Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**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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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jun 13, 14, 15, 16, 17, 20, 21, 22, 24, 27, 28, 29, 30, Jul 4, 5, 6, 2011 | 2011_066107_0003 | Annual |

**Licensee/Titulaire de permis**

DELHI NURSING HOME LTD
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

MICHELLE WARRENER (107), DEBORA SAVILLE (192), ELISA WILSON (171), LISA VINK (168)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct an Annual inspection.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, the Assistant Director of Care, the Director of Food Services and Environmental Services, the Business Manager, the maintenance staff, registered staff, the Registered Dietitian, Personal Support Workers, Dietary Aides, Cooks, Physiotherapy Assistant, Recreation Manager and staff, Corporate staff support, residents and resident family members.**

**During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, and care provided to residents, reviewed plans of care for identified residents, reviewed policies and procedures of the Home,and observed the general maintenance, cleaning and condition of the home.**

**The following Inspection Protocols were used in part or in whole during this inspection:**

**Accommodation Services - Housekeeping**

**Accommodation Services - Laundry**

**Accommodation Services - Maintenance**

**Admission Process**

**Continence Care and Bowel Management**

**Dignity, Choice and Privacy**

**Dining Observation**

**Falls Prevention**

**Family Council**

**Hospitalization and Death**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Pain**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Quality Improvement**

**Recreation and Social Activities**

**Resident Charges**

**Residents' Council**

**Responsive Behaviours**

**Safe and Secure Home**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON-RESPECT DES EXIGENCES | |
|---|---|
| Definitions<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Définitions<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 15. Bed rails**

**Specifically failed to comply with the following subsections:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

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**Findings/Faits sayants :**

1. When bed rails are used, not all steps are taken to prevent resident entrapment, specifically taking into consideration all potential zones of entrapment. [O.Reg. 79/10, s.15(1)(b)]
On June 14, 2011, it was observed that a number of mattresses were not the appropriate length for the bed frame, including the mattresses for two identified residents. This concern was immediately brought to the attention of the management team. The home had an independent bed survey conducted on June 15, 2011, to assess potential zones of entrapment. During an interview with the Executive Director, on June 20, 2011, it was confirmed that due to the results of the bed survey the home is considering replacing up to 33 mattresses and 5 bed frames due to current bed/mattress configurations presenting potential zones of entrapment.

***Additional Required Actions:***

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

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**WN #2: 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 subsections:

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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
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.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. 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:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits sayants :

1. Documentation for an identified resident does not include consent for the use of two bed rails that prevent them from exiting the bed. [O.Reg. 79/10, s.110(7)4.]
An interview with a PSW indicated that the resident used two bed rails when in bed. The resident was observed in bed with two bed rails in place. No consent for the use of two bed rails was evident in the medical record.

2. The licensee has not always ensured all assessments, reassessments and monitoring, including resident responses for residents requiring a physical device to restrain have been documented.
[O.Reg. 79/10, s.110(2)6.]

a) An identified resident did not consistently have their condition reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances. The homes restraint policy indicates that registered staff will document the resident's condition and the effectiveness of the restraint, each shift a restraint is in use, on the progress notes. There is no documentation related to the effectiveness of the restraint on fourteen shifts documented during a one week span in June, 2011. (192)

b)An identified resident's condition has not been reassessed and the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances. The resident used two bed rails when in bed to prevent them from falling out of the bed and was reclined in a special chair to prevent them from rising. The policy related to restraints indicates that registered staff will evaluate the use of restraints each shift and document their evaluation in the progress notes. A review of the progress notes since May 1, 2011 finds that there has been no evaluation of the use of bed rails for this resident. An interview with the Executive Director indicates that bed rails for this resident have not been considered a restraint and the policy has not been adhered to.

3. Documentation for an identified resident does not include the removal of the device (bed rails, tilt chair), including time of removal or discontinuance and the post restraining care.
[O.Reg. 79/10, s.110(7)8.]
An identified resident was observed in a reclined position in a specialized chair to prevent the resident from rising and in bed with two bed rails in the up position. The plan of care indicates that the resident is to have two bed rails up when in bed, and may have their chair tilted back slightly for comfort and safety when sleeping in the chair. Documentation in Point of Care indicates that bed rails are used each shift since June, 2011 but does not include the time of removal and post-restraining care. Documentation in Point of Care does not include the use of a tilt chair for safety. Discussion with the Executive Director indicates that use of bed rails and a tilt chair have not been considered restraints and documentation has not been completed related to removal of the devices and post restraining care.

4. Documentation does not include every release of the device and repositioning for an identified resident. [O.Reg. 79/10, s.110 (7)7.] The resident was observed with two bed rails in place. The plan of care indicates that two bed rails are to be up when the resident is in bed to prevent them from falling from the bed. A review of the Point of Care documentation completed by PSWs indicates that bed rails were in place each shift since June, 2011. There is no indication of when the bed rails were released or when the resident was repositioned.

5. Documentation of the application of bed rails for an identified resident does not include assessment, reassessment and monitoring or the resident's response. [O.Reg. 79/10, s.110(7)6.]
The resident was observed with two bed rails in place. Documentation on Point of Care confirms that on each shift since June, 2011 bed rails have been utilized to prevent the resident from falling from the bed. A review of the medical record could not locate any assessments related to the use of bed rails to prevent the resident from falling from bed. The policy on restraints indicates that the resident using a restraint is to be assessed every eight hours by the registered staff and this assessment is to be included in the progress notes. A review of the progress notes confirms that no assessments are documented related to the use of bed rails for the identified resident.

6. Documentation for an identified resident does not include who applied the device and time of application. [O.Reg. 79/10, s.110(7)5.]
An identified resident was observed in bed with two bed rails in place. The plan of care indicates that two bed rails are to be used to prevent the resident from falling from the bed. Documentation in Point Click Care - Point of Care, completed by PSWs indicates that the resident is in bed with two bed rails up each shift since June, 2011, but does not indicate the specific time of

application or by whom.

7. Documentation does not include the person who made the order for restraints, what device was ordered or any instructions relating to the order. [O.Reg. 79/10, s.110(7)3.]
An identified resident was observed using two bed rails. The plan of care indicates that two bed rails are to be up when the resident is in bed, to prevent falling from the bed. A review of the medical record was unable to locate orders related to the use of bed rails or instructions related to their use. An interview with the Executive Director confirmed that bed rails are used within the home without an order.

8. Documentation does not include alternatives to restraint considered and why those alternatives were inappropriate. [O.Reg. 79/10, s.110(7)2.]
There is no indication in the medical record of an identified resident that alternatives to the use of two bed rails have been considered. Discussion with the Executive Director confirms that the bed rails in use have not been considered a restraint and no alternatives have been trialed.

9. An identified resident was not repositioned at least once every two hours during an observation period greater than two hours on June 24, 2011. [O.Reg. 79/10, s.110(2)4.]
The identified resident was observed reclined in a broda chair that prevented the resident from rising. Between 1109 and 1342 the resident's position was not adjusted. During an interview a PSW indicated that the resident was positioned in the chair at approximately 0730 and that her position is changed as often as possible. There is no documentation to support that position changes are occurring at least every two hours.

10. Bed rails used to prevent an identified resident from falling from the bed were not ordered by the physician or a registered nurse in the extended class. [O.Reg. 79/10, s.110(2)1.]
The plan of care indicates that an identified resident is to have two bed rails up while in bed, to prevent the resident from falling from the bed. The resident was observed in bed with two bed rails in the up position. Documentation on Point Click Care, Point of Care completed by PSW indicates that bed rails were used each shift since June, 2011.

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits sayants :

1. The written plan of care does not always provide clear direction to staff and others who provide direct care to the resident. [LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c)]

a) On June 21, 2011 the plan of care was reviewed for an identified resident. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) data for May 2011 and the Quarterly Continence Review completed in May 2011 indicate the resident is frequently incontinent of bowel, however the care plan summary regarding bowel incontinence which was updated in June 2011 indicates the resident is usually continent of bowel. The Point of Care documentation reviewed for a 30 day time period ending June 22, 2011 indicated the resident was incontinent of bowel 17 times. The Executive Director and the Assistant Director of Care (ADOC) confirmed that this information did not provide clear direction regarding the resident's bowel continence.(171)

b)On June 21, 2011 the plan of care was reviewed for an identified resident. The Quarterly Continence Review completed in April, 2011 indicated the resident's frequency of toileting is "on demand". The care plan summary which was completed in April, 2011 indicated the resident is on a toileting plan of ac, pc meals, hs and prn (before and after meals and in the evening and as needed), the Kardex does not include a toileting plan. One staff member indicated the resident for the most part toilets themself, however requires assistance with changing their incontinent product. Another staff member indicated the resident requires assistance and needs to be escorted to the washroom before and after every meal. The Executive Director and ADOC confirm that the plan of care does not give clear direction regarding a toileting plan. (171)

c) The plan of care for an identified resident does not include direction for staff related to the use of bed rails. During an interview, the Personal Support Worker (PSW) was unable to identify where to locate information related to restraint use. The PSW indicated that they had been instructed that day to refrain from using two bed rails for the identified resident, but that it had been daily practice to lift both bed rails when putting the resident to bed. A review of the plan of care indicates that no direction is provided to staff related to bed rail use or monitoring of the resident while the resident is in bed. The resident was observed in bed with both rails elevated on June 13, 2011.

2. Staff and others did not collaborate with each other in the assessment of an identified resident so their assessments were integrated, consistent with and complement each other for the RAI-MDS assessment completed in May, 2011.[LTCHA, 2007, S.O. 2007,c.8,s.6(4(a)]
Coding in the RAI-MDS assessment indicates there has been no change and that the resident's mood and behavioural symptoms have improved. This is contrary to and not consistent with the outcome scale data which confirms an increase in the depression rating scale and an increase in the aggressive behaviour scale when compared to the previous RAI-MDS assessment completed in February, 2011.

3. An identified resident was not given an opportunity to participate fully in the development and implementation of their plan of care in relation to medication changes. [LTCHA, 2007, S.O. 2007, c.8, s.6(5)]
The resident voiced concerns to inspectors on June 13 and 27, 2011 about not being consulted with changes to blood pressure medications. Documentation does not reflect that the resident was consulted about several medication changes. Two Registered staff interviewed were unable to confirm that the resident was consulted about the medication changes in September, 2010. The staff stated that they do not consistently document when residents have been consulted about medication changes.

4. The licensee does not always ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change.[LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)]

a) The plan of care for an identified resident was not reviewed and revised when the resident's care needs changed at the May, 2011 quarterly review assessment. The resident had a decline in status (in comparison to the February, 2011 Quarterly review assessment) in Depression Rating Scale (DRS), increase in Aggressive Behaviour Scale (ABS), and increase in Personal Severity Index (PSI). Interventions on the resident's plan of care for the management of depression and behaviours were not revised to address the decline in status. (107)

b)An identified resident was not reassessed and the plan of care was not reviewed and revised when their care needs changed. According to the RAI-MDS data in May 2011 in Section H regarding continence and the Quarterly Continence review the resident had increased frequency of bowel incontinence between February 2011 and May 2011, however a complete assessment had not been documented and the plan of care had not been revised for bowel incontinence. The Executive

Director and ADOC confirm that the expectation would be to have a reassessment completed based on this care needs change.(171)

c) An identified resident was not reassessed and the plan of care was not reviewed and revised when their care needs changed. According to the RAI-MDS data reviewed on June 21, 2011 the resident had a decline in bowel continence function from being totally continent to occasionally incontinent between January 2011 and April 2011, however there was no documented reassessment addressing this decline and there were no changes in the plan of care regarding bowel continence. The Quarterly Continence review completed in April 2011 indicated the resident experienced constipation, however there were no comments or follow-up included on the review, no assessment of the current interventions for bowel management and no changes in interventions since the last quarter regarding bowel management. The resident required increasing number of as needed laxitive doses between April and June 2011 and had suppositories on two occasions in April, once in May, and once in June, 2011, however there were no assessments or revisions in the care plan to address constipation. The Executive Director confirmed that this change in care needs would require an assessment and update to the care plan summary in regards to bowel continence.

5. A reassessment of the plan of care, including different approaches to consider in the revision of the plan of care had not been documented for an identified resident.[LTCHA, 2007, S.O. 2007,c.8,s.6(11)(b)]
The resident had a decline in bladder continence noted in the RAI-MDS data in October 2011. There has been no change in the resident's bladder continence noted since that time, however the Resident Assessment Protocol (RAP) documentation and care plan interventions for toileting and bladder incontinence have remained the same over three quarters (October 2010, January 2011 and April 2011). There is no documentation regarding any different approaches or different interventions tried during this six month period. The Executive Director and ADOC confirm that documentation regarding different approaches would be expected in this case.

6. The licensee does not always ensure that the care set out in the care plan is provided to the resident as specified in the plan. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)]
An identified resident was observed from 1109 to 1340 hours on June 24, 2011. During this time frame the resident did not have their position changed and did not have their incontinence product checked. The plan of care indicates that the resident is to be checked for wetness ac, pc meals, qhs prn (before and after meals, in the evening and as needed) and on rounds during the night. The resident was not checked before the noon meal on June 24, 2011. The plan of care indicates that the resident is to be checked hourly and repositioned every two hours. During an interview the PSW indicated that they check and reposition the resident when they can. The PSW was not able to articulate that the resident was to be checked hourly, repositioned every two hours or have their incontinence product checked before and after meals.

***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 prepare a written plan of correction for achieving compliance for section 6 related to the plan of care specifically, s. 6(1)(c), s. 6(4)(a), s. 6(5), s. 6(10)(b), s. 6(11)(b), s. 6 (7), to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following subsections:**

**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;**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and**
**(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).**

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**Findings/Faits sayants :**

1. The licensee has not ensured that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [O.Reg. 79/10, s.15(2)(c)]

a) The legs on the chairs and tables in the main dining room are significantly scuffed and marked and surfaces cannot be cleaned easily. Staff interviewed identified they are aware of the poor condition of the tables and chairs.(107)

b) It was noted on June 27, 2011, that several resident washrooms have vanities with chipped surfaces, specifically five identified rooms and the washroom sink in an identified room has a chip in the surface of the bowl. An interview with the Maintenance staff on June 27, 2011, confirmed that a number of bathroom vanities are in need of replacement or repair due to chipped areas and that the identified sink should be repaired. A review of the Maintenance Requisitions book on June 27, 2011, does not include any of these concerns as items in need of repair/replacement.

***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 furnishings and equipment are maintained in a good state of repair, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

**Specifically failed to comply with the following subsections:**

**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 sayants :**

1. On June 17, 2011 in the Residents' Council interview, it was determined that the licensee has not responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [LTCHA, 2007, S.O.2007,c.8, s.57(2)] There were concerns regarding removal of the vending machine that was accessible to residents and family members noted in the minutes in July, August and September of 2010, concerns regarding water temperature in the shower room in the minutes in April 2011 and concerns regarding missing laundry items in the minutes in May 2011. There are no response notes or letters provided on the bulletin board in the hallway with the minutes of the currently posted April 2011 meeting and no response notes or letters included in the Residents' Council Meetings binder for any of the above noted concerns. The Residents' Council president confirms written responses were not provided for these items.

***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 the licensee, within 10 days or receiving advice, responds to Residents' Council in writing, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.**

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**Findings/Faits sayants :**

1. On July 17, 2011 in the Residents' Council interview it was determined that the licensee has not consulted regularly with the Residents' Council in the past year. [LTCHA,2007, S.O.2007,c.9,s.67] The current Executive Director has been in place for two months and is unaware of the previous consultations with Residents' Council, prior to this time.

**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications**
**Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,**
**(a) have the proper skills and qualifications to perform their duties; and**
**(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..**

**Findings/Faits sayants :**

1. The licensee has not ensured that all the staff of the home, have the proper skills and qualifications to perform their duties. [LTCHA, 2007, S.O.2007,c.8,s.73(a)]
Formalized training on the Point of Care computer system was not provided to the Recreation Department to ensure they have the appropriate skills to be able to complete their duties effectively. Staff interviews confirm that training was not provided and a reference manual is not available for reference by recreation staff or personal support workers when required.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff of the home have the proper skills and qualifications to perform their duties, to be implemented voluntarily.***

**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.**
**Specifically failed to comply with the following subsections:**

**s. 78. (2) The package of information shall include, at a minimum,**
**(a) the Residents' Bill of Rights;**
**(b) the long-term care home's mission statement;**
**(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;**
**(d) an explanation of the duty under section 24 to make mandatory reports;**
**(e) the long-term care home's procedure for initiating complaints to the licensee;**
**(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;**
**(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;**
**(h) the name and telephone number of the licensee;**
**(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;**
**(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;**
**(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;**
**(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;**
**(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;**
**(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;**
**(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;**
**(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;**
**(q) an explanation of the protections afforded by section 26; and**
**(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)**

**Findings/Faits sayants :**

1. As of June 20, 2011, the admission package and Resident and Family Handbook, provided to new residents or their representative on admission to the home, did not include the name and telephone number of the licensee. [LTCHA, 2007, S.O.2007,c.8, s.78(2)(h)]
This omission was confirmed during an interview with the Executive Director and Assistant Director of Care (ADOC) on June 20, 2011. During the interview with the Executive Director it was indicated that the package would be changed immediately to include the name and telephone number of the licensee.

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

**Specifically failed to comply with the following subsections:**

**s. 79. (3) The required information for the purposes of subsections (1) and (2) is,**
**(a) the Residents' Bill of Rights;**
**(b) the long-term care home's mission statement;**
**(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;**
**(d) an explanation of the duty under section 24 to make mandatory reports;**
**(e) the long-term care home's procedure for initiating complaints to the licensee;**
**(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;**
**(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;**
**(h) the name and telephone number of the licensee;**
**(i) an explanation of the measures to be taken in case of fire;**
**(j) an explanation of evacuation procedures;**
**(k) copies of the inspection reports from the past two years for the long-term care home;**
**(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;**
**(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;**
**(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;**
**(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;**
**(p) an explanation of the protections afforded under section 26; and**
**(q) any other information provided for in the regulations. 2007, c. 8, ss. 79 (3)**

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**Findings/Faits sayants :**

1. On June 20, 2011, the name and the telephone number of the licensee was not posted and communicated during a tour of the home.[LTCHA, 2007, S.O.2007, c.8,s.79(3)(h)]
During an interview with the Executive Director on June 20, 2011, it was confirmed that this information was not posted and communicated as required.

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following subsections:**

**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);**
**(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;**
**(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and**
**(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 sayants :**

1. The licensee did not ensure that the advice of the Residents' Council was sought in development and carrying out of the survey; that the results of the survey were documented and made available to the Residents' Council to seek their advice; that the actions taken to improve the long-term care home, and the care, services, programs and goods based the the results of they survey were documented and made available to the Residents' Council; that the documentation was made available to residents and their families; and that the documentation was kept in the long-term care home and made available during an inspection. [LTCHA, 2007, S.O. 2007, c.8, s.85(3),(4)(a)(b)(c)(d)]
The home does not have survey results and actions taken to improve the home. During an interview with the Executive Director it was confirmed that satisfaction surveys had not been conducted by the home prior to May of 2011. No documents setting out survey results and actions taken were available in the home. As a result of the surveys not being completed, the Residents' Council was not consulted in the development of the surveys, actions were not taken as a result of the survey, and the results were not shared with the Residents' Council or families. The Residents' Council interview, conducted on June 17, 2011, and review of the Residents' Council meeting minutes for the past year, confirm that satisfaction surveys were not conducted and information was not documented or shared with the Council.(171)

**WN #11: 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 subsections:**

**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**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits sayants :**

1. The licensee did not always ensure that policies and protocols put in place for continence and bowel management were complied with.[O.Reg. 79/10, s.8(1)(b)]

a) The bowel protocol for the Home was reviewed. The Home was not complying with this protocol for an identified resident. The resident required suppositories twice in April, 2011 (as noted in the Medication Administration Record(MAR)), once in May, 2011 (as noted in the progress notes) and once in June, 2011 (as noted in the progress notes). The Delhi Long Term Care Bowel Protocol indicates that when a suppository is given on the 4th day without a bowel movement, an assessment is to be completed and a referral to the interdisciplinary team should be initiated. There were no assessments or referrals documented regarding this requirement for suppositories. The administrator confirmed the bowel protocol should have been followed in this case. The dietitian confirmed a referral had not come through in any of those instances.

b) The Promoting Continence policy (#008010.00)for the Home was reviewed. The Home was not complying with this policy for an identified resident. The documentation regarding toilet use had only been completed in three instances per day, however, according to staff actual toilet use occurred more often than once per shift. The policy states "document all voiding and bowel activity on the resident's Point of Care screen".

c) The Home is not complying with the Promoting Continence policy for an identified resident. The documentation regarding toilet use and bladder continence had only been completed in three instances per day for a one week span between May and June, 2011, however actual toilet use, according to staff happened more often.

2. The Licensee did not ensure that the Recreation policies and procedures are in compliance with all applicable requirements under the Act. [O.Reg. 79/10, s.8(1)(a)]
The policies and procedures for the Recreation department have not been revised since 2009 and do not reflect current legislative requirements. The policies and procedures also do not include information about documentation requirements for resident participation in recreation activities. Staff interviewed confirmed that the policies have not been revised to reflect current legislative requirements and confirmed that requirements for documentation and evaluation are not included in the policy and procedures.

***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 any plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements and is complied with, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program**

**Specifically failed to comply with the following subsections:**

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

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**Findings/Faits sayants :**

1. The recreation program does not include the provision of information to residents about community activities that may be of interest to them. [O.Reg. 79/10, s.65(2)(e)]
Recreation staff interviewed confirmed that the program does not currently include communication of community activities that may be of interest to residents and this was confirmed during three resident interviews.

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

**Specifically failed to comply with the following subsections:**

**s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,**
**(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;**
**(b) a cleaning schedule for all the equipment; and**
**(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).**

**Findings/Faits sayants :**

1. The licensee did not ensure that there was a cleaning schedule in place for all the equipment related to the food production system and dining and snack areas. [O.Reg. 79/10, s.72(7)(b)]
Interviews with staff confirmed that a cleaning schedule for equipment is not currently in place.
2. The licensee did not ensure there was a cleaning schedule for the production areas, servery areas, and dishwashing areas. [O.Reg. 79/10, s.72(7)(c)]
Staff interviews confirm a cleaning schedule is not currently in place for the production areas, servery areas, and dishwashing areas.

**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following subsections:**

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

**Findings/Faits sayants :**