff will set

up then resident can do the rest.
Interview with resident #579 indicated staff performs extensive assistance (staff does everything) with brushing teeth which was confirmed by interview with identified PSW. The interview with the private care giver and the resident indicated he\she has sensitive teeth and he/she wants to try by herself first. If he/she is tired and not able to do it then staff to help her with gentle brushing.
Interview with RN confirmed she was not informed about the preference of the resident in order to update the care plan for oral care. [s. 6. (4) (a)]

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

A review of the plan of care for resident #550 in relation to falls indicated the resident is at high risk for falls and the call bell to be within reach when the resident is in the bed.

Interview with the resident and observation conducted on April 22, 2014, at 1:00 p.m., revealed that resident #550 was in bed and the call bell was not in reach, but placed at the bottom side of the bed and the resident was not able to locate it or reach it. [s. 6. (7)]

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

A review of the written plan of care for resident #579 indicated resident to be toileted at 7:30a.m., 9:30 a.m., 11:30 a.m., 1:30 p.m, 4 p.m., 6 p.m., 7:30 p.m. and when the resident asks.

Interview with the resident's private care giver indicated on April 23, 2014, she came on duty at 8 a.m., and the resident was not toileted nor the incontinent product was changed. Interview with identified PSW indicated he/she has not read the care plan in order to know and provide assistance to resident #579 with toileting and incontinent product change at 7:30 a.m. [s. 6. (8)]

7. The licensee failed to ensure staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it.

Interview with an identified PSW indicated staff follow the short form of the plan of care called Kardex but there is a paper copy of the detailed plan of care that is located in the binder with the flow sheets. The Kardex does not contain all the details for the level of assistance in personal care, such as oral care.

Observation and interview with the PSW confirmed the paper copy of the care plan for resident #579 was not in the binder with the flow sheets and a PSW was not able to find out the details about the oral care of resident #579. [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 the written plan of care for each resident sets out, clear directions to staff and others who provide direct care to the resident, staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the care set out in the plan of care is provided to the resident as specified in the plan, staff and others who provide direct care to a resident, are kept aware of the contents of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has received 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.

A review of the progress notes indicated in the last quarter of 2012, resident #555's buttock was excoriated and had two open areas (0.2x0.2cm each), staff applied Calmoseptine, repositioned resident to the sides, and the plan was to continue to monitor. The resident complained of discomfort/pain in the middle lower back and coccyx area,two weeks after the skin problems were noted. The nurse applied protective dressing on the area and the physician recommended a donut cushion for the wheelchair. The resident developed two Stage 2 ulcers one month after they the skin problems were noted.

A review of the clinical record indicated resident #555 had not received a skin assessment when he/she acquired two pressure ulcers, (on the coccyx and the right ischium), in the last quarter of 2012. The skin assessment was completed one month after the initial skin problems were noted, using the pressure ulcer/wound assessment record.

Interview with an identified RN confirmed that registered nursing staff did not initiate a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment until the skin ulcer was identified as Stage 2. The staff indicated that it is the home's practice to manage Stage 1 or red area by application of Calmoseptine, protective dressing, turning, repositioning and monitoring.

A skin assessment was not completed by a member of the registered nursing staff for resident #555 in the last quarter of 2012, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment when he/she was exhibiting altered skin integrity. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has received 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who is incontinent received an assessment that includes identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions.

A review of the recent bowel and bladder assessment form V2 for resident #550, indicated resident was aware of the urge to void, he/she was incontinent of bladder and the degree of bladder incontinence was incontinent (multiple daily episodes).

A review of the plan of care for resident #550, in relation to potential to restore function with specific intervention, indicated the resident required extensive assistance by one person for toileting at 7:30 a.m., 12:00 p.m., and 5:00 p.m. Interview with RN confirmed the form for bowel and bladder assessment does not include an assessment for identification of casual factors and the type of incontinence. [s. 51. (2) (a)]

2. A review of the bowel and bladder assessment V2 for resident #559 indicated resident was aware of the urge to void, he/she was continent of bladder and he/she was frequently incontinent (some control but incontinent daily).

A review of the plan of care for resident #559 in relation to potential to restore function with specific interventions, indicated resident required one person assistance with fastening his/her incontinent product when he/she was having difficulty, toileted independently unless he/she asked for assistance. However the assessment does not include an assessment that includes identification of causal factors and the type of incontinence. [s. 51. (2) (a)]

3. A review of the recent bowel and bladder assessment V2, for resident #579 indicated the resident was not aware of the urge to void, he/she was incontinent of bladder with multiple daily episodes.

A review of the plan of care for resident #579 indicated assistance at 7:30 a.m., 9:30 a.m., 11:30 a.m., 1:30 p.m., 4 p.m., 6 p.m., 7:30 p.m. and when resident asked. However the assessment does not include an assessment that includes identification of causal factors. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident who is incontinent received an assessment that includes identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions, 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of the clinical record for resident # 559 indicated he/she was prescribed a medication, to be administered.

Interview with ADOC indicated that when registered staff administer medications they have to sign the electronic medication administration record (eMAR) at the moment of administration and registered staff has thirty minutes timeframe before and after the prescribed time to give the medications.

Interview with the resident and ADOC and review of the clinical record confirmed that resident #559 received the medication out of the time limit on following occasions:
on April 26, 2014 medication was administered 137 minutes later,
on April 20, 2014 medication was administered 76 minutes later,
on April 19, 2014 medication was administered 55 minutes later,
on April 18, 2014 medication was administered 94 minutes later,
on April 13, 2014 medication was administered 77 minutes later,
on April 3, 2014 medication was administered 69 minutes later,
on April 1, 2014 medication was administered 142 minutes later. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

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

Shared washrooms were observed on April 16, 2014, at 9:48 a.m., and April 29, 2014 at 10 a.m. An identified PSW confirmed a tooth brush, hair brush and denture cup on the sink countertop in room #324, a tooth brush and tooth paste on the sink countertop, a urine collection basin on the toilet water tank in room #509 as not being labeled. [s. 229. (4)]

2. The licensee failed to ensure that an identified private caregiver was trained and monitored for compliance in the implementation of the infection prevention and control program at the home.

Observation conducted on April 25, 2014 at 3 p.m. revealed that a private caregiver of resident #579 used the same pair of vinyl gloves on a soiled incontinence brief, then picked up a clean brief with the intention of applying it on the resident.

Interviews with the private caregiver and the DOC confirmed that the private caregiver should have removed the used vinyl gloves and performed hand hygiene prior to handling the clean incontinent brief. [s. 229. (4)]

3. The licensee failed to ensure staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of an employment record and interview with ADOC indicated a staff was hired at the begining of 2014, and there was no record of tuberculosis screening test. The home's policy for TB Mantoux Skin testing (August 2103) stated an assessment must be initiated within 6 months before starting work or within 14 days of starting work. If any previous tuberculosis screening test (TST) was positive a chest x-ray had to be performed within the last 3 months unless the person was symptomatic. [s. 229. (10) 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 that staff participates in the implementation of the infection prevention and control program, staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: 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 policy Skin and Wound Care is in compliance with and is implemented in accordance with all applicable requirements under the Act.

A review of the Skin and Wound Care Policy, dated March 2014, describes procedures for identifying residents at risk for altered skin integrity. Registered staff should make referrals to multidisciplinary team members as required (e.g. registered dietitian (RD), physiotherapist (PT) etc.). For residents with pressure ulcers the RD will participate in the monthly Skin and Wound Action Team (SWAT) rounds.

The policy is not in compliance with the applicable requirements under the Acts.O. Reg. 79/10, s. 50 (2) which states that every licensee of a long-term care home shall 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.

A review of the clinical record for resident #555 indicated when staff noted altered skin integrity in the last quarter of 2012, the RD was not informed until one month later.

Interview with RN confirmed that registered staff would send a referral to RD for assessment only if there is an open skin area, Stage 2 ulcer. [s. 8. (1) (a)]

2. The licensee failed to ensure that the home's policy on expired medication was complied with.

A record review revealed that the home's policy titled Medication - Storage of Surplus, Discontinued and Drug Destruction with revision date of January 2013, stated in it's procedure section item number one, that "When a medication is discontinued or expired, registered staff should remove the medication from the medication cart/treatment cart". Item number three in the same section stated that "Staff should be checking expiry dates monthly on eye drops, creams , stock medications, vaccines and any other items in medication cart and medication room fridges. Any expired medications should be placed in drug destruction box."

Observation conducted on April 23, 2014, at 2:00 p.m., on the medication cart on unit 4 west revealed that the following medications in the medication cart were expired: Senokot expired in April 2013, Mucilluin expired in April 2013, and Dimenhydrinate 50 mgm expired in February 2014.

Interviews with an identified RPN on unit 4 west and DOC confirmed that the expired medications should have been removed from the medication cart. The RPN stated that he/she was not aware of any practice at the home for checking the expiry date of medications on a regular bases, but registered nursing staff would check every time before a medication is given. [s. 8. (1) (b)]

3. The licensee failed to ensure that the policy Falls Prevention and Management is in compliance with and is implemented in accordance with all applicable requirements under the Act.

A review of home's policy titled Falls Prevention and Management, revised December 2013, indicates "to complete the Post-Fall Assessment (Apendix D) in Point Click Care"

A review of plan of care revealed that resident #587 had a fall on January 22, 2014. The post fall assessment was conducted using the fall risk assessment tool that is used to assess the risk for falls at admission and quarterly.

Interview with registered nursing staff, professional practice, quality and risk leader and DOC confirmed that staff was required to use electronic post fall assessment form after each fall. Nursing staff used inappropriate tool for post fall assessment for the resident. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are provided with food and fluids that are safe, and adequate in quantity.

Observation conducted on April 15, 2014, at 12:00 p.m., on 2 west dining room revealed that resident #594 was served thickened cranberry juice with nectar consistency.

A review of the resident's plans of care revealed that the resident should be provided with thickened fluids with honey consistency.

Interviews with the dietary staff and director of support services confirmed that fluids with nectar consistency were not safe for this resident.

Observation conducted on March 19, 2014, at 12:00 p.m., on 2 west dining room revealed that dietary staff did not use standardized scoop size when serving food. A scoop size #8 was used instead of #16 for serving apple sauce and a scoop #10 was used instead #16 for serving minced cantaloupe. Interview with identified staff confirmed appropriated scoop sizes should be used for all food items as per the menus and the scoop size may alter the quantity and nutrient value of the foods. [s. 11. (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, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Observation conducted on April 22, 2014, at 2:30 p.m., and interview with maintenance services technician indicated the wall board was detached from the wall half way and it was not safe while the resident was in bed. A request for maintenance was not sent to the maintenance department. The maintenance service technician indicated that the regular check ups or rounds for safety are performed every three months. [s. 15. (2) (c)]

2. Observation conducted on April 16, 2014, at 11:34 a.m., revealed that two quarter side rails were up for bed #A and the right side rail was wobbling and was not fitted properly to the bed. Interview with staff indicated the side bed rail is used by resident for transferring. The same side rail was observed to be in a similar condition on April 29, 2014 at 11:05 a.m., and April 30, 2014 at 11:30 a.m.

An interview with maintenance staff confirmed that the side bed rail on the right side of the bed was loose and needed tightening. [s. 15. (2) (c)]

WN #9: 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 ensure that 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.

A review of Resident's Council meeting minutes for August 2013, revealed that there was a concern on unit 4 west about residents not having privacy during bath, as doors were kept open and people were coming in and out of the bathroom.

An interview with identified staff confirmed that there was no documentation available to indicate that written response was provided to the Resident's Council for the above mentioned concern. [s. 57. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 62. Every licensee of a long-term care home shall ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents' needs. O. Reg. 79/10, s. 62.

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents' needs.

An interview with identified staff indicated that a Social Worker had not been employed at the home since October 2013, and DOC was performing the social work duties since then. A review of the social work services brochure that was given to residents and family members stated the social work services are provided by professionally trained social workers, who are registered members of the Ontario College of Social Workers and Social Service Workers.

The written description of the social services work provided in the home if not performed by a licensed social worker is not available. [s. 62.]

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 the planned menu items are offered and available at each meal.

Observation conducted on April 15, 2014, at lunch time on 2 west revealed that, lamb patty was included in the planned menu for minced and pureed texture. Dietary staff did not open pans of minced and pureed lamb patty until the meal service was completed. Residents on minced and pureed texture received only one choice of fresh fruit salad with cottage cheese/cheddar cheese. Alternate entree choice at lunch was available but it was not offered to residents.

An interview with the dietary staff confirmed that he/she did not use the alternate entree choice (lamb patty) for minced and pureed residents but served only the fresh fruit salad plate with cottage cheese/cheddar cheese. [s. 71. (4)]

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. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has and that the staff of the home comply with, a cleaning schedule for the food production, servery and dish washing areas.

Observation conducted on April 29, 2014, on west wing serveries on second, third, fourth and fifth floor revealed that there was dust deposited on the hot water dispensers and coffee machines. The tap of the hot water dispensers were not descaled. Microwaves, fridges and freezers were not cleaned inside and dry food particles were noted stuck around the inside walls. Hand washing stations in the serveries, the inside of an ice machine and corners of dish washing area were not cleaned.

Observation conducted with dietary supervisor in the main kitchen on April 29, 2014 revealed that juice machines were not cleaned from inside walls and on top surface, and there were spilled juice on the racks of the juice containers, food wagons were not cleaned.

Interviews with dietary staff confirmed that the home did not have cleaning schedules for all the kitchen equipment. Cleaning for some of the equipment was included in dietary staff's job routines and staff usually did not have time to clean the equipment thoroughly.

An interview with the director of support services confirmed that home did not have cleaning schedule for food production and servery area but cleaning was part of the daily job routines.

A review of dietary service work schedules revealed that cleaning of microwaves, fridges, freezers, food wagons, oven, juice machines, coffee machines was part of the job routine however the inspector found that staff did not clean all the equipment. [s. 72. (7) (c)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

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

Observation conducted on April 15, 2014, at 10:40 a.m., revealed that a bottle of chart cover cleaning solution and a can of air wick was stored on a shelf in the unlocked clean utility room on one of the units.

An interview with the environmental supervisor confirmed that the chemicals should not be kept in the room accessible to residents. [s. 91.]

WN #14: 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 area or a medication cart that is used exclusively for drugs and drug-related supplies.

Observation conducted on April 23, 2014, at 2:00 p.m., on the medication cart on 4 west revealed a latex mask in bottom drawer, and a Beck taxi authorization book in the top drawer of the medication cart. The following non-medication items were found in the narcotic drawer of the medication cart:
-One pair of eye glasses
-A wallet with content
-A metal ash tray wrapped in plastic bag
-A silver-colored ring
-One senior's privilege card

Interviews with a RPN on the unit and the DOC confirmed that the above non-medication items should not be stored in the medication cart. [s. 129. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home: the date the drug is received in the home, and the signature of the person acknowledging receipt of the drug on behalf of the home.

A record review of the drug record book on 5 west revealed that the record book for delivery of reordered medications was not signed and dated in one occasion in April 2014, upon receipt, and deliveries of medications in striped pouches were not signed and dated in two occasions in March and April, 2014.

Interview with identified staff confirmed that the registered nursing staff did not sign the drug record book when the deliveries of medications were received on the above dates. [s. 133.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where a drug is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the reason for destruction in the drug record.

Record review revealed that the home used Narcotic Count Sheet as record for drug destruction. The reasons for destruction of the controlled substances were not stated in the drug record.

An interview with identified staff confirmed that the home did not record the reason for destruction of the controlled substances. [s. 136. (4)]

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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, training is provided to all staff who provide direct care to residents.

A review of the staff training attendance record for falls prevention and management for 2013, revealed that direct care and nursing staff have not been provided training in post fall prevention and management. [s. 221. (1) 1.]

2. Interview with identified staff indicated he\she was not able to provide evidence for staff training in skin and wound care in 2013. [s. 221. (1) 2.]

3. A review of the education record for continence care and bowel management and interview with DOC indicated only 34% staff who provide direct care to residents received the training in 2013. [s. 221. (1) 3.]

Issued on this 10th day of June, 2014

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