1. The licensee of the long term care home did not ensure that the home has a dining and snack service that included, at a minimum, 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. [r. 73. (1) 11.]

a) Resident 4003 did not have a dining room table at an appropriate height to meet their needs during the lunch meal on specified date in 2012. The resident's wheel chair was positioned sideways to the table and personal support staff confirmed that they are unable to position the resident up to the table because the table is too low for the resident's wheelchair.

b) Resident 5001 was observed sitting in a wheelchair, positioned sideways to the table. Staff confirmed that they are unable to position the resident up to the table as the table is too low. (192)

2. The licensee of the long term care home did not ensure that the home had a dining and snack service that included at a minimum, providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [r. 73. (1) 9]

a) On a specified date in 2012 during the morning nourishment pass resident 783 had 125ml fluid placed on the table in their room. The Personal Support Worker (PSW) stated she would return to the resident's room later to offer the fluid. The PSW did not return to the resident's room to provide assistance with the beverage and staff escorted the resident to the dining room at 11:40. The resident's plan of care indicated the resident required one person physical assistance to consume fluids.

b) On a specified date in 2012 during the morning nourishment pass resident 792 had 125ml of thickened fluid placed on the table in his room. The PSW stated she would return to offer the resident his beverage once the beverage sat for a bit to thicken. The PSW did not return to provide assistance with the beverage and it remained on the table at 13:20.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home has a dining and snack service that includes, at a minimum, 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 and providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. r.26(3)14 was previously issued 2011/02/14 as a WN and VPC.

The licensee failed to ensure a plan of care is based on, at a minimum, interdisciplinary assessment of the resident hydration status and any risks relating to hydration. [r. 26. (3) 14.]

a) The resident 857 had a dehydration resident assessment protocol (RAP) trigger related to a recent urinary tract infection and insufficient fluid intake. The RAP completed in 2012 identified that dehydration and fluid maintenance would be addressed in the resident's plan of care however, the registered practical nurse confirmed that there was no plan of care developed to address the resident's poor fluid intake, hydration status and any risks relating to hydration despite that the resident's fluid intake was poor.

b) Resident 840 had a dehydration resident assessment protocol (RAP) trigger related to a recent urinary tract infection and insufficient fluid intake. The RAP in 2012 identified that the resident only consumed 562-937ml/day which did not meet the fluid needs and dehydration and fluid maintenance would be addressed in the resident's plan of care however, the registered practical nurse confirmed that there was no plan of care developed to address the resident's hydration status and any risks relating to hydration.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of continence, including bladder and bowel elimination and hydration status and any risks relating to hydration, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack. [r. 71. (4)]

Resident 792 was not offered tomato juice as indicated on the home's planned menu or a choice of beverage during the lunch meal on a specified date in 2012. The resident was only offered the main entree and was not offered or provided a choice of beverages while being fed the lunch entree in the room.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy to promote zero tolerance of abuse and neglect in place and that the policy was complied with. [s. 20. (1)]

The home's resident non-abuse policy LP-B-20 indicated the employee who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report immediately to the Executive Director or most senior supervisor. The first priority ensure the safety and comfort of the resident through completion of full assessments, a determination of the resident's needs and a documented plan to meet those needs. Disclosure of the alleged abuse will be made to the resident's family/substitute decision maker as soon as possible after the incident.

The Registered Practical Nurse (RPN) confirmed that in 2012 resident 857 alleged that someone abused them during the night. The RPN confirmed she reported the alleged incident to the Director of Care. The clinical record indicated that there were no assessments or determination of the resident's needs and a documented plan to meet those needs completed. The Director of Care confirmed there was no disclosure of the alleged abuse made to the resident's family/substitute decision maker. The Executive Director confirmed she was unaware of the incident prior to the Ministry of Health Inspector disclosing it.

WN #14: 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).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

Documentation review and interview with the Executive Director confirm that the satisfaction survey was developed corporately without input from Residents' Council or Family Council. (192)

The Chair of Family Council and the Executive Director confirmed the council received the results of the survey, however did not participate in the development of it. The policy labeled "Family Council" LTC-AA-10 confirmed Family Council was not involved in the development of the satisfaction survey.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received fingernail care, including the cutting of fingernails. [r. 35. (2)]

a) Resident 778 was observed in 2012 with long, jagged, dirty finger nails. The resident indicated that staff are to cut the finger nails on bath day. The plan of care indicated that registered staff are responsible for nail care. Interview with the registered staff identified that the bath nurse is to notify the registered nurse when nails require trimming. Documentation review indicates that the residents nails have not been trimmed through the month of July. (192)

b) Clinical records for a designated month in 2012 indicated that resident 857 only received cleaning of the fingernails on one occasion and nails were last trimmed one month prior in 2012. Clinical records for the month of July 2012 indicated that the resident received cleaning and trimming of fingernails on one occasion. The resident's fingernails were noted to be unclean and untrimmed in July 2012. The resident's plan of care indicated the resident's fingernails are to be trimmed and filed by staff routinely on bath days.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use. [r. 130. 1.]

a) On July 17, 2012 at 1300 hours the medication care cart was observed to be left unlocked and unattended outside the first floor dining room, in front of the main entrance to the home.
b) No staff member was in attendance and medication was accessible to residents sitting in the area of the cart and anyone entering the home.
c) The registered staff member and a corporate representative confirmed that the medication cart was unlocked and unattended.

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 subsections:

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

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [r. 131. (1)]

a) Resident 817 has pain. The resident had been receiving a regular dose of narcotic analgesic for pain control. This medication was stopped on return from hospital in 2012 and prn (as necessary) medication was ordered. The prn medication had not been administered through a designated month in 2012. The Personal Support Worker (PSW) interviewed identified that the resident has pain 3-5 days per week and that an analgesic rub is supplied by the family and applied by the PSW at the resident's request. Documentation review and interview with the registered staff member indicated that there was no physician order for analgesic rub for this resident.

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [r. 131. (2)]

a) Resident 788's medication administration record indicated the resident was to receive identified treatments daily however, records indicted the resident only received one of the treatments eleven times and the second treatment ten times over a designated period in 2012. The resident stated that they do not always receive the treatment from staff and the registered practical nurse confirmed that if there was no signature then staff did not provide the treatment.

3. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. [r. 131. (5)]

a) Resident 1003 was identified in a progress note in 2012 to have requested that a prescribed topical medication be left at the bedside for self administration - the medication was left at the bedside. Review of the physician orders confirms that there was no order for resident 1003 to self administer the medication.
Resident 1003 was noted in 2012 to have several bottles of medication in the top drawer of their dresser, including medication that had not been prescribed by the physician. Interview with the resident confirms that the resident purchased medications and stored them in a drawer of the bedside table which was not secure and that the resident consistently self medicated.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents. [r. 89 (1)].

Related to H-00328-12

a) On July 31, 2012 resident rooms 101, 102, 103, 105, 106, 108 and 112 were observed at 1030 a.m. - no towels and facecloths were available for use by residents in the bathrooms or by the bedside. Two of four residents interviewed identified that the home does run short of towels and face cloths on occasion. There were no towels and facecloths available on linen carts or in the linen room.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. [s. 3. (1) 11. iv.]

On July 18, 2012 at 1330 when exiting the home's fenced area, a piece of paper containing resident names, capillary blood sugars, and treatments was found laying on the ground and accessible to anyone passing by the home. Personal health information was not protected.

Issued on this 24th day of October, 2012

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

Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
1-800-461-7137

Facsimile: 905-546-8255

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119, rue King Ouest, 11ième étage
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Téléphone: 905-546-8294
1-800-461-7137

Télécopieur: 905-546-8255

Date(s) of inspection/Date de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
July 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31, Aug 1, 2, 3, 2012	2012_027192_0037	Resident Quality Inspection

Licensee/Titulaire de permis
Revera Long Term Care Inc.
55 Standish Court, 8th Floor, Mississauga, ON, L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Dover Cliffs
501 St. George Street, PO Box 430, Port Dover, ON N0A 1N0

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

Debora Saville (192), Carol Polcz (156), Tammy Szymanowski (165), Yvonne Walton (169), Bernadette Susnik (120)

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

(***Please delete empty rows. Ensure the signature box is on the same page as the last row of corrected requirement.***)

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007, S.O. 2007 c. 8, s.71(3)b	CO #001	2011_165_1056_18feb12 2254	156

Issued on this 10th day of October, 2012

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

Debora Saville (192) for Carol Polcz (156)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére 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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), CAROL POLCZ (156), TAMMY SZYMANOWSKI (165), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2012_027192_0037
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Jul 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31, Aug 1, 2, 3, 7, 10, Sep 4, 5, 6, 10, 11, 12, Oct 9, 10, 2012
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	DOVER CLIFFS 501 St George Street, P.O. BOX 430, Port Dover, ON, N0A-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PAULINE ~~LYNE~~ ROBINSON

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall prepare and submit a plan ensuring that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is implemented in the home.

The plan shall be implemented.

The plan is to be submitted electronically to Debora Saville, Long Term Care Homes Inspector, Performance Improvement and Compliance Branch, Ministry of Health and Long-Term Care, Hamilton Service Area Office at debora.saville@ontario.ca by October 31, 2012.

Grounds / Motifs :

1. The licensee failed to ensure that a skin and wound care program is implemented in the home that promotes skin integrity, prevents the development of wounds and pressure ulcers, and provides effective skin and wound care interventions. [r. 48. (1) 2.]

a) The home acknowledges, during interview, that a corporate skin and wound care program that includes development of internal interdisciplinary skin and wound care team, the use of assessment tools and wound care protocols, wound management algorithms and quality improvement tools for monitoring and reporting is available for use in the home.

b) Interview confirms that the home has not implemented the available program; no interdisciplinary wound care team has been developed, wound care protocols are not consistently followed (4 of 4 residents reviewed were receiving treatments that did not follow wound care protocols), supplies identified in protocols are not readily available within the home, and resident's of the home are not consistently referred to specialized resources.

c) The homes policy related to skin and wound care was not complied with, including weekly wound assessments by a member of the registered staff were not completed for 2 of 3 residents reviewed, assessment and documentation of newly identified areas of altered skin integrity were not completed for 9 residents on the first floor, and assessment of residents with altered skin integrity on return from hospital were not completed for 2 of 3 residents reviewed.

The home has not implemented the skin and wound care program available to them through corporate resources. (192) (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2012

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that care set out in the plan of care is provided to residents 776, 787 and 857 as specified in their plans of care.

Grounds / Motifs :

1. s. 6(7) was previously issued 2010/09/08 and 2010/10/18 as a WN and VPC.

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

a) Resident 776 sustained a fall in November 2011, resulting in injury. The resident was found on the floor, by a staff member, no staff member was in attendance to assist the resident although the resident had demonstrated changes in condition and had sustained a fall without injury two days prior while self transferring. The plan of care in effect at the time indicated that the resident required one person physical assist when in the bathroom. The Director of Care confirmed that care was not provided as set out in the plan of care. (192)

b) Resident 787's plan of care directed staff to notify the dietitian of any choking episodes immediately. The resident experienced three documented choking episodes in 2012 however, their was no referral or notification to the home's Registered Dietitian for reassessment. The food service supervisor confirmed their was no referral sent for any of the choking episodes. (165)

c) Resident 857's plan of care for constipation indicated that staff provide bowel medications as needed per protocol. The protocol directed staff to provide bowel medication on the third consecutive day of no bowel movement. The resident's daily flow sheet indicated the resident did not have a bowel movement over a specified period in 2012, however, the medication administration record indicated the resident was not offered a laxative until the fourth consecutive day without a bowel movement. The registered practical nurse confirmed that laxatives are provided on the third consecutive day without a bowel movement however, this was not followed for this resident. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 26, 2012

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (1) Every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section. O. Reg. 79/10, s. 229 (1).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure the infection prevention and control program required under subsection 86(1) of the Act complies with the requirements of O. Reg. 79/10, s. 229.

The plan is to include, but is not limited to:
a) Education in infection prevention and control related to infectious diseases, cleaning and disinfection, data collection and trend analysis, for the co-ordinator of the infection prevention and control program.
b) Screening of residents and staff for tuberculosis.

The plan shall be implemented.

The plan shall be submitted electronically to Debora Saville, Long Term Care Homes Inspector, Hamilton Service Area Office, Performance Improvement and Compliance Branch, Ministry of Health and Long-Term Care at debora.saville@ontario.ca by October 31, 2012.

Grounds / Motifs :

1. a) The licensee failed to designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including infectious diseases [r. 229. (3) (a)], cleaning and disinfection [r. 229. (3) (b)], and data collection and trend analysis. [r. 229. (3) (c)]

Interview with the Director of Care and Executive Director confirm the Infection Prevention and Control co-ordinator does not have education and experience in infection prevention and control practices including, infectious disease, cleaning and disinfection and data collection and trend analysis.

b) The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis (TB) within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [r. 229. (10) 1.]

Resident 2001 was admitted to the home in 2012 and did not receive a TB skin test until 5 months after admission, not within 14 days of admission. This was confirmed by the Registered Nurse, Director of Care and Executive Director.

c) The licensee failed to ensure staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [r. 229. (10) 4.]

The Executive Director and Director of Care confirmed newly hired staff are not screened for tuberculosis. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére 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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 10th day of October, 2012

Signature of Inspector / Signature de l'inspecteur : Debora Saville (192)

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

Service Area Office / Bureau régional de services : Hamilton Service Area Office