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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Jan 29, 2015;	2014_226192_0038 (A1)	L-001533-14	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE ARTHUR NURSING HOME
215 ELIZA STREET P.O. BOX 700 ARTHUR ON N0G 1A0

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

DEBORA SAVILLE (192) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An e-mail from the Administrator of the home requesting an amendment to compliance dates for orders #001, #005 and #006 was received by Inspector #192 on January 22, 2015.

Phone discussion was held with Administrator, Lisa Canada at 1720 hours on January 22, 2015.

A) Compliance Order #001 related to LTCHA, 2007, S. 6(7) The liscensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Following discussion it was confirmed that the complaince date for this order would remain January 30, 2015.

B) Compliance Order #005 related to O. Reg 79/10 s. 50(2)(b)(i) A resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.

During discussion it was identified by the home that additional time was required to ensure that every resident of the home received a comprehensive skin assessment and that the plan of care would then be updated to reflect the assessed need. It was mutually agreed that the compliance date for this order would be amended to February 27, 2015.

C) Complaince Order #006 related to O. Reg 79/10 s.51(2)(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

During discussion it was identified by the home that additional time was required to ensure that every resident of the home received a comprehensive assessment of their continence needs and that the plan of care would then be updated to reflect the assessed need. It was mutually agreed that the

compliance date for this order would be amended to February 27, 2015.

The report reflects the agreed upon amendments to compliance dates for orders #005 and #006.

Issued on this 29 day of January 2015 (A1)

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

Original report signed by the inspector.

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Jan 29, 2015;	2014_226192_0038 (A1)	L-001533-14	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE ARTHUR NURSING HOME
215 ELIZA STREET P.O. BOX 700 ARTHUR ON N0G 1A0

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

DEBORA SAVILLE (192) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 13, 24, 25, 26, 27, December 1, 2, 3, 4 and 5, 2014.

Critical Incident Inspection 004043-14 was completed and is included within this Resident Quality Inspection.

Complaint Inspection 006604-14 was completed concurrently with this inspection and findings related to the inspection were issued under inspection number 2014_226192_0039.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Nursing, Assistant Director of Nursing, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support workers, Cook, Dietary Aides, Housekeeping Aides, Laundry Aides, Maintenance person, Activities Coordinator, Pharmacist, Clerical Clerk, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

25 WN(s)
14 VPC(s)
8 CO(s)
0 DR(s)
0 WAO(s)

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

In 2014 resident #006 was observed to have altered skin integrity.

Review of the resident's clinical health record indicated that the physician visited the resident and indicated that staff were to monitor the area of altered skin integrity.

A review of the residents clinical health record indicated there was no plan of care developed identifying the impaired skin integrity and directions for staff to monitor. The Director of Nursing confirmed there was no plan of care developed to address the impaired skin integrity and reported that the area of altered skin integrity had changed in size.

The licensee failed to ensure that the written plan of care set out the planned care for resident #006. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to

staff and others who provide direct care to the resident.

A) The plan of care for resident #010 related to hygiene dated as revised in 2014, indicated the resident required extensive assistance. To provide weight bearing support three or more times per week, or complete staff performance of task, most days but not everyday.

Interview with the Director of Nursing confirmed that the plan of care does not provide clear direction to staff and other who provide direct care to the resident in relation to the hygiene needs of the resident.

B) The plan of care related to hygiene, dated as created in 2014, for resident #009 indicated staff were to encourage and praise resident for completed steps in personal hygiene and for appearance when appropriate. That the resident required extensive assistance. Provide weight bearing support 3 or more times per week or complete staff performance of task, most days but not everyday and that the resident required total dependence. Staff perform total care of activities every day.

Resident #009 was observed to have long facial hair in 2014. Interview with the Director of Nursing confirmed that staff would be expected to remove facial hair on bath days.

Interview with the Assistant Director of Care confirmed that the plan of care for resident #009 does not provide clear direction to staff and others who provide direct care to resident #009 in relation to hygiene. [s. 6. (1) (c)]

3. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Resident #011's plan of care related to personal hygiene last revised October 15, 2013 indicated that the resident required extensive assistance. Staff were to provide weight bearing support three or more times per week, or complete staff performance of task, most days but not everyday.

The plan of care did not set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that there was a written plan of care for each

resident that sets out, clear directions to staff and others who provide direct care to the resident.

Observation of resident #006 on three specified dates in 2014 and staff interviews confirmed that the resident had an assistive device and a tilt wheel chair in place that did not inhibit the resident's movement.

A review of progress notes in the resident's clinical health record indicated a specified restraint was discontinued.

The resident's plan of care for PASD directed staff that when the resident was in the tilt wheelchair and resting in the day, the resident was to be positioned correctly.

The resident's plan of care for mobility indicated that the resident used a wheelchair with a specified restraint and an assistive device. Monitor resident every eight hours by registered staff and reposition resident hourly by two PSW's.

The resident's plan of care for falls directed staff to chart the effectiveness of the restraint every shift and indicated the resident used the assistive device for fall prevention.

The resident's plan of care for restraint device directed staff to apply a restraint while the resident was in their wheelchair and readjust every hour.

Interview with the DON confirmed that the plan of care did not provide clear direction for staff related to the devices to use for the resident including monitoring and repositioning.

The plan of care did not provide clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

5. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Observation of resident #005 on two specified dates in 2014 and staff interviews confirmed that the resident currently had a tilt wheel chair in place that did not inhibit the resident's movement.

The resident's plan of care for mobility indicated that the resident uses a wheelchair assistive device.

Interview with the DON confirmed that the plan of care did not provide clear direction for staff related to the type of device used, when to apply the device, and when the resident required repositioning.

The plan of care did not provide clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

The plan of care for resident #002 in effect at the time of this inspection, indicated under recreation that the resident enjoys watching television in their room. The plan of care under falls indicated that staff are to ensure that the resident remains in the lounge area where staff can monitor them until the resident can be taken to their room and safely placed in bed.

Resident #002 was observed at the bedside, unattended with the television turned on.

Interview with the Assistant Director of Nursing confirmed that the plan of care fails to provide clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

A) The plan of care for resident 002 indicated that the resident was on a toileting program fashioned after their own routine. Toilet resident at specified times.

Resident #002 was observed continuously on November 27, 2014 between 1055 and 1145 hours when the resident was taken to the Dining Room and between 1300 and 1335 hours when the resident was removed from the Dining Room, positioned in the lounge and then assisted into bed. The resident was not assisted to the toilet during these periods of observation as identified in the plan of care as being their normal routine.

A PSW interviewed confirmed that the resident was assisted to the toilet at 0700

hours and at 1030 hours.

A PSW interviewed confirmed that the resident had been placed in bed at 1335 without being assisted to the toilet.

Interview with the Director of Nursing confirmed that PSW's are to follow the individualized toileting routines identified in the plan of care.

B) The plan of care for resident #002 under transfers indicated that the resident is to be transferred with a transfer belt and two staff.

During observation of resident #002 on November 27, 2014 a Personal Support Worker was observed to transfer the resident to bed by taking the resident by the hands and assisting them to a standing position and then onto the bed. The staff member then lifted the resident's feet onto the bed, raised the bed rail and went to obtain a face cloth.

The Assistant Director of Care and Resident Assessment Instrument Coordinator confirmed that the resident has been assessed to require two staff for all transfers and use of a transfer belt.

The licensee failed to ensure that resident #002 was toileted and transferred according to the plan of care. [s. 6. (7)]

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

Resident #012's plan of care related to a Personal Assistance Services Device (PASD) directed staff to apply an assistive device when the resident was in the wheelchair, monitor the resident for correct positioning frequently and change the residents position frequently.

On December 2, 2014 the resident was observed from 0935 hours to 1157 hours to have the assistive device in place however, the resident was not repositioned by staff during this time.

Interview with a Personal Support Worker (PSW) confirmed that the resident had not been repositioned since personal care was provided at 0800 hours, at least five hours prior. The PSW reported that the resident would only be repositioned if they required

a transfer to their recliner chair or bed or if they were toileted.

The Director of Nursing (DON) reported that the expectation for the resident with a PASD would be that staff reposition the resident every two hours.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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

Resident #006's plan of care related to toileting indicated that the resident would be toileted every two hours.

The resident was observed on December 2, 2014 from 0930 hours until 1150 hours in which the resident was not toileted during this time, this was confirmed by a Personal Support Worker (PSW).

A PSW reported that the resident had a brief change at 0730 hours but was not toileted when provided personal care in the morning. The resident was not toileted for at least four hours and 20 minutes.

The care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

Resident #005's plan of care related to toileting indicated that the resident would be toileted every two hours.

The resident was observed on December 2, 2014 from 0930 hours until 1200 hours in which the resident was not toileted during this time.

Interview with a PSW confirmed that the resident had not been toileted during the observed period and was usually toileted in the afternoon. A PSW reported that the resident had been toileted at 0745 hours when provided personal care in the morning. The resident was not toileted for at least five and a half hours and had not yet been toileted at the time of the interview.

The DON confirmed that the resident should have been toileted every two hours as indicated in the resident's plan of care.

The care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

Resident #012's plan of care related to toileting last dated October 25, 2014 indicated that the resident would be toileted every two hours.

The resident was observed on December 2, 2014 from 0930 hours until 1200 hours in which the resident was not toileted during this time.

During an interview, the resident confirmed that staff had not toileted the resident since morning care was provided before breakfast.

Interview with a PSW confirmed that the resident had not been toileted during the observed period. The resident was not toileted for at least five hours and 15 minutes and had not yet been toileted at the time of the interview.

The DON confirmed that the resident should have been toileted every two hours as indicated in the resident's plan of care.

The care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

12. The licensee has 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.

The plan of care for resident #002 under recreation indicated that they are to have one to one contacts three to four times each month, participate in the back to basics schedule and are on the sensory stimulation list.

Interview with the Activities Coordinator indicated that participation in the back to basics schedule includes the one to one visits and sensory stimulation and is intended

for residents who attend less than eight programs each month.

Assessment of resident #002 was completed on September 17, 2014 with a review of the plan of care completed October 1, 2014. Interview with the Activities Coordinator confirmed that the resident #002 would not qualify for the back to basics program as they had attended more than eight activities in each of September, October and November 2014 and that the plan of care was not updated when reviewed.

The licensee failed to ensure that when resident #002 was reassessed, the plan of care was revised when care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 ensuring that the plan of care sets out clear directions to staff and others who provide direct care to the resident and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

Review of the Registered Nursing schedules and interview with the Assistant Director of Nursing confirmed that a Registered Nurse who is an employee of the licensee and a member of the regular nursing staff is not on duty and present at all times.

Interview confirmed that there is only one registered staff member on the twelve hour night shift and that a Registered Practical Nurse covered the night shift on September 2, 5, 7, 19, 20, 21, 22, 29 and 30, 2014. No registered nurse was available and present in the home.

The home has attempted to recruit registered nurses and had been successful but interview identified that a lack of orientation resulted in some of the registered nurses resigning and leaving the home without adequate registered nurses to cover all shifts. [s. 8. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 of the long term care home failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Interview with the DON December 4, 2014, confirmed that where bed rails were used residents of the home have not been assessed to minimize the risk to residents.

During observation in stage 1 of this inspection by inspector #192 and #165 19 of 40 residents were observed to have one or more bed rails in the up position.

Review of the home's Facility Entrapment Inspection Sheet on December 4, 2014 indicated that 14 of the 19 bed systems observed to have bed rails in use by the inspectors had not been evaluated to minimize risk to the resident.

The Environmental Supervisor reported that bed system evaluations were initiated in September 2014 however, confirmed that where bed rails were used not all bed systems were evaluated.

A review of the home's Facility Entrapment Inspection Sheet indicated that resident #022's bed system failed entrapment zones two and three. The Maintenance person confirmed that the home had identified bed systems that failed one or more entrapment zones. A review of the Facility Entrapment Inspection Sheet indicated that 14 bed system evaluations had one or more failed zones of entrapment.

During an Interview December 4, 2014 the Maintenance person confirmed that the identified 14 beds that had one or more failed zones of entrapment had not been modified or corrected to mitigate the entrapment risk to residents.

The licensee failed to ensure that where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 can be easily seen, accessed and used by residents, staff and visitors at all times.

During stage one of this inspection it was observed on November 24, 2014 that the resident-staff communication and response system located in a specified room, and attached to bed two could not be activated. A Personal Support Worker confirmed that the call bell could not be activated.

On November 24, 2014 the call bell in a specified room and attached to bed one was not able to be activated.

On November 24, 2014 four call bells were observed to be out of the reach of residents in specified rooms. The inaccessible call bell in one room was confirmed with the Administrator.

On December 5, 2014 a resident in a specified room was observed at the foot of the bed. The resident demonstrated specified signs of distress. A Personal Support Worker confirmed that the call bell, which was attached to the pillow on the bed, would not be accessible to the resident.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

Interview with the Assistant Director of Care and the home's wound care champion confirmed that bruising would be considered altered skin integrity and that a resident with bruising would be assessed by the registered staff of the home and a note would be made in the progress notes.

A) Resident #007 was observed to have bruising in 2014.

During observation of the resident in the presence of the home's wound care champion, resident #007's bruising was confirmed. A review of the progress notes with the wound care champion confirmed that the bruise had not been documented as having been assessed. Interview confirmed that the wound care champion was not aware of the bruising until it was pointed out by the inspector three days after it was first observed in 2014.

B) Resident #009 was observed to have bruising in 2014.

During observation of the resident in 2014 in the presence of the home's wound care

champion, resident #009's bruising was confirmed. A review of the progress notes with the wound care champion confirmed that the bruising had not been documented as having been assessed. Interview confirmed that the wound care champion was not aware of the bruising until it was pointed out by the inspector two days after it was first observed in 2014.
The licensee failed to ensure that resident #007 was assessed when they exhibited bruising.

C) Resident #032 was observed in 2014 to have a bruise. A review of the residents medical record failed to identify that the bruise had been assessed.

Interview with the ADON confirmed that a bruise would be recorded in the progress notes and would be investigated by registered staff when it was identified by staff. Interview with the Director of Nursing confirmed that the presence of a bruise should be investigated to rule out potential abuse of the resident.

The home's policy titled Skin Care, dated as reviewed August 2013 stated that the skin integrity of each resident will be assessed for areas of pressure or breakdown each time personal care is delivered. Interview with the ADON confirmed that this would include bruising and that staff providing personal care in the morning and evening would be expected to report a change in condition, such as bruising, to registered staff so that it could be assessed and an investigation into the cause initiated.

The licensee failed to ensure that residents #007, #009 and #032 were assessed when they exhibited altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

In 2014, resident #006 was observed to have altered skin integrity.

A review of clinical health records indicated on a specified date in 2014 the Physician visited the resident, indicated that the altered skin integrity should be observed by the staff and referral to a specialist if family desired.

A review of the clinical health record and confirmation from a Registered Nurse indicated that there was no skin assessment completed by a member of the registered nursing staff related to the altered skin integrity.

Interview with the DON confirmed that a skin assessment and monitoring of the resident's skin was not completed by a member of the registered nursing staff and the area of altered skin integrity had increased in size. [s. 50. (2) (b) (i)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

WN #6: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. On a specified date in 2014 resident #011 was observed to be incontinent of bladder with visible urine stains on their pants.

On a specified date in 2014 the resident was observed for more than two hours. During the observed time, staff did not check the residents brief or toilet the resident until after the resident was incontinent and wet.

Interview with a PSW confirmed that the resident was not checked or toileted since morning care was provided. The PSW reported that the resident would have been checked and changed after lunch however, it was completed earlier since the resident was incontinent and their clothing required changing.

The residents plan of care related to toileting directed staff to toilet the resident every two hours.

The DON reported that the resident should have been checked/toileted after the breakfast meal.

The licensee has failed to ensure that residents who require continence care products have sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 006

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres (cm).

During the initial tour of the home on November 13, 2014 it was observed by inspector #519 that windows on either side of the exit in the resident lounge opened greater than 15 cm and that the window on the left side of the door had no screen in place.

Observation with the Maintenance person on December 5, 2014 confirmed that the windows are accessible to residents and that they open to the full width of the window which is greater than 15 cm. In addition, it was confirmed that the window to the left of the door had no screen in place.

The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 cm. [s. 16.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

In 2014, during the lunch observation it was noted that a specified resident was positioned in an unsafe manner throughout the meal.

Two weeks later in 2014, during the lunch observation it was again noted that a specified resident was positioned in an unsafe manner. The resident was observed to be choking; the staff member assisting the resident identified that they had only given the resident a small amount of liquid. The Assistant Director of Nursing was in attendance and the resident was able to clear their airway.

Review of the resident plan of care under eating identified that they are to have pillows behind the resident's back and head to ensure that they are sitting upright during meals.

Interview with the Assistant Director of Care confirmed that the resident was in a reclined position, that the plan of care indicated the use of pillows to position the resident in an upright position and that the resident had sustained choking episodes in the past.

The resident was observed on on two further occasions in 2014, during the lunch meal and noted to be in a reclined position and was not in an upright position with pillows supporting the resident's back and head.

The licensee failed to ensure that the specified resident was positioned safely during meals. [s. 73. (1) 11.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 ensuring that there appropriate furnishings and equipment in resident dining areas, including tables at an appropriate height to meet the needs of all residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, 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:
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 of the long term care home failed to ensure that every resident had the right to have his or her participation in decision making respected.

A review of resident #012's clinical health record indicated that in 2014 family of the resident requested to have a specified health care provider see the resident and approached the Assistant Director of Nursing (ADON) to arrange for the appointment. The ADON indicated that the health care provider would be contacted via email.

A progress note in 2014, indicated that the resident had pain. On examination the Registered Nurse indicated that the resident reported pain to a specified area, and noted some redness in the area. The Registered Nurse advised the resident to see if it improved and staff were to continue to monitor the resident.

The ADON confirmed that they did not contact the health care provider via email to arrange an appointment as indicated however; if the resident was seen by the health care provider it would have been documented in the progress notes under vitals and assessments.

A review of the residents progress notes indicated the resident had not been seen by the health care provider.

On a specified date in 2014 a progress note indicated that the family reported that they requested the resident be seen by the health care provider however; the resident had not been seen. Family indicated they would arrange for resident to be taken out of the home in order to see an alternative provider.

The home did not respect the residents right to have their participation in decision making respected. [s. 3. (1) 9.]

2. The licensee has failed to ensure the resident's right to have his or her personal health information kept confidential.

In 2014 the Power of Attorney for resident #002 identified that they are informed of changes to the residents status while standing at the nursing station where other residents, visitors and staff would overhear the conversation.

Interview with a registered nurse confirmed that communication with family members usually occurs at the nursing station.

A review of the minutes of Residents' Council and interview with a member of Residents' Council identified that residents have expressed concerns about others being able to listen in on conversations held at the nursing station and the Residents'

Council minutes indicated that residents were told they are not to be sitting at the desk listening to staff members on the phone, about other residents personal information.

In December 2014 registered staff were observed speaking to family members on the phone at the nursing station with regard to personal health information for a resident. Several residents were seated next to the nursing station and visitors and staff were observed at and around the nursing station.

The licensee failed to ensure the resident's right to have his or her personal health information kept confidential. [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 ensuring that every resident has the right to have his or her participation in decision making respected and that every resident has the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act respected., to be implemented voluntarily.

WN #10: 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 has failed to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's Bladder and Bowel Management Program policy indicated that a continence assessment would be completed on all residents who score a two or higher on section H1a or H1b of any Minimum Data Set (MDS) assessment or at any time upon resident change of status.

A review of two of resident #011's MDS assessments in 2014 indicated the resident had a score of four on section H1a and H1b however; there was no continence assessment completed.

The Resident Assessment Instrument (RAI) Co-ordinator confirmed that continence assessments were not completed on both occasions despite the resident scoring four on section H1a and H1b.

The licensee failed to ensure that the home followed their Bladder and Bowel Management Program policy. [s. 8. (1) (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 ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, 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 equipment was kept clean and sanitary.

A) On November 27, 2014 resident #002 was observed to be sitting in a dirty wheelchair. The wheels and frame of the chair are heavily soiled with dust and spilled food. Spilled food was observed on the cushion of the chair.

On December 4, 2014, one week later, observation with the Director of Nursing found resident #002 to be sitting in the same wheelchair. The wheels and frame of the chair remained heavily soiled with dust and spilled food. The cushion cover had been removed and the resident was sitting on a specified cushion with no cover.

Review of the homes wheelchair cleaning record initiated in November 2014 with the Director of Nursing confirmed that the wheelchair resident #002 was sitting in had not been cleaned in November or December.

Interview with the Director of Nursing (DON) confirmed that the wheelchair is dirty and that the home had cushion covers available so that the resident should not need to sit on a cushion with no cover. The DON indicated that a contracted provider has a quarterly schedule for the cleaning of wheelchairs in the home. The schedule indicated that all chairs were to have been cleaned on November 27, 2014 but the provider failed to arrive as scheduled.

The home was unable to provide documentation related to when resident #002 last had their wheelchair cleaned.

B) During stage 1 observations made by inspection #519 and #165 on November 24 and 25, 2014 it was noted that raised toilet seats in bathrooms in five specified rooms were soiled with feces. Arms of the raised seat were spotted with a white substance.

Observation with the Administrator on December 5, 2014 confirmed that raised toilet seats were dirty with a white substance on the arms attached to the seat.

The licensee failed to ensure that equipment was kept clean and sanitary. [s. 15. (2) (a)]

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

During observation on November 24, 2014 five bathrooms were observed to have raised toilet seats in place that were not fastened to the toilet bowl and were unsteady when pressure was applied to either side, presenting a fall risk to residents using these bathrooms.

During observation with the Maintenance person it was confirmed that raised toilet seats are not secured in place on the toilet bowl and that they provide a potential hazard to residents.

The licensee failed to ensure that the equipment was maintained in a safe condition. [s. 15. (2) (c)]

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 ensuring that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

A review of resident #011's Minimum Data Set (MDS) assessment indicated the resident was incontinent of bladder and bowel.

Personal Support Workers reported that the resident was incontinent of bladder and bowel and the resident was observed to be incontinent of bladder in 2014.

The resident's plan of care indicated the resident was occasionally incontinent of bladder.

The RAI Co-ordinator and DON confirmed that the plan of care was not based on the interdisciplinary assessment related to the residents continence. [s. 26. (3) 8.]

2. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment with respect to the resident's drugs and treatments.

A) A review of resident #003's clinical health record indicated that the resident received a psychotropic drug twice daily.

The Minimum Data Set (MDS) assessment for resident #003 identified that a Resident Assessment Protocol (RAP) was triggered for psychotropic drug use. The RAP indicated that the resident was on psychotropic drugs with no side effects at that time. Staff were to monitor the resident for side effects and report any decline in the residents mental status to registered staff. The RAP indicated that Psychotropic Drug use would be addressed in the care plan. This was confirmed by the RAI

Co-ordinator.

A review of the resident's plan of care indicated there was no plan of care with respect to the resident's psychotropic drug use. This was confirmed by the RAI Coordinator.

B) A review of resident #011's clinical health record indicated that the resident received a psychotropic drug.

The Minimum Data Set (MDS) assessment for resident #011 identified that a RAP was triggered for psychotropic drug use. The RAP indicated that the resident was on psychotropic drugs with no side effects at that time. Staff were to monitor the resident for side effects and report any decline in the residents mental status to registered staff. The RAP indicated that Psychotropic Drug use would be addressed in the care plan.

A review of the resident's plan of care indicated there was no plan of care with respect to the resident's psychotropic drug use. This was confirmed by the RAI Coordinator.

The resident's plan of care did not include, at a minimum, a focus with interventions to address associated risks related to the resident's drugs and treatments. [s. 26. (3) 17.]

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 ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of Continence including bladder and bowel elimination and the drugs and treatments, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) Record review identified that the Continence Care and Bowel Management Program was last evaluated April 23, 2013. The period being evaluated was not identified on the record. The Administrator and Assistant Director of Nursing (ADON) identified that the evaluation was for a period in 2012 and 2013 but were unable to identify the specific time frame.

Record review and interview identified that an evaluation for 2014 is currently in progress and is anticipated to be completed by the end of December 2014.

Interview with the ADON confirmed and documentation supports that the evaluation currently being completed is for the 2014 year.

The licensee failed to ensure that the Continence Care and Bowel Management Program was evaluated for the 2013 year.

B) Record review identified that an evaluation of the Skin and Wound Program was completed for the period between March 1, 2012 and February 28, 2013. The 2014 evaluation is dated as having been completed October 31, 2014 and included meeting dates from November 2013 to October 2014.

Interview with the Administrator confirmed that an evaluation of the eight month period between March and October 2013 was not completed.

C) Record review identified that no evaluation of the Accommodation Services was completed by the home. The Administrator confirmed that the Program Evaluation Schedule 2014 does not include evaluation of the Accommodation Service and evaluation had not been completed. [s. 30. (1) 3.]

2. The licensee of the long term care home failed to ensure that the Nutrition and Hydration Program was evaluated and updated at least annually in accordance with evidence-based practices and if there are non, in accordance with prevailing practices.

Interview with the Food Nutrition Manager on December 1, 2014 verified that there was no annual evaluation of the Nutrition and Hydration program completed since her employment commenced in December 2013.

Interview with the Administrator confirmed that there was no Nutrition and Hydration program evaluation completed for 2013 or 2014. [s. 30. (1) 3.]

3. The licensee of a long-term care failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Record review for an evaluation of the Continence Care and Bowel Management Program dated April 2013 includes a summary of changes made over the past year, but does not include the date that changes were implemented.

Interview with the Assistant Director of Nursing confirmed that evaluations completed do not include the date that changes were implemented.

The Administrator confirmed that the summary of changes for the Skin and Wound Program did not include the dates changes were implemented.

The licensee failed to ensure that a summary of changes made to the Continence Care and Bowel Management Program and Skin and Wound Program included the date that changes were implemented. [s. 30. (1) 4.]

4. The licensee of the long term care home failed to ensure that the Responsive Behaviours program included a written record relating to each evaluation under paragraph three that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the home's Responsive Behavioural Program evaluation for August 2012 to August 2013 indicated that the program summary evaluation was completed however, there was no dates that indicated the changes were implemented.

The Assistant Director of Nursing confirmed that dates were not included in the summary that identified when the changes in the program were implemented. [s. 30. (1) 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 ensuring that programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation are evaluated and updated at least annually in accordance with evidence-based practices and if there are none, in accordance with prevailing practices and shall shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work.

The licensee was unable to provide a written staffing plan that included a back-up plan for nursing and personal care staffing. Interview with the Assistant Director of Nursing identified that the home frequently is unable to replace personal care staff when there are call-ins and the home frequently works with less staff than the home identified are required to meet the assessed needs of the residents.

Review of schedules identified that for the week of November 2 to 8, 2014 the home worked short personal care staff on eight occasions. For the week of November 9 to 15, 2014 on ten occasions; November 16 to 22, 2014 six occasions and November 23 to 29, 2014 on four occasions.

Interview identified nine night shifts in September when a registered nurse was not present and in attendance in the home. No backup plan is available in the event of an absence of the registered nurse.

Negative outcomes identified by staff of the home included missed baths, missed morning and bedtime care, missed shaving and an increase in the number of resident falls.

The licensee failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work. [s. 31. (3) (d)]

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 ensuring that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the recreational and social activities program included the assistance and support to permit the residents to participate in activities that may be of interest to them if they are not able to do so independently.

During interview on November 26, 2014 the Power of Attorney for resident #002 identified that the resident is not encouraged to participate in activities. That they are placed in the Activity Room with the television on and the resident sleeps in their chair.

Resident #002 was not observed to participate in activities during the course of this inspection.

Review of the plan of care for resident #002 indicated that the resident is to be invited to all musical programming and entertainment, participates in group exercises, is to attend all church services and that the resident requires transport to activities.

Review of the residents attendance at activities for September, October and November 2014 identified that resident #002 participated in an average of 3.7 activities per week. Review of the home's activity calendar identified that based on the resident's identified preferences from the plan of care and no documented refusals to participate, resident #002 could potentially have participated in an average of 18 activities per week if provided assistance and support to attend.

Interview with the Activities Coodinator confirmed that the calendar provided many additional opportunities for the resident's participation and there is no documentation to support that the resident refused to participate.

The licensee has failed to ensure that the recreational and social activities program included the assistance and support to permit resident #002 to participate in activities that may be of interest to them if they are not able to do so independently. [s. 65. (2) (f)]

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 ensuring that the recreational and social activities program included the assistance and support to permit the residents to participate in activities that may be of interest to them if they are not able to do so independently, to be implemented voluntarily.

WN #16: 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 has failed to ensure that the planned menu items were offered and available at each meal and snack.

On December 1, 2014 it was observed that the planned menu items for the renal menu were not offered and available during the lunch meal service.

A review of resident #021's clinical health record indicated that the physician diet order was a renal modified diabetic diet.

Interview with the cook and Food Nutrition Manager reported that the renal therapeutic menu was the menu staff followed for the resident. The therapeutic menu for the lunch meal indicated that the resident was to be offered two ounces of pork in place of sausage links.

During the lunch meal the resident was offered the regular sausage links. Interview with the cook confirmed that pork was not prepared for the resident to be offered during the lunch meal.

The Food Nutrition Manager confirmed that the renal menu was to be offered first and if the resident refused then the regular diet could be offered.

The licensee failed to ensure that the planned menu items were offered and available at each meal and snack. [s. 71. (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 ensuring that the planned menu items were offered and available at each meal and snack, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure as part of the organized program of laundry services under clause 15(1)(b) of the Act, that residents' soiled clothes were collected, sorted, cleaned and delivered to the resident.

In 2014, it was reported that one resident had a black pair of pants that returned from laundry brown, and one resident had white socks that returned from laundry purple.

On December 5, 2014 a Laundry aide confirmed that resident's personal clothing was not sorted from darks and whites prior to being washed.

The Laundry Aide reported that residents dark and white personal clothing were washed together on either the pre-programmed personal dark cycle or the personal white cycle. The Laundry Aide reported that bleach would automatically be added if the pre-programmed personal whites cycle was selected and verified that the personal white cycle would be selected despite the personal clothing not being sorted.

The Laundry Aide confirmed that resident's personal clothing items have been discoloured and reported that was why she washed all personal clothing on the pre-programmed dark cycle.

The Administrator reported that resident's personal clothing was to be sorted by the laundry staff and verified that they had previously received concerns regarding discoloured clothing being returned from laundry.

The licensee failed to ensure that resident's soiled clothes were collected, sorted, cleaned and delivered to the resident. [s. 89. (1) (a) (iii)]

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 ensuring that as part of the organized program of laundry services under clause 15(1)(b) of the Act, that residents' soiled clothes were collected, sorted, cleaned and delivered to the resident, to be implemented voluntarily.

WN #18: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff only permits a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if the staff member has been trained by a member of the registered nursing staff in the administration of topicals.

On December 2, 2014 a written complaint was received that indicated that staff of the home are asked to administer topical medications to residents without having received training.

Interview with the Administrator and Director of Nursing confirmed that training on the application of topicals had taken place in March 2014. Record review, confirmed by the Administrator, identified that 71 percent of the direct care staff had participated in the mandatory training provided in March 2014. Interview with the Director of Nursing confirmed that the home had not maintained a record of staff who had successfully completed training on the application of topicals that would be readily accessible.

Information provided by the home related to the material presented to staff included a "Certificate for Administration of Creams and Ointments". Interview with the Administrator confirmed that the home had not used this certificate to identify staff who had received the training.

Interview with Personal Support Workers being asked to administer topical medications identified that one in three interviewed had not received training related to the application of topicals to residents and that they continued to be asked to apply the topicals. Two of three PSW's interviewed were recorded as having completed training on the application of topicals, but during interview identified they had not received training and indicated they did not recognize the training material shown them at the time of the interview.

On December 5, 2014 the Director of Nursing confirmed that Personal Support Workers of the home need to be trained on the application of topical medications.

The licensee failed to ensure that a member of the registered nursing staff only permits a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if the staff member has been trained by a member of the registered nursing staff in the administration of topicals. [s. 131. (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 ensuring that a member of the registered nursing staff only permits a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if the staff member has been trained by a member of the registered nursing staff in the administration of the topical, to be implemented voluntarily.

WN #19: 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:
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).

s. 221. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure 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.

Record review and interview confirmed that 8 of 62 direct care staff received training related to skin and wound care in 2013.

Record review and interview confirmed that as of December 1, 2014 71 percent of direct care staff had received training related to skin and wound care in 2014.

Interview with the Administrator confirmed that there are no planned training sessions in 2014 for the remaining 29 percent of direct care staff.

The licensee failed to ensure that all direct care staff receive annual training related to skin and wound care. [s. 221. (1) 2.]

2. The licensee has failed to ensure that training related to continence care and bowel management was provided to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs.

Interview with the Director of Care and Assistant Director of Care and review of training records confirmed that 12 of 56 direct care staff participated in training related to continence care and bowel management in 2013.

Interview with the Administrator confirmed that that 40 of 56 direct care staff participated in mandatory training that included continence care and bowel management in March of 2014. The Administrator confirmed that training for the remaining 29 percent of the direct care staff was not scheduled as of December 1, 2014.

The licensee failed to ensure that all staff who provide direct care to residents received training related to continence care and bowel management. [s. 221. (1) 3.]

3. The licensee has failed to ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours.

A review of the home's Inservice Tracking Sheet for 2013 indicated that there was no direct care staff that participated in training for techniques and approaches related to responsive behaviours. This was confirmed by the home's Administrator.

The RAI Coordinator verified that education took place on November 26 and

December 11, 2013, however, only 19 of the 62 direct care staff participated.

The Administrator reported that Dementia training occurred in March 2014, as part of the home's mandatory education however, only 43 of 56 direct care staff participated. The Administrator confirmed on December 1, 2014, that there was no plan in place to provide the education for the remaining 13 direct care staff members prior to the end of December 2014. [s. 221. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that staff who provide direct care to residents receive training related to; skin and wound care, continence care and bowel management, and responsive behaviours, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the initial tour of the home on November 13, 2014 at 1154 hours it was observed that in the three tub/shower rooms there was soiled, unlabeled blue ware.

In the Ash Wing tub room there was an empty commode basin lying on the tile floor.

In the Balsam shower room, on the white shelf beside the shower there was used glove and a soiled unlabeled blue basin on the bottom shelf.

In the Cedar Wing tub room on the black shelving unit there were two soiled, unlabeled blue basins. [s. 229. (4)]

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

During observation of the lunch meal on November 13, 2014 it was observed that staff serving the meal did not use gloves. The chicken sandwich requested by residents were observed, in the presence of the Food and Nutrition Manager, to be positioned on the plate without the use of gloves. Interview with the Food and Nutrition Manager confirmed that when touching the food, staff would be expected to wear gloves.

During observation of the lunch meal on November 13, 2014 a sandwich and salad were observed to be plated, taken to a resident and, placed on the table in front of resident. The resident then requested an alternative, the sandwich plate was returned to the hot cart located in the kitchen, placed at the back of the cart and was observed to be served to another resident who requested the sandwich choice. Interview with the Food and Nutrition Manager confirmed that the expectation would be that a fresh plate of food is prepared and served for each resident.

On December 2, 2014 a dietary aid was observed to place a bowl of soup in front of a resident. A table mate identified that the resident does not like crackers in their soup and the soup was removed from in front of the resident. The staff member then proceeded to serve the bowl of soup to the next resident at the table, before she was stopped by the Assistant Director of Nursing.

During observation of the lunch meal on November 13, 2014 the Dietary Aide was observed to prepare a plate of food, then enter the dining room and serve the food to residents on multiple occasions. While in the dining room the Dietary Aide was observed to wipe their nose with their hand, touch and readjust their hair net and touch residents in the room. The Dietary Aide was then observed to return to the kitchen and continue to serve food without completing hand hygiene. Interview with the Food and Nutrition Manager confirmed that hand hygiene should be performed before serving food.

The licensee failed to ensure that staff participate in the implementation of the

infection prevention and control program. [s. 229. (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 ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

For the purposes of this section, "bathing " includes tub baths, showers, and full body sponge baths.

Record review for resident #032 identified that they had received a bath on only three occasions in October 2014 and two occasions in November 2014. Refusal of bathing was documented for two specified dates in each of October and November 2014.

The plan of care for resident #032 indicated that the resident prefers to have a tub bath once weekly and does not address a second bath in the week.

Interview with the Assistant Director of Nursing confirmed that when a resident requests only a tub or shower once weekly, only one tub or shower is offered. A full body sponge bath is not offered as an alternative to a tub or shower. The ADON confirmed that resident #032 was offered only one bath per week. [s. 33. (1)]

WN #22: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that within 10 days of receiving Residents Council concerns or recommendations, the licensee respond to the Residents' Council in writing.

A review of Resident Council meeting minutes indicated that written responses to Resident's Council was not within 10 days of the home receiving concerns or recommendations.

The following residents council meetings did not have a written response within 10 days:
January 8, 2014 residents council meeting was not responded to in writing until January 31, 2014;
March 12, 2014 residents council meeting was not responded to in writing until April 11, 2014;
May 14, 2014 residents council meeting was not responded to in writing until June 30, 2014;
June 12, 2014 residents council meeting was not responded to in writing until July 9, 2014.

The Administrator confirmed that written responses were not completed within 10 days of receiving the advice from residents council.

Interview with two members of residents council reported that they did not receive the written responses until the next residents council meetings.

The licensee has failed to ensure that within 10 days of receiving Residents Council concerns or recommendations, the licensee respond to the Residents' Council in writing. [s. 57. (2)]

WN #23: The Licensee has failed to comply with LTCHA, 2007, s. 72. Medical Director

Specifically failed to comply with the following:

s. 72. (1) Every licensee of a long-term care home shall ensure that the home has a Medical Director. 2007, c. 8, s. 72. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a Medical Director.

Interview with the Director of Nursing identified that the home has two physicians that started working at the home in June 2014, but the home does not have a designated/contracted Medical Director. [s. 72. (1)]

WN #24: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3

Findings/Faits saillants :

1. The licensee failed to ensure that the required information for the purposes of subsections (1) and (2) is posted in the home; (h) the name and telephone number of the licensee.

Review of posted items with the Administrator confirmed that the name and telephone number of the licensee is not posted in the home. [s. 79. (3) (h)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 217. The licensee shall ensure that there is a designated lead for the training and orientation program. O. Reg. 79/10, s. 217.

Findings/Faits saillants :

1. The licensee failed to ensure that there is a designated lead for the training and orientation program.

Interview with the Administrator on December 1, 2014 indicated that the home does not have a designated lead for the training and orientation program and that all managers participate in the training of staff. [s. 217.]

Issued on this 29 day of January 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DEBORA SAVILLE (192) - (A1)

Inspection No. / No de l'inspection : 2014_226192_0038 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-001533-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 29, 2015;(A1)

Licensee / Titulaire de permis : CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

LTC Home / Foyer de SLD : CARESSANT CARE ARTHUR NURSING HOME
215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LISA CANADA

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall ensure that residents of the home receive care as specified in their plan of care in relation to toileting, transfers and monitoring while using Personal Assistance Services Devices.

Grounds / Motifs :

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

Resident #012's plan of care related to toileting indicated that the resident would be toileted every two hours.

The resident was observed on December 2, 2014 from 0930 hours until 1200 hours in which the resident was not toileted during this time.

During an interview, the resident confirmed that staff had not toileted the resident since morning care was provided before breakfast.

Interview with a PSW confirmed that the resident had not been toileted during the

observed period. The resident was not toileted for at least five hours and 15 minutes and had not yet been toileted at the time of the interview.

The DON confirmed that the resident should have been toileted every two hours as indicated in the resident's plan of care.

The care set out in the plan of care was not provided to the resident as specified in the plan.

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

Resident #005's plan of care related to toileting indicated that the resident would be toileted every two hours.

The resident was observed on December 2, 2014 from 0930 hours until 1200 hours in which the resident was not toileted during this time.

Interview with a PSW confirmed that the resident had not been toileted during the observed period and was usually toileted in the afternoon. A PSW reported that the resident had been toileted at 0745 hours when provided personal care in the morning. The resident was not toileted for at least five and a half hours and had not yet been toileted at the time of the interview.

The DON confirmed that the resident should have been toileted every two hours as indicated in the resident's plan of care.

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

Resident #006's plan of care related to toileting indicated that the resident would be toileted every two hours.

The resident was observed on December 2, 2014 from 0930 hours until 1150 hours in which the resident was not toileted during this time, this was confirmed by a Personal Support Worker (PSW).

A PSW reported that the resident had a brief change at 0730 hours but was not

toileted when provided personal care in the morning. The resident was not toileted for at least four hours and 20 minutes.

The care set out in the plan of care was not provided to the resident as specified in the plan.
(165)

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

Resident #012's plan of care related to a Personal Assistance Services Device (PASD) directed staff to apply an assistive device when the resident was in the wheelchair, monitor the resident for correct positioning frequently and change the resident's position frequently.

On December 2, 2014 the resident was observed from 0935 hours to 1157 hours to have the assistive device in place however, the resident was not repositioned by staff during this time.

Interview with a Personal Support Worker (PSW) confirmed that the resident had not been repositioned since personal care was provided at 0800 hours, at least five hours prior. The PSW reported that the resident would only be repositioned if they required a transfer to their recliner chair or bed or if they were toileted.

The Director of Nursing (DON) reported that the expectation for the resident with a PASD would be that staff reposition the resident every two hours.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. (165)

3. The plan of care for resident 002 indicated that the resident was on a toileting program fashioned after their own routine. Toilet resident at specified times.

Resident #002 was observed continuously on November 27, 2014 between 1055 and 1145 hours when the resident was taken to the Dining Room and between 1300 and 1335 hours when the resident was removed from the Dining Room, positioned in the lounge and then assisted into bed. The resident was not assisted to the toilet during these periods of observation as identified in the plan of care as being their normal routine.

A PSW interviewed confirmed that the resident was assisted to the toilet at 0700 hours and at 1030 hours.

A PSW interviewed confirmed that the resident had been placed in bed at 1335 without being assisted to the toilet.

Interview with the Director of Nursing confirmed that PSW's are to follow the individualized toileting routines identified in the plan of care.

B) The plan of care for resident #002 under transfers indicated that the resident is to be transferred with a transfer belt and two staff.

During observation of resident #002 on November 27, 2014 a Personal Support Worker was observed to transfer the resident to bed by taking the resident by the hands and assisting them to a standing position and then onto the bed. The staff member then lifted the resident's feet onto the bed, raised the bed rail and went to obtain a face cloth.

The Assistant Director of Care and Resident Assessment Instrument Coordinator confirmed that the resident has been assessed to require two staff for all transfers and use of a transfer belt.

The licensee failed to ensure that resident #002 was toileted and transferred according to the plan of care. (192)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

Jan 30, 2015

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that there is at least on registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

Review of the Registered Nursing schedules and interview with the Assistant Director of Nursing confirmed that a Registered Nurse who is an employee of the licensee and a member of the regular nursing staff is not on duty and present at all times.

Interview confirmed that there is only one registered staff member on the twelve hour night shift and that a Registered Practical Nurse covered the night shift on September 2, 5, 7, 19, 20, 21, 22, 29 and 30, 2014. No registered nurse was available and present in the home.

The home has attempted to recruit registered nurses and had been successful but interview identified that a lack of orientation resulted in some of the registered nurses resigning and leaving the home without adequate registered nurses to cover all shifts. (192)

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

Jan 30, 2015

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

O.Reg 79/10, 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

Order / Ordre :

The licensee shall ensure that where bed rails are used;

a) the resident is assessed and his or her bed system evaluated to minimize risk to the resident and

b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Grounds / Motifs :

1. The licensee of the long term care home failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Interview with the DON December 4, 2014, confirmed that where bed rails were used residents of the home have not been assessed to minimize the risk to residents.

During observation in stage 1 of this inspection by inspector #192 and #165, 19 of 40 residents were observed to have one or more bed rails in the up position.

Review of the home's Facility Entrapment Inspection Sheet on December 4, 2014 indicated that 14 of the 19 bed systems observed to have bed rails in use by the inspectors had not had his or her bed system evaluated to minimize entrapment risk.

The Environmental Supervisor reported that bed system evaluations were initiated in September 2014 however, confirmed that where bed rails were used not all bed systems were evaluated.

A review of the home's Facility Entrapment Inspection Sheet indicated that resident #022's bed system failed entrapment zones two and three. The Environmental Supervisor confirmed that the home had identified bed systems that failed one or more entrapment zones. A review of the Facility Entrapment Inspection Sheet indicated that 14 bed system evaluations had one or more failed zones of entrapment.

During an Interview December 4, 2014 the Environmental Supervisor confirmed that the identified 14 beds that had one or more failed zones of entrapment have not been modified or corrected to mitigate the entrapment risk to residents.

The licensee failed to ensure that where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. (165)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

Mar 27, 2015

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(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).

Order / Ordre :

The licensee shall ensure that the home's resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

Grounds / Motifs :

1. Previously issued August 13, 2012 as a VPC.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

During stage one of this inspection it was observed on November 24, 2014 that the resident-staff communication and response system located in a specified room, and attached to bed two could not be activated. A Personal Support Worker confirmed that the call bell could not be activated.

On November 24, 2014 the call bell in a specified room and attached to bed one was not able to be activated.

On November 24, 2014 four call bells were observed to be out of the reach of residents in specified rooms. The inaccessible call bell in one room was confirmed with the Administrator.

On December 5, 2014 a resident in a specified room was observed at the foot of the bed. The resident demonstrated specified signs of distress. A Personal Support Worker confirmed that the call bell, which was attached to the pillow on the bed, would not be accessible to the resident.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. (192)

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

Jan 30, 2015

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that resident #006 and all other residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On November 25, 2014, resident #006 was observed to have altered skin integrity.

A review of clinical health records indicated on a specified date in 2014 the Physician visited the resident, indicated that the altered skin integrity should be observed by the staff and referral to a specialist if family desired.

A review of the clinical health record and confirmation from a Registered Nurse indicated that there was no skin assessment completed by a member of the registered nursing staff related to the altered skin integrity.

Interview with the DON confirmed that a skin assessment and monitoring of the resident's skin was not completed by a member of the registered nursing staff and the area of altered skin integrity had increased in size. (165)

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

Interview with the Assistant Director of Care and the home's wound care champion

confirmed that bruising would be considered altered skin integrity and that a resident with bruising would be assessed by the registered staff of the home and a note would be made in the progress notes.

Resident #009 was observed to have bruising.

During observation of the resident in the presence of the home's wound care champion confirmed the resident had bruising. A review of the progress notes with the wound care champion confirmed that the bruising had not been documented as having been assessed. Interview confirmed that the wound care champion was not aware of the bruising until it was pointed out by the inspector two days after it was first observed in 2014.

B) Resident #032 was observed to have a bruise. A review of the residents medical record failed to identify the presence of a bruise. Interview with the ADON confirmed that a bruise would be recorded in the progress notes and would be investigated by registered staff when it was identified by staff. Interview with the Director of Nursing confirmed that the presence of a bruise should be investigated to rule out potential abuse of the resident.

The home's policy titled Skin Care, dated as reviewed August 2013 stated that the skin integrity of each resident will be assessed for areas of pressure or breakdown each time personal care is delivered. Interview with the ADON confirmed that this would include bruising and that staff providing personal care in the morning and evening would be expected to report a change in condition, such as bruising, to registered staff so that it could be assessed and an investigation into the cause initiated.

The licensee failed to ensure that resident #009 was assessed when they exhibited bruising. (192)

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

Interview with the Assistant Director of Care and the home's wound care champion confirmed that bruising would be considered altered skin integrity and that a resident with bruising would be assessed by the registered staff of the home and a note would be made in the progress notes.

Resident #007 was observed to have bruising.

During observation of the resident in 2014 in the presence of the home's wound care champion, resident #007's bruise was confirmed. A review of the progress notes with the wound care champion confirmed that the bruise had not been documented as having been assessed. Interview confirmed that the wound care champion was not aware of the bruising until it was pointed out by the inspector three days after it was first observed in 2014.

The home's policy titled Skin Care, dated as reviewed August 2013 stated that the skin integrity of each resident will be assessed for areas of pressure or breakdown each time personal care is delivered. Interview with the ADON confirmed that this would include bruising and that staff providing personal care in the morning and evening would be expected to report a change in condition, such as bruising, to registered staff so that it could be assessed and an investigation into the cause initiated.

The licensee failed to ensure that resident #007 was assessed when they exhibited bruising. (192)

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

Feb 27, 2015(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that resident #011 and all other residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

Grounds / Motifs :

1. The licensee has failed to ensure that residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

On a specified date in 2014 resident #011 was observed to be incontinent of bladder with visible urine stains on their pants.

On a specified date in 2014 the resident was observed for more than two hours. During the observed time, staff did not check the residents brief or toilet the resident until after the resident was incontinent and wet.

Interview with a PSW confirmed that the resident was not checked or toileted since morning care was provided. The PSW reported that the resident would have been checked and changed after lunch however, it was completed earlier since the resident was incontinent and their clothing required changing.

The residents plan of care related to toileting directed staff to toilet the resident every two hours.

The DON reported that the resident should have been checked/toileted after the breakfast meal.

The licensee has failed to ensure that residents who require continence care products have sufficient changes to remain clean, dry and comfortable.
(165)

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

Feb 27, 2015(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

Grounds / Motifs :

1. Previously issued as a compliance order on August 13, 2012.

The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres (cm).

During the initial tour on November 13, 2014 it was observed by inspector #519 that windows on either side of the exit in the resident lounge opened greater than 15 cm and that the window on the left side of the door had no screen in place.

Observation with the Maintenance person on December 5, 2014 confirmed that the windows are accessible to residents and that they open to the full width of the window which is greater than 15 cm. In addition, it was confirmed that the window to the left of the door had no screen in place.

The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 cm. (192)

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

Jan 30, 2015

Order # /
Ordre no : 008

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

Ontario

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The license shall ensure that resident #031 is positioned safely while receiving assistance for all meals.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

In 2014 during the lunch observation it was noted that a specified resident was positioned in an unsafe manner throughout the meal.

Two weeks later in 2014, during the lunch observation it was again noted that a specified resident was positioned in an unsafe manner. The resident was observed to be choking; the staff member assisting the resident identified that they had only given the resident a small amount of liquid. The Assistant Director of Nursing was in attendance and the resident was able to clear their airway.

Review of the resident plan of care under eating identified that they are to have pillows behind the resident's back and head to ensure that they are sitting upright during meals.

Interview with the Assistant Director of Care confirmed that the resident was in a reclined position, that the plan of care indicated the use of pillows to position the resident in an upright position and that the resident had sustained choking episodes in the past.

The resident was observed on on two further occasions in 2014, during the lunch meal and noted to be in a reclined position and was not in an upright position with pillows supporting the resident's back and head.

The licensee failed to ensure that the specified resident was positioned safely during meals.

(192)

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

Dec 31, 2014

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29 day of January 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE - (A1)

Service Area Office /
Bureau régional de services : London