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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2015;	2014_321501_0021 (A1)	T-011-14	Resident Quality Inspection

Licensee/Titulaire de permis

Downsview Long Term Care Centre Limited
3595 Keele Street NORTH YORK ON M3J 1M7

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

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

SUSAN SEMEREDY (501) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The licensee has requested an amendment of Compliance Order #001, issued pursuant to O.Reg. 79/10 s. 221(2), pertaining to the abuse recognition and prevention annual training for 2013 and annual training for falls prevention, skin care and responsive behaviours in 2014. The licensee has requested an extension to provide this training to all relevant staff. The wording was changed to clarify dates educational records were reviewed and produced and the compliance date was extended to allow the licensee sufficient time to ensure all staff receive the required training.

The licensee has also requested an amendment of Compliance Order #002, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s 19. (1), pertaining to protecting residents from abuse and neglect. This compliance order has been amended in response to a request for clarification by the licensee in the description of the grounds as originally written.

Issued on this 27 day of February 2015 (A1)

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

Original report signed by the inspector.

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

SUSAN SEMEREDY (501) - (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): October 29, 30, 31, November 3, 4, 5, 6, 7, 10, 12, 13, 14, and 17, 2014.

This inspection was conducted concurrently with two complaint inspections (T-1103-14, T-1308-14, T-669-14), and four follow up inspections (T-980-14, T-981-14, T-982-14 and T-983-14). Findings from these are contained in this report. As well, follow up inspections (T-639-14 and T-640-14) were inspected during this time and findings of these inspections can be found in inspection report number 2014_357101_0050.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), clinical coordinator, resident family resource worker, director of resident programs (DRP), environmental manager (EM), food service manager (FSM), food services supervisor (FSS), registered dietitian (RD), physiotherapist (PT), resident assessment instrument (RAI) lead coordinator, education/special projects director, registered nursing staff, personal support workers (PSWs), dietary aides, maintenance staff, housekeeping staff, residents and substitute decision makers (SDMs).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
35 WN(s)
15 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 100.	CO #002	2014_163109_0019	109
O.Reg 79/10 s. 101. (1)	CO #003	2014_163109_0019	109

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 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. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

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

Interview with an identified registered staff who stated that he/she was the treatment nurse and responsible for wound care on his/her unit confirmed that wound care training was not provided to him/her. The LTCH's education director confirmed during an interview that annual staff training cannot be verified because all records of staff training for 2013 and prior have been lost. The ADOC confirmed that yearly training in skin and wound care should be provided to all direct care staff. [s. 221. (1) 2.]

2. The licensee failed to ensure that staff who provide direct care to the residents receive annual training in all the areas required under section 76(7) of the Act.

O.Reg. 79/10 s. 221 (2) has been the subject of a previous compliance order to the licensee with a compliance date of September 2014 (inspection #2014_163109_0021 from May 23, 2014).

Record review and staff interview reveal the home has not met the compliance order to ensure that all staff who provide direct care to the residents receive training in the areas required under section 7 6(7) of the Act.
Education records reveal the following:
32.3% of the staff did not receive training for falls prevention.
36% of staff did not receive training for the skin care policy.
51% of the direct staff did not receive training for responsive behaviors policy.
The education director and DOC confirmed that staff have not been trained in the areas mentioned above as required. Furthermore, there are no records to identify that the staff members who did not receive the required training were individually assessed as not needing this training. [s. 221. (2)]

3. The licensee has failed to ensure all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually.

Interview with the Director of Education revealed that all records of staff training prior to 2013 have been lost and confirmed that annual staff training cannot be verified. Interview with the DOC revealed that staff have not received training annually related to abuse recognition and prevention and confirmed that staff should receive this training annually. [s. 221. (2)]

4. The licensee has failed to ensure staff who apply physical devices or who monitor residents restrained by physical devices, receive training in the application, use and potential dangers of these physical devices.

Interview with the clinical coordinator revealed that all records of staff training prior to 2014 have been lost and confirmed that annual staff training cannot be verified as having been completed. It was also confirmed by the clinical coordinator that he/she did not believe all staff received annual training for 2013 in the area of the application, use and potential dangers of physical devices used to restrain residents. Records were provided that indicated the home had trained more than 70% of staff for 2014 in the area of restraints and were hoping to have 100% by the end of the year. [s. 221. (2) 1.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that direct care staff are provided training in skin and wound care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents protected from abuse and from neglect.

On an identified date, at an identified time, interview with resident #63's family member revealed that he/she received a call from staff that the resident had been assaulted and suffered an injury as a result. On identified days, interviews with the DOC revealed that an investigation of alleged abuse had been initiated and that the video tape surveillance confirmed that resident #65 was seen entering and exiting the resident's room unsupervised while the staff on duty were asleep for several hours. The DOC confirmed that the resident was not protected from abuse by anyone in the home. [s. 19. (1)]

2. On an identified date, at an identified time, interview with resident #64 revealed that he/she was attacked by a caregiver. The resident showed the inspector a cut that was bleeding. The resident told the inspector that he/she likes to keep the lights off because they bother his/her eyes.

The accused PSW told the inspector that he/she tried to turn the bedroom light on and the resident came from behind to strike him/her and he/she put up his/her hand in defense and hit the resident in the process. The resident stated that he/she has been hit in the past by the same employee.

The plan of care for responsive behaviors directed the staff to approach the resident politely and provide reasoning with him/her as to why the light needs to be put on to prevent the resident from verbal and physical aggression toward staff. Staff is directed to recognize and avoid behaviors that provoke aggressive behaviors from resident #64.

On an identified date, interview with an identified registered staff revealed that the staff member accused of abusing the resident continued working unsupervised with resident #64 for two days during the home's internal investigation. Resident #64 also told the inspector that he/she objected to having the accused employee present on the unit and responsible for his/her care after the alleged assault.

On identified days, interviews with the DOC revealed that an investigation of alleged abuse had been initiated, the police were notified and the incident was reported to the Ministry of Health and Long Term Care. The DOC confirmed that the resident was not protected from abuse by staff in the home. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the following:

* The Residents' Bill of Rights
* The home's policy to promote zero tolerance of abuse and neglect of residents
* The duty to make mandatory reports under section 24
* The whistle-blowing protections

The LTCH's education director confirmed during an interview that annual staff training cannot be verified because all records of staff training for 2013 and prior have been lost. Interview with the DOC revealed that staff have not received training annually in the above mentioned areas and confirmed that staff should receive this training annually. [s. 76. (4)]

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 LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

LTCHA s. 22(1) has been the subject of a previous compliance order to the licensee with a compliance date of July 31, 2014 (inspection #2014_163109_0019 from June 12, 2014).

Record review and staff interview identified a written complaint which was dated an identified date, from the family of resident #64 indicating concerns about a medication error which was not forwarded to the Director as required. [s. 22. (1)]

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 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. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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

On an identified date, the inspector observed that resident #43 was served thickened

beverages during the lunch meal. Review of the card on the table for use by PSWs indicated that this resident is to receive nectar thick beverages while the diet list used by dietary staff indicated he/she is to receive honey thick beverages. Interview with the FSM and FSS confirmed that this resident should be getting honey thick beverages and the card on the table needed to be updated. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM have been provided the opportunity to participate fully in the development and implementation of the plan of care.

Record review revealed that the resident #62's SDM was not notified of his/her inappropriate behaviours when it was initially exhibited. Interview with the resident's SDM revealed that staff did not notify him/her of the resident's behaviours until several months after they had begun. The DOC and the identified registered staff confirmed that the SDM should have been provided the opportunity to participate in the development and implementation of the plan of care. [s. 6. (5)]

3. 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.

On an identified date, the inspector observed resident #41 to be on the toilet in a shower room with no staff member in the room and the door was closed. Record review of the plan of care for resident #41 revealed that one person is to constantly supervise and physically assist with toileting. Interview with the registered staff confirmed that the resident should not have been left unattended in the shower room. [s. 6. (7)]

4. Record review of the plan of care for resident #6 revealed a restraint is applied while resident is up in a wheelchair which is related to restlessness and a high risk for falls.

On an identified date, at an identified time, resident #6 was observed sitting in a wheelchair in his/her room without the restraint applied. The restraint was seen hanging over a second wheelchair in the resident's room. Interview with a PSW confirmed the restraint belonged to the resident, that the plan of care had not changed and did not know why the restraint was not applied.

The care set out in the plan of care for resident #6 related to the application of a restraint was not provided as specified in the plan. [s. 6. (7)]

5. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Record review of the plan of care for resident #45 revealed that the resident has impaired vision and wears glasses. The plan of care directs staff to ensure that glasses are on and are cleaned each morning. Observations made on identified days, revealed the resident was not wearing glasses. Interviews with the resident indicated the resident could see adequately and did not require glasses, except for reading. The resident acknowledged that a pair of glasses was located in his/her room. Staff interviews suggested the resident does not require or wear glasses. An interview with an identified registered staff revealed the resident used to wear glasses and wears glasses when reading. This registered staff located a pair of glasses in the resident's room.

Interviews with registered staff and the ADOC confirmed that the plan of care should be revised to reflect the specific care needs of resident #45. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; the resident, the SDM, if any, and the designate of the resident/SDM have been provided the opportunity to participate fully in the development and implementation of the plan of care, that the care set out in the plan of care is provided to the resident as specified in the plan; 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 #6: 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 has failed to ensure that the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation.

On October 30, 2014, the inspector observed on the second floor centre unit the audio of the call bell system was not working. Interview with registered staff revealed that it had been silenced by maintenance workers by pushing a button on the panel and he/she proceeded to push the button to reinstate the audio. The registered staff stated this could be done by anyone at any time and there was no way of knowing whether it was on or off. Interview with the EM confirmed that on this unit, as well as on two other units within the home, the call system can be silenced at the nursing station. He/she also stated that this will be changing very soon with the implementation of a new adjoining fire panel. [s. 17. (1) (c)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available at each toilet used by residents.

On an identified date, the inspector observed resident #41 to be on the toilet in a shower room with no staff members in the room. Later the same day, the inspector observed that in this same toilet area of the shower room there was no call bell cord connected to the call system which was at ceiling height. Interview with registered staff confirmed that this needed to be reported to maintenance. [s. 17. (1) (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 to ensure that the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation and is available at each toilet used by residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Review of the home's policy #NM-II-R005 titled Resident Abuse, dated September 2013, revealed the written policy for preventing abuse and neglect of residents states:

1. The administrator or designate who has reasonable grounds to suspect abuse of a resident by a staff that resulted in harm of the resident will immediately report it to the Director, Ministry of Health and Long Term Care.
2. The administrator or designate will notify outside agencies if the investigation determines it is necessary to do so.
3. Ensure that the alleged abuser has no further contact with the resident involved, or is only allowed supervised contact with the resident during the course of the investigation.

Interview with the DOC confirmed that as per the home's policy, the alleged abuse of resident #64 was not immediately reported to the Ministry of Health and Long Term Care and the home did not notify the police. On an identified date, interview with an identified registered staff revealed that the alleged abuser during the course of the investigation was still working unsupervised with resident #64. The DOC confirmed that the home's policy was not complied with. [s. 20. (1)]

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall provide for a program, that complies with the regulations, for preventing abuse and neglect.

Review of the home's policy #NM-II-R005 titled Resident Abuse, dated September 2013, revealed that a program for preventing abuse and neglect is not included. Interview with the DOC revealed that a program for preventing abuse and neglect is not included in the policy and the DOC confirmed that it should be included. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with and the policy shall provide for a program, that complies with the regulations, for preventing abuse and neglect, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Interview with the DOC revealed that on an identified date, an investigation of an incident of alleged abuse of resident #63 by resident #65 was initiated. The DOC confirmed that the incident was not reported to the Director until two days later, but should have been reported immediately.

Interview with resident #63's family member revealed that three weeks ago the resident had a head injury. Interview with the DOC revealed that an investigation was initiated and the result was that the resident suffered an injury as a result of neglect by staff. The DOC confirmed that the neglect was not reported to the Director but should have been. [s. 24. (1)]

2. Interview with the DOC revealed that an investigation of an alleged incident of staff to resident abuse had been initiated on an identified date, but the incident was not reported to the Director until the following day. The DOC confirmed that the alleged abuse of resident #64 should have been reported immediately. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #9: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's safety risks.

On an identified date, the inspector observed resident #44 yelling and hitting him/herself on the head in the common area close by the nursing station. Interview with the registered staff revealed this resident does not like the device that is used as a restraint to prevent him/her from falling.

Record review revealed that since at least January 2014, this resident has been unhappy and noncompliant with this restraint. On an identified date it was documented that this resident was found standing up with his/her wheelchair with a restraint attached to the wheelchair. Record review and interviews with registered staff, the clinical coordinator and the PT confirmed that after this incident there was no assessment with respect to safety risks.

Review of the manufacturer's instructions for the device states that severe emotional , physiological, or physical problems may occur if the applied device is uncomfortable and if symptoms ever appear for any reason, staff are to get help from a qualified medical authority and find a less restrictive, product or intervention. As well, the instructions state to stop if the patient has a tendency to self-release. Observation, record review and interviews reveal that resident #44 is emotionally upset with this restraint and has on several occasions been able to self-release. Interviews with staff including the clinical coordinator, confirmed that this restraint has continued to be used as the main form of fall prevention for this resident without regularly assessing safety, emotional well-being and resident preference using an interdisciplinary approach. [s. 26. (3) 19.]

2. Record review revealed that on an identified date, resident #29 was noted to be in a restraint and to become increasingly agitated in the evening. Registered staff documented on the same day that an Interdisciplinary Team Referral Form was initiated to help relieve some of the adverse effects of the restraint being used and copies were left in mail boxes of activation, occupational therapy, physiotherapy, resident/family resource worker and clinical coordinator.

Record review revealed that on an identified date, resident #29 was found flipped backward in his wheelchair with a restraint still on. Record review and interviews with the registered staff and PT confirmed that this fall was never assessed by the interdisciplinary team in terms of the restraint being a safety risk to the resident. [s. 26. (3) 19.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident safety risks, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident has been assessed and a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Staff interview revealed resident #17 had a fall on an identified date. Record review failed to reveal a post-fall assessment using a clinically appropriate assessment instrument. Interview with an identified registered staff revealed that the fall was documented in the progress notes and the post-fall assessment was not completed as the resident had slid from the wheelchair onto the footrests.

Interview with the ADOC identified that a fall is defined as any change in position from one height to a lower height regardless of how the resident comes to be in that position. Further, if a resident slides off a wheelchair and onto the footrests, it is considered a fall and a post-fall assessment should be completed.

The ADOC identified the electronic post-fall assessment instrument and confirmed the assessment was not completed for resident #17. [s. 49. (2)]

2. Staff interview revealed resident #6 had a fall on an identified date. Record review failed to reveal a post-fall assessment using a clinically appropriate assessment instrument. Interview with an identified registered staff revealed that the fall was documented in the progress notes and the post-fall assessment was not completed.

The ADOC identified the location of the electronic post-fall assessment instrument and confirmed the assessment was not completed for resident #6. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident has been assessed and a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #11: 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 a response is made in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with the Residents' Council president revealed that the home does always respond in writing within 10 days of receiving concerns. Record review of minutes of the Residents' Council meeting minutes revealed that in July 2014, there were concerns that staff were unaware of residents' plan of care regarding correct feeding equipment and in May 2014, there were concerns that there were cluttered hallways because staff were leaving carts in the hallways. Interview with the DRP confirmed that the home did not respond in writing to these concerns within 10 days. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a response is made in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system prepared all menu items according to the planned menu.

Record review of the plan of care for resident #17 revealed the resident is to receive a minced textured diet. During a lunch observation on an identified date, the inspector

observed resident #17 receiving regular textured grilled zucchini. The therapeutic menu indicated minced grilled zucchini is to be provided to residents on a minced textured diet.
Interviews with the dietary aide and cook revealed regular texture zucchini is served for regular and minced texture diets as the zucchini is soft enough for those receiving minced texture.

Interviews with the FSS and FSM confirmed that the minced grilled zucchini was not prepared according to the planned menu. [s. 72. (2) (d)]

2. The licensee has failed to ensure that all menu substitutions are communicated to residents and staff.

On October 29, 2014, the inspector observed during the lunch meal residents were served blackberries instead of blueberries with the pancake sausage patty entrée for regular textured meals and minced and pureed strawberries for texture modified meals. This change in menu items was not communicated to residents or staff. Interview with the FSM confirmed that the cooks had identified that the wrong product was sent by the supplier, went ahead and did a menu substitution but did not inform the FSS so that it could be communicated to residents and staff. [s. 72. (2) (f)]

3. The licensee has failed to ensure that menu substitutions are documented on the production sheet.

On October 29, 2014, the inspector observed that during the lunch meal residents were served blackberries instead of blueberries with the pancake sausage patty entrée for regular textured meals and minced and pureed strawberries for texture modified meals. Record review of the production sheets revealed that this menu change was not documented and interview with the FSS and FSM confirmed that the menu change was not documented. [s. 72. (2) (g)]

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

Review of the home's policy #FN-II-30.5 titled Meal Service Refrigerated Storage and Food Labelling revised September 2013, states that all food or drinks should be placed in containers and covered or should be well wrapped; the containers should be clearly labelled to indicate the date of preparation and contents.

On November 6, 2014, the inspector observed in the servery of the second floor central dining room to have unlabelled items in the refrigerator:
- Glasses of thickened milk
- Plastic bags of food items possibly brought in by families
- Cheddar cheese wrapped in plastic wrap.

The inspector also observed a plastic container on a cart containing bananas and soiled clothes. Interview with the FSS confirmed that the items in the refrigerator should be labelled and the bananas should not be stored with dirty cloths. [s. 72. (3) (b)]

5. The licensee has failed to ensure that there is a cleaning schedule for all equipment related to the food production system.

On November 7, 2014, the inspector observed that the steamer in the food production was grimy. Record review revealed that the steamer is not on any of the cleaning schedules. Interview with the FSS and FSM confirmed that this piece of equipment is not on the schedule and were unable to produce any evidence that staff are complying with any cleaning schedules in the food production area. [s. 72. (7) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system prepared all menu items according to the planned menu, that all menu substitutions are communicated to residents and staff, menu substitutions are documented on the production sheet and that there is a cleaning schedule for all equipment related to the food production system., to be implemented voluntarily.

WN #13: 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 has failed to ensure that the home posts copies of inspection reports from the past two years for the long term care home.

On October 29, 2014, the inspector observed that the home had not included in their postings the following reports:
2013_162109_0011 dated February 21, 2013;
2013_162109_0012 dated February 21, 2013;
2013_162109_0013 dated February 21, 2013;
2013_162109_0014 dated February 20, 2013; and
2013_162109_0015 dated February 20, 2013.

Interview with the DOC confirmed that these reports were not posted. [s. 79. (3) (k)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home posts copies of inspection reports from the past two years for the long term care home, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect.

Review of the home's policy #NM-II-R005 titled Resident Abuse, dated September 2013, revealed that the written policy for preventing abuse and neglect of residents does not identify measures and strategies to prevent abuse and neglect. Interview with the DOC revealed that measures and strategies to prevent abuse and neglect are not included in the policy and confirmed that they should be included. [s. 96. (c)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.

Review of the home's policy #NM-II-R005 titled Resident Abuse, dated September 2013, revealed that the written policy for preventing abuse and neglect of residents does not identify the training and retraining requirements for all staff. Interview with the DOC revealed that the training and retraining requirements for all staff are not included in the policy and confirmed they should be included. [s. 96. (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect and that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.

Interview with resident #63's family member revealed that he/she was notified by staff of an incident of neglect that had occurred on an identified date, and had resulted in a fall and injury. Interview with the DOC revealed that the incident of neglect of the resident resulting in a fall and injury was not reported. Interview with the DOC revealed that the home documents an analysis of every incident reported to the Director however this incident was not reported so there is no evidence of an analysis of the incident. The DOC confirmed that an analysis should have been completed. [s. 99. (a)]

2. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at
the home is undertaken promptly after the licensee becomes aware of it.

On an identified date, interview with resident #63's family member revealed that he/she was notified by staff
of an incident that had occurred on an identified date that resulted in a fall and injury.
Interview with the DOC revealed that the incident of alleged neglect by the identified PSW of the resident resulting in the fall and injury was not reported.
Interview with the DOC revealed that the home documents an analysis of every incident reported to
the Director however this incident was not reported so there is no evidence of an analysis of the
incident. The DOC confirmed that an analysis should have been completed. [s. 99. (a)]

3. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Interview with the DOC revealed that an evaluation to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences has not been completed at least once in every calendar year. The DOC confirmed that this should be completed. [s. 99. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it and that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff apply the physical device in accordance with instructions specified by the physician.

Record review revealed the physician's order for resident #44's restraint states that the device is to be applied when needed for safety when the resident falls once to twice daily. Interview with the registered staff revealed that the restraint is only applied after the resident has fallen at least once during the day. Record review of the restraint monitoring record revealed that it was applied from November 2-6, 2014, and there was no record that the resident had had a fall on those days. Interview with registered staff confirmed that the restraint has not been applied in accordance with instructions specified by the physician. [s. 110. (2) 2.]

2. The licensee failed to ensure that staff release the resident from the physical device and reposition at least once every two hours.

Record review revealed that resident #29 has a history of having pressure ulcers. On an identified date, the inspector observed resident #29 was wearing a restraint and was observed in the same position from 9:40 a.m. to 11:30 a.m. Interview with an identified PSW confirmed he/she does not release the resident from the restraint and reposition him/her every two hours. [s. 110. (2) 4.]

3. The home has failed to ensure that there is documentation which includes what alternatives were considered and why those alternatives were inappropriate.

Record review revealed that resident #29 was admitted on an identified date, and the registered staff recommended a device to restrain him/her and prevent falls the day after. Staff interview with the registered staff revealed that there is no documentation to indicate that alternatives to restraining were considered and tried. [s. 110. (7) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff apply the physical device in accordance with instructions specified by the physician, release the resident from the physical device and reposition at least once every two hours and that there is documentation that includes what alternatives were considered and why those alternatives were inappropriate, to be implemented voluntarily.

WN #17: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

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

Record review revealed that the physician's order for the medications did not include instructions for resident #66 to self-administer medication.

Interview with resident #66 confirmed that he/she was self-administering his/her medication. Interview with two identified registered staff confirmed that the physician's order did not include instructions for self-administration of the medication, and confirmed that the order should include the instructions. [s. 131. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #18: 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.

On an identified date, the inspector observed resident #22's gastric feed tubing lying on the floor beside the pump. The cap was not on the end of the tubing and the insertion end of the tube was touching the floor.

Record review revealed resident #22 had been previously treated for an infection at the insertion site of the g-tube. [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 The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #19: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect is fully respected and promoted.

Interview with resident #71 revealed staff do not treat the resident with respect and dignity. There are occasions staff have addressed the resident by a matriarchal term or by the resident’s surname. The resident stated “I really don’t like it” and has informed the staff to address the resident by his/her given name.

Record review revealed that on an identified date, a complaint form was completed related to the aforementioned issue and was addressed by the resident clinical coordinator at that time. A review of the resident’s current plan of care did not locate resident #71’s preferred name and the coordinator confirmed this.

During an interview on an identified date, at an identified time, a registered staff entered the resident’s room to administer medication and addressed the resident by his/her surname. Resident #71 confirmed this registered staff member has been asked previously not to refer to the resident by his/her surname.

The licensee failed to ensure that resident #71's right to be treated with courtesy and respect is fully respected and promoted. [s. 3. (1) 1.]

WN #20: 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 any policy put in place is complied with.

The home's policy #NM-II-W015 titled Weight Management states that any unplanned significant changes will be evaluated using a co-ordinated interdisciplinary approach and the registered nursing staff will:
-report the residents with significant weight changes to the RD;
-arrange a monthly meeting with the RD to investigate the reason for the weight change and to collaborate on a plan of action to manage the weight; and
-document on the resident's plan of care and on the individual weight record, the observations/findings related to the weight change and any planned interventions.

Record review and interviews with the RD and registered staff revealed that resident #13 and #22 had significant weight changes between June and July of 2014 that were not assessed. Interview with the RD and the registered staff revealed that registered nursing staff do not report or refer significant weight changes to the RD nor do they meet monthly or document on the resident's plan of care regarding weight management. Interview with the DOC confirmed that they are not following the home's policy. [s. 8. (1) (b)]

WN #21: 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 has failed to ensure that the home, its furnishings and equipment are kept clean and sanitary.

On October 29 and November 6, 2014, the inspector observed a corner in the second floor central dining room where plates are scraped, to have soiled walls. Interview with an identified maintenance worker stated it is dietary’s responsibility to clean this area and interview with the FSS revealed it is housekeeping’s responsibility. Both the maintenance worker and FSS confirmed this area needs to be cleaned on a regular basis by someone. Interview with the EM confirmed this area is troublesome and he/she would have it scrubbed by housekeeping and work with the dietary department to keep it clean.

On November 6, 2014, the inspector observed in the second floor central dining room to have the following unclean areas:
- The refrigerator had spills inside and was dirty on the outside
- Carts were unclean and had personal staff items on them
- The steam table had caked on food underneath the shelf
- The stereo system was dusty
- The floor between the refrigerator and wall had bits of dirt
- The air flow unit at ceiling height was dirty.
Interview with the FSS confirmed these areas were unclean and should not have personal staff items stored on them. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home is maintained in a good state of repair.

On October 29 and November 6, 2014, the inspector observed a corner in the second floor central dining room where dirty plates are scraped to have walls and an airflow vent that are chipped and have peeling paint. Interview with an identified maintenance person and EM confirmed that this area needed to be painted and better maintained.

On November 6, 2014, the inspector observed a cupboard door missing from a cabinet in the second floor central dining room. Interview with the EM revealed that the broken cupboard door had been placed at the side of the cabinet and he would have it replaced. [s. 15. (2) (c)]

3. On November 7, 2014, the inspector observed the floor in the dish machine room to be black and unfinished. As well, there was a door close to this area that had a screen

with a hole in it. Interview with the EM confirmed that the floor in this area is difficult to maintain due to various factors and that the screen needed to be repaired. [s. 15. (2) (c)]

WN #22: 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 has 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.

On October 30, 2014, the inspector observed in room #228 a window that did not have a screen and could be opened approximately 24 centimetres. Interview with the EM revealed that this was an old window that was slated to be replaced and had just recently had an air conditioning unit removed. The EM confirmed that this was a safety issue and would put a chain on it so it could not be opened more than 15 centimetres. Later in the day, the inspector observed this window had a chain on it and the window could not be opened more than 15 centimeters. [s. 16.]

WN #23: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to minimize restraining of residents is complied with.

Review of the home's policy #NM-II-R008 titled Restraint: Physical & PASD, Chemical and Environmental effective September 2013, states that the approved physical restraint devices to be used in the home are:
-geriatric chairs or wheelchairs, with table tops in place,
-lap belts and seat belts secured in the front of the resident.

Observations and staff interviews confirmed that the home uses an identified device as a restraint that is secured at the back of a chair and that this type of restraint is not included in their policy. [s. 29. (1) (b)]

WN #24: 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 has failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes its:

* goals and objectives
* relevant policies, procedures, protocols
* methods to reduce risk
* methods to monitor outcomes, and
* protocols for referral of resident to specialized resources where required

Record review of the skin and wound policies revealed that the program does not include a written description that includes the legislated requirements.

Interviews with the ADOC and the DOC revealed that the home's Skin and Wound program does not include a written description of the program that includes the legislated requirements. [s. 30. (1) 1.]

2. The licensee has failed to ensure that the falls prevention and management program has been evaluated and updated at least annually.

Interview with the DOC confirmed the home did not complete an evaluation of the falls prevention and management program in 2013. [s. 30. (1) 3.]

WN #25: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The home has failed to ensure the restraint plan of care includes alternatives to restraining that were considered, and, tried, but have not been effective in addressing the risk.

Record review revealed that resident #29 was admitted on an identified date, and the registered staff recommended a device to restrain him/her and prevent falls the day after. Staff interview with the registered staff revealed there is no evidence to indicate that alternatives to restraining were considered and tried. Interview with the PT revealed that he/she was not involved in the assessment of a physical restraint for this resident. [s. 31. (2) 2.]

WN #26: 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 has failed to ensure that resident #52 was bathed, at a minimum, twice a week by the method of his/her choice, including tub baths, unless contraindicated by a medical condition.

At the time of admission for resident #52, the substitute decision maker (SDM) informed the home that the resident prefers to have a bath as opposed to a shower. Record review and family interview revealed that on an identified date, the SDM spoke to the staff and asked that the resident be bathed instead of showered. Up until an identified date, the SDM assumed that he/she was being bathed instead of being showered until he/she was told that he/she had never received a bath. The SDM complained to the home and in response an assessment was completed on the resident by the physiotherapist. The assessment determined that the resident was unsafe to sit in a tub chair.

Interview with the SDM revealed that he/she also raised concerns that his/her family member was not receiving two baths per week. Record review and staff interview revealed the resident changed bedrooms, and was placed on a bath list for two days in a row, Monday and Tuesday. Staff interview and record review revealed that resident #52 only received a shower on Mondays for an identified period of time. [s. 33. (1)]

WN #27: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that semi-annual meetings are convened to advise residents' families and persons of importance to residents of their right to establish a Family Council.

Interview with the Administrator, DRP, resident family resource worker and social worker revealed that semi-annual meetings regarding the initiation of a Family Council have not been held from July 2010 until June 2014. It was revealed that a meeting was held for families in June of 2014 regarding initiating a Family Council and the home would now plan for a similar meeting in December of 2014. [s. 59. (7) (b)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that weight changes are assessed using an interdisciplinary approach.

Record review revealed that resident #13 had significant weight loss within an identified month of 3.8 kilograms or 5.6 per cent of body weight. Interviews with the RD and registered nursing staff confirmed that this weight loss not assessed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. Record review revealed that resident #22 had significant weight gain within an identified month of 2.3 kilograms or 5.1 per cent body weight. Interviews with the RD and registered nursing staff confirmed that this weight gain was not assessed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items are offered at each meal.

On October 29, 2014, the inspector observed during the lunch meal, that resident #42 was not offered a choice at dessert by an identified PSW. Interview with a PSW revealed that he/she knows that this resident prefers fruit so he/she just gives him/her the fruit. Record review of the plan of care did not indicate this resident prefers fruit at dessert. Interview with the food service manager and supervisor confirmed that this resident should have been offered a choice of desserts. [s. 71. (1) (d)]

WN #30: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the Residents' Council president revealed that the home does not seek the advice of the Residents' Council regarding the satisfaction survey. Record review of the Residents' Council meeting minutes revealed that there was no mention of a satisfaction survey. Interview with the DRP and resident family resource worker confirmed that they do not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the satisfaction survey are made available to the Residents' Council in order to seek the advice of the Council about the survey.

Interview with the Residents' Council president revealed that the home does not make available to the Residents' Council the results of the satisfaction survey. Record review of the Residents' Council meeting minutes revealed that there was no mention of a satisfaction survey. Interview with the DRP and resident family resource worker confirmed that results of satisfaction surveys are not made available to the Residents' Council. [s. 85. (4) (a)]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of devices, including personal assistance services devices, assistive aids and positioning aids.

On November 10, 2014, the inspector observed that the wheelchairs for resident #6 and #15 were not clean. Record review revealed that the cleaning of these wheelchairs had been signed off as cleaned the previous week. Interview with the clinical coordinator confirmed that these wheelchairs were not clean and probably had not been cleaned the previous week. [s. 87. (2) (b)]

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to minimize restraining of residents addresses alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach.

Review of the home's policy #NM-II-R008 titled Restraint: Physical & PASD, Chemical and Environmental effective September 2013, revealed that it does not include alternatives to physical devices and how these alternatives are planned, developed and implemented, using an interdisciplinary approach. Interview with the clinical coordinator confirmed that the policy does not include the above mentioned areas. [s. 109. (f)]

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The home has failed to ensure that there is an analysis of the restraining of residents by use of a physical device undertaken on a monthly basis.

Observations and staff interviews confirmed that the home uses an identified device as a restraint for many of its residents. Interview with the clinical coordinator who confirmed with the administrator revealed that the home does not do an analysis of the restraining of residents by use of a physical device on a monthly basis. [s. 113. (a)]

2. The home has failed to ensure that an evaluation to determine the effectiveness of the policy to minimize restraining of residents is conducted once in every calendar year.

Interview with the clinical coordinator, who confirmed with the administrator, revealed that the home does not conduct an annual evaluation to determine the effectiveness of the policy to minimize restraining of residents. [s. 113. (b)]

WN #34: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Interviews with identified registered staff revealed that there are no medication policies or protocols available and accessible to them. Interview with the administrator confirmed that the home does not have medication policies or protocols. [s. 114. (2)]

WN #35: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or medication cart that is secure and locked.

On October 30 and November 13, 2014, the inspector observed a treatment cart on the second floor east unit to be open and unattended by staff. The cart contained prescription creams such as anusol HC, silvasorb gel, lyderm cream and hydrocortisone. Interviews with identified registered staff confirmed this treatment cart should have been locked. [s. 129. (1) (a) (ii)]

Issued on this 27 day of February 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SUSAN SEMEREDY (501) - (A1)

Inspection No. / No de l'inspection : 2014_321501_0021 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : T-011-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Feb 27, 2015;(A1)

Licensee / Titulaire de permis : Downsview Long Term Care Centre Limited
3595 Keele Street, NORTH YORK, ON, M3J-1M7

LTC Home / Foyer de SLD : Downsview Long Term Care Centre
3595 Keele Street, NORTH YORK, ON, M3J-1M7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Christiana Burns

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To Downsview Long Term Care Centre 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_163109_0021, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how the home will ensure all direct care staff receive, as a condition of continuing to have contact with residents training in the following areas:
• Abuse recognition and prevention.
• Mental health issues, including caring for persons with dementia.
• Behavior management.
• Falls prevention and management.
• Skin and wound care.
The plan should include who will be responsible for coordinating the training program and assessing the learning needs of staff.

Please submit compliance plan to susan.squires@ontario.ca on or before January 23, 2015.

Grounds / Motifs :

(A1)
1. O.Reg. 79 10 s. 221 (2) has been the subject of a previous compliance order to the licensee with a compliance date of September 30, 2014 (inspection #2014_163109_0021 from May 23, 2014).

The licensee has failed to ensure all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually.

Interview with the education director revealed that all records of staff training for 2013 had been misplaced and confirmed that annual staff training cannot be verified. Interview with the DOC revealed that the home could not produce documentation to confirm that staff have received staff training annually related to abuse recognition and prevention and confirmed that staff should receive this training annually. (591)

(A1)
2. The licensee failed to ensure that staff who provide direct care to the residents receive annual training in all the areas required under section 76(7) of the Act.

O.Reg. 79 10 s. 221 (2) has been the subject of a previous compliance order to the licensee with a compliance date of September30, 2014 (inspection #2014_163109_0021 from May 23, 2014).

Record review and staff interview revealed the home has not met the compliance order to ensure that all staff who provide direct care to the residents receive training in the areas required under section 7 6(7) of the Act.
Education records for 2014 revealed the following:
Only 67.7% of the staff received training for falls prevention.
Only 64% of the staff received training for the skin care policy.
Only 49% of the direct staff received training for responsive behaviors policy.

The education director and DOC confirmed that not all staff have been trained in the areas mentioned above as required. Furthermore, there are no records to identify that the staff members who did not receive the required training were individually assessed as not needing this training. (109)

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

Aug 31, 2015(A1)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents #63 and #64 are protected from abuse.
The plan shall include, but not limited to:
• Developing a process to monitor and evaluate the care being provided to resident #63 to ensure it is consistent with the plan of care including ensuring staff are present on the unit for the safe monitoring of the resident.
• Ensuring that staff comply with the responsive behaviour plan of care for resident #64 to provide safe care for the resident.
The compliance plan must identify short and long-term strategies to ensure the actions taken are monitored and evaluated.

Please submit compliance plan to natasha.jones@ontario.ca on or before January 23, 2015.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that residents protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date, at an identified time, interview with resident #64 revealed that he she was attacked by a caregiver and his or her dentures had been broken. The resident showed the inspector a cut on his or her upper lip which was bleeding. The resident told the inspector that he or she likes to keep the lights off because they bother his or her eyes.

The accused PSW told the inspector that he or she tried to turn the bedroom light on and the resident came from behind to strike him or her and he or she put up his or her hand in defence and hit the resident in the process. The resident stated that he or she has been hit in the past by the same employee.

The plan of care for responsive behaviors directed the staff to approach the resident politely and provide reasoning as to why the light needs to be turned on to prevent the resident’s verbal and physical aggression toward staff. Staff is directed to recognize and avoid behaviors that provoke aggressive behaviors from resident #64.

On an identified date, interview with an identified registered staff revealed that the staff member accused of abusing the resident continued working unsupervised with resident #64 for two days during the home’s internal investigation. Resident #64 also told the inspector that he or she objected to having the accused employee present on the unit and responsible for his or her care after the alleged assault.

On identified dates, interviews with the DOC revealed that an investigation of alleged abuse had been initiated, the police were notified and the incident was reported to the Ministry of Health and Long Term Care. (591)

(A1)
2. On an identified date, at an identified time, interview with resident #63’s family member revealed that he or she received a call from staff that resident #63 had been dragged out of bed to the bathroom by an identified resident and suffered an injury as a result. On identified dates, interviews with the DOC revealed that an investigation of alleged abuse had been initiated and that the video tape surveillance confirmed that resident #65 was seen entering and exiting the resident s room unsupervised while the staff on duty were asleep for several hours.
The DOC confirmed that the resident was not protected from abuse by the staff on an identified date. (591)

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

Feb 27, 2015

Order # / Ordre no : 003 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff are retrained in the following areas:
• The Residents' Bill of Rights.
• The home's policy to promote zero tolerance of abuse and neglect of residents.
• The duty to make mandatory reports under section 24.
• The whistle-blowing protections.
The plan should include who will be responsible for coordinating the training program and assessing the learning needs of staff.
Please submit compliance plan to natasha.jones@ontario.ca on or before January 23, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the following:
• The Residents' Bill of Rights.
• The home's policy to promote zero tolerance of abuse and neglect of residents.
• The duty to make mandatory reports under section 24.
• The whistle-blowing protections.

The LTCH's education director confirmed during an interview that annual staff training cannot be verified because all records of staff training for 2013 and prior have been lost. Interview with the DOC revealed that staff have not received annual training in the above mentioned areas and confirmed that staff should receive this training annually.

(591)

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

Mar 31, 2015

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_163109_0019, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Order / Ordre :

The licensee shall ensure that all written complaints concerning the care of a resident or the operation of the home, are immediately forwarded it to the Director.

Grounds / Motifs :

1. The licensee has failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

LTCHA s. 22(1) has been the subject of a previous compliance order to the licensee with a compliance date of July 31, 2014 (inspection #2014_163109_0019 from June 12, 2014).

Record review and staff interview identified a written complaint which was date and from the family of resident #64 indicating concerns about a medication error which was not forwarded to the Director as required.

(109)

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

Feb 27, 2015

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

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

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

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 27 day of February 2015 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : SUSAN SEMEREDY - (A1)

Service Area Office / Bureau régional de services : Toronto