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

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Date(s) of Inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 16, 17, 18, 19, 20, 23, 24, 25, 26, 30, 31, Aug 1, 2, 3, 7, 8, 9, 13, 14, 2012	2012_087128_0013	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6

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

EXETER VILLA
155 JOHN STREET EAST, EXETER, ON, N0M-1S1

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

RUTH HILDEBRAND (128), JUNE OSBORN (105)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Office Manager, Director of Care, 5 Registered Nurses, 2 Registered Practical Nurses, 19 Personal Support Workers/Health Care Aides, Registered Dietitian, Dietary and Building Services Supervisor(Food Service Supervisor), 2 Cooks, 2 Dietary Aides, Director of Activities and Volunteer Services, Director of Rehab and Assistant Activity Director, Physiotherapy Assistant, Maintenance Supervisor, Assistant Maintenance Supervisor, Housekeeping Aide, Laundry Aide, 3 Family Members and 40 Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident areas and common areas, observed residents and the care provided to them, and observed meal service. Medication administration and storage were observed and clinical records for identified residents were reviewed. The inspectors reviewed admission and resident charges records, policies and procedures pertaining to the inspection, as well as minutes of meetings related to L-001132-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

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	
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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. A registered nurse was observed drawing blood samples from two residents in the main lounge and in the hallway beside the lounge.
The DOC confirmed that this did not meet her expectations in terms of these residents being afforded the right to privacy in treatment.
[LTCHA, 2007, S.O. 2007, c.8, s.3(1)8.]
2. July 16, 2012, it was noted that an identified resident was not treated with dignity and respect while finishing the lunch meal. The resident was approached twice by a dietary aide to clear his/her table. The first time the dietary aide stood over the resident, did not address him/her face to face, and removed all his/her fluids except for the coffee. The second time the dietary aide again did not address him/her face to face, stood behind him/her, to the side, and started to remove his/her plate.
The Food Service Supervisor intervened when the MOHLTC inspector brought it to her attention. She acknowledged that this did not meet the home's expectation related to treating residents with dignity and respect.
[LTCHA, 2007, S.O. 2007, c.8, s. 3(1)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 Residents' Bill of Rights, including the right to be treated with dignity and respect and the right to be afforded privacy in treatment, are complied with, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. A clinical record review for an identified resident revealed that the resident's assessed need and the interventions in the plan of care are not consistent, related to the amount of assistance required with eating. Additionally, the assessment done by the registered dietitian does not coincide with the required eating assistance documented by nursing.
Two registered nurses and the registered dietitian acknowledged that the care plan should be based on the resident's assessed needs and the plans of care and assessments should be integrated, collaborative and consistent.
[LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(b)]
2. A clinical record review for an identified resident revealed that the last assessment indicates that the resident is totally dependent for toilet use. The assessment indicates that the resident requires two persons to assist with toileting and the resident is toileted regularly. However, the care plan has goals that indicate that the resident should maintain ability to toilet self safely and appropriately. Interventions in the care plan and the kardex include no toileting required and use verbal reminders for urine control.
The Director of Care confirmed that the plan of care is not based on the resident's assessment and the conflicting goals and interventions do not provide clear direction to staff.
[LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that plans of care provide clear direction to staff and others who provide direct care and to ensure that different aspects of care are integrated and are consistent with and complement each other in the plan of care, to be implemented voluntarily.

WN #3: 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 saillants :

1. A review of the admission package revealed that it does not include the following:
- 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, with respect to the supply of drugs;
- the home's policy on minimizing of restraining although there is a leaflet related to restraints included. There are 21 pages of policies related to restraints ranging in dates from September 2, 2009 to September 16, 2010; and
- an explanation of the duty under section 24 to make mandatory reports related to all incidents resulting in harm or risk of harm to a resident.
The Administrator confirmed that the admission package does not contain the required information.
[LTCHA, 2007, S.O. 2007, c.8, s. 78(2)(d),(g) and (m)]

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 admission package includes all the required information, to be implemented voluntarily.

WN #4: 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. (2) Every licensee of a long-term care home shall ensure that the required information is communicated, in a manner that complies with any requirements that may be provided for in the regulations, to residents who cannot read the information. 2007, c. 8, s. 79. (2).

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)

Findings/Faits saillants :

1. A review of information posted in the home revealed that evacuation procedures have not been posted nor communicated to residents.
The Administrator acknowledged that evacuation procedures have not been posted in the home nor communicated.
[LTCHA, 2007, S.O. 2007, c.8, s. 79(3)(j)] (105)
2. Although procedures for making a complaint are posted, the Director's name and telephone number have not been included in the posting.
The Administrator acknowledged the posting does not list the Director's name and contact information.
[LTCHA, 2007, S.O. 2007, c.8, s. 79(3)(f)] (105)
3. There is no evidence to support that all posted information is communicated to residents who cannot read.
The Administrator acknowledged that the home needed to do a better job of communicating posted information to residents who cannot read the information.
[LTCHA, 2007, S.O. 2007, c.8, s. 79(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 all the required information is posted and communicated to residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. There is no documented evidence to support that the home has developed and implemented a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents.
The Administrator acknowledged while the home has components of a quality improvement program in place, the program has not been fully developed and implemented yet. She confirmed that the home does monitoring, but the analysis and evaluation components are deficient.
[LTCHA, 2007, S.O. 2007, c. 8, s. 84]

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 develops and implements a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following 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 saillants :

1. The Resident Council policy entitled Resident Council Goals, dated September 2004, regarding the Resident Council Suggestion/Complaint Form is not in compliance with the LTCHA since it indicates a reply regarding actions taken is to be returned to the council within 21 days.
This Administrator verified that it does not state a response is required within 10 days.
[O.Reg. 79/10, s. 8(1)(a)]
2. The home's policy entitled Staff Reporting and Whistle-blowing Protection, dated September 7, 2011, includes a section related to Staff Orientation and Training. It indicates that staff members will receive orientation and annual re-training on the reporting obligations under the Long Term Care Act, the home's internal reporting procedures, and the whistle-blowing protections in the Long Term Care Act.
The policy has not been complied with as a review of the 2011 staff training records revealed 25 of 92 (27%) staff have not had any abuse retraining.
There are no training records available for 2012.
The Administrator verified that all staff have not received annual abuse training.
[O.Reg. 79/10, s. 8(1)(b)]
3. A review of the Classic Care Pharmacy Policy # 1.5, entitled Emergency Medication Box Procedure, dated October 2010, revealed that it indicates "the registered staff should audit the contents and their expiry dates on a monthly basis."
Two of two registered staff interviews revealed the policy is not complied with as this is done by the pharmacist when in the home.
[O.Reg. 79/10, s. 8(1)(b)]
4. Clinical record reviews revealed that the Fall and Post Fall Assessment and Management policy, dated May 30, 2011, was not complied with related to assessment for post falls by registered nursing staff. There is no evidence to support that a head to toe assessment was done post fall, for three identified residents, as indicated in the policy.
Additionally, there is no documented evidence to support that head injury routine was implemented, as per the policy, post the unwitnessed falls for two identified residents.
A Registered Nurse stated that he/she was unaware that the policy stated that head injury routine had to be initiated for all unwitnessed falls.
The Director of Care acknowledged that the policy was not followed and that the expectation is that a head to toe assessment is done and head injury routine should be implemented for all unwitnessed falls.
[O.Reg. 79/10, s. 8(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that policies and procedures are implemented in accordance with the LTCHA and/or Regulations and that policies are complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following subsections:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. There is no evidence to support that the registered dietitian was involved in the development and implementation of the newly implemented Point of Care food and fluid documentation system.
The registered dietitian acknowledged that she was not involved in the change over to this system.
[O. Reg. 79/10, s.68(2)(a)]
2. It was observed that an identified resident was not in the dining room for a lunch meal. The resident was provided fluids but did not receive a tray or any food until MOHLTC intervention was provided. The resident is cognitively impaired and had missed 19 meals in a two week period. Although food and fluid intake has been documented, there has been no evaluation of the food and fluid intake for this resident.
The home does have a system in place, in Point of Care, to monitor the food and fluid intake of residents. However, there is no evidence to support that there is an evaluation component to this system.
The food service supervisor and registered dietitian both acknowledged that somebody needed to be responsible for evaluating the intake of residents and that this did not seem to be assigned to anyone.
[O. Reg. 79/10, s.68(2)(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 all policies and procedures relating to the nutrition care and dietary services and hydration programs are developed and implemented in consultation with the registered dietitian, and a system to evaluate food and fluid intake of residents is developed and implemented, to be implemented voluntarily.

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

Specifically failed to comply with the following 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 saillants :

1. A clinical record review revealed that an identified resident requires physical assistance with meals and is at high nutritional risk related to decreased food/fluid intake.
This resident was provided no assistance, encouragement or cueing for 20 minutes at a lunch meal.
PSW staff provided assistance to the resident after MOHLTC identified this to the Director of Care who acknowledged that the resident should have been assisted throughout the entire meal.
[O.Reg. 79/10, s. 73(1)9.]
2. All residents were not monitored during a lunch meal, including the following observations affecting food and fluid intake:
1. An identified resident did not consume the entree provided and an alternate was not offered to the resident. The resident was quite upset that an alternate meal was not provided and stated somebody should be monitoring to see what happens in the dining room.
The Food Service Supervisor acknowledged that an alternate should have been offered to the resident and did offer the resident something else to eat after MOHLTC intervention. The resident was too upset to eat, at this point, and left the dining room.
2. An identified resident was provided no assistance or encouragement for 45 minutes. The resident did not eat anything during this time nor was he/she asked if he/she would like an alternate meal.
The food service supervisor did assist at this point and agreed the resident should have been monitored and offered assistance earlier than he/she was.
[O.Reg. 79/10, s. 73(1)4.] (105)

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 monitoring system is in place at all meals and to ensure that all residents are provided with the required personal assistance and encouragement to safely eat and drink, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following subsections:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
1. Treatments and interventions to promote continence.
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.
3. Toileting programs, including protocols for bowel management.
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. There is no documented evidence that an annual satisfaction evaluation of continence care products is completed, in consultation with residents and substitute decision-makers(SDMs).
Personal support workers acknowledged that they have input into the continence care products used.
However, the Administrator confirmed that residents and SDMs are not involved in an annual evaluation of continence care products.
[O. Reg. 79/10, s. 51(1)5]
2. A clinical record review for an identified resident revealed that an individualized plan to promote bladder continence has not been established for this resident.
The Director of Care acknowledged that individualized toileting routines are not in place for all residents in the home.
[O. Reg. 79/10, s. 51(2)(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 residents and substitute decision makers participate in an annual satisfaction evaluation of the continence care products used; and to ensure that individualized plans to promote bowel and bladder continence are based on assessed needs and implemented for residents who are incontinent, to be implemented voluntarily.

WN #10: 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 subsections:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. Three of five staff interviews with registered and non-registered staff confirmed that they were not aware of interventions and expectations in the falls prevention program.
A review of the training records revealed that all direct care nursing staff have not had annual training in the following required areas:
- continence care and bowel management - 10 of 44 (23%) direct care nursing staff have not had training; and
- falls prevention and management - 9 of 44 (20%) direct care nursing staff have not had training.
The Administrator acknowledged that all direct care staff have not been trained and confirmed the accuracy of these training records.
[O.Reg. 79/10, s.221(1)1 and 3]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff who provide direct care to residents receive all required annual training, to be implemented voluntarily.

WN #11: 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 subsections:

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. During a lunch meal service, it was noted that personal support worker staff who were feeding or assisting more than one resident were not completing any hand hygiene/hand washing after touching one resident or their utensils and moving to another resident.
Staff were also observed touching residents and wheelchairs, at this meal, without evidence of hand washing/hand hygiene before serving meals to other residents.
The food service supervisor confirmed that staff are expected to wash their hands or use hand hygiene between touching dirty and clean items. (128)
2. The following infection control risks were also noted:
- incorrectly labelled or illegibly labelled wash basins were observed in the shared washrooms of five resident rooms;
- an unlabelled urinal was observed in the shared washroom of an identified resident room;
- an identified room had an unlabelled urinal containing urine hanging on the grab bar; and
- the toilet ring had liquid stool on it, in an identified room.
The Administrator acknowledged that staff were expected to maintain infection control practices and that the home was in the process of re-labelling all personal care items.
[O.Reg. 79/10, s. 229(4)] (105)

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 participate in the infection control program; personal care items are labelled and hand hygiene/hand washing is complied with, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. There is no documented evidence to support that the home's quality improvement and utilization review system has a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review.
Additionally, there is no evidence to support that there is a record maintained of improvements made through the quality improvement program nor are improvements communicated to the Residents' Council and the staff of the home on an ongoing basis.
The Administrator confirmed that although departmental goals are developed, the quality monitoring program itself is just in the initial stages and goals, objectives, policies and procedures have not been established. She also acknowledged that a process to identify initiatives for review has not been established, either.
The Administrator confirmed that despite improvements being made in the home, a record has not been kept nor have the improvements been shared with staff or Residents' Council.
[O. Reg. 79/10, s. 228.1, 3 and 4] 105

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 quality improvement and utilization review system develops a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review. Additionally improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must have a record kept and be communicated to the Residents' Council and the staff of the home on an ongoing basis, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

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.
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.
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.
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. A review of the pain management and continence care and bowel management policies and procedures revealed that these programs have not been implemented in accordance with the LTCHA and Regulations.
The Director of Care confirmed the pain management and continence care and bowel management programs have not been fully implemented yet. She acknowledged that although the home has had some preliminary meetings and components of programs exist, they are still in the initial stages of program development.
2. Although the home has a policy entitled, Registered Dietitian Referral, dated October 2011, there is no documented evidence to support that protocols for a referral process are in place for the nutrition care and hydration program.
Registered nursing staff did not notify the registered dietitian when an identified resident's care needs changed after missing 19 meals in 14 days.
The food service supervisor indicated that the referral process is informal. The registered dietitian also confirmed that the referral process needs to be more formalized as she was not notified about this resident's change of condition and she should have been.
[O. Reg. 79/10, s. 30(1)1] (105)

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 each organized program includes 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 when required, to be implemented voluntarily.

WN #14: 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 saillants :

1. The licensee does not respond to Residents' Council recommendations or concerns in writing within 10 days, despite concerns being noted in the Residents' Council minutes.
This was verified by the Food Services Supervisor and the Administrator.
[LTCHA, 2007, S.O. 2007, c.8, 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 Residents' Council's recommendations and concerns are responded to, in writing, within 10 days, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. Three of four direct care staff shared they they have not received abuse training annually.
A review of the 2011 Staff Training Records revealed 25 of 92 staff did not receive the annual retraining.
There is no documented evidence that annual retraining for any direct care staff occurred in 2012.
The Administrator verified that all staff have not received the required annual abuse training.
[LTCHA, 2007, S.O. 2007, c.8, s. 76(7)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 direct care staff receive all the required annual training, to be implemented voluntarily.

WN #16: 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 home's policy entitled Staff Reporting and Whistle-blowing Protection, dated September 7, 2011, does not identify training and retraining requirements for 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.
The Administrator verified that the policy was not in compliance with the LTCHA and Regulations.
[O.Reg. 79/10, s. 96(e)(i) and (ii)]
2. A review of the home's policy entitled Resident Abuse, dated October 2011, revealed that it does not identify measures and strategies to prevent abuse and neglect.
This was verified by the Administrator.
[O.Reg. 79/10, s. 96(c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy to promote zero tolerance of abuse is in compliance with the LTCHA and regulations, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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
(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. An inspection of the medication room and the emergency drug box revealed the following medications were expired:
(1) Medication Room
Anuzinc - 1 tube expired November 2009; 1 tube expired
February 2010; and 2 tubes expired June 2011;
Blink eye drops - expired March 2011.
(2) Emergency Drug Box
APO-Clarithromycin - expired May 2012;
Levofloxacin - expired June 2012; and
Novotrimel - expired June 2012.
It was noted that there was no stated expiry date included for
the following:
Amoxicillin 250 mg. (14 caps);
Nitrofurantin 100mg (6 caps); and
Ciprofloxacin 250 mg (14 tabs.
These findings were verified by a registered nurse and the Director of Care.
[O.Reg. 79/10, s. 129(1)(a)(iv)]
2. Controlled substances were not stored in a separate, double locked area in the medication cart, or stationary cupboard. Controlled drugs were supplied in strip packages for regular doses and prn doses on cards that were not stored in a separate locked area.
The Director of Care verified that all controlled substances were not double locked.
[O.Reg. 79/10, s. 129(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in a manner that complies with manufacturer's instructions and that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Four of six staff interviews with registered and non-registered staff revealed that non-registered staff apply topical treatment creams without prior training, or supervision.
The Director of Care confirmed it is the expectation that the registered staff apply the topical treatment creams.
[O.Reg. 79/10, s. 131(4)(a),(b) and (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that registered staff provide training and supervision to non-registered staff prior to permitting administration of topicals to residents, to be implemented voluntarily.

WN #19: 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. (2) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly. 2007, c. 8, s. 85. (2).

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 saillants :

1. An interview with a Resident Council representative revealed that the home does not seek the advice of Residents' Council in developing and carrying out the annual satisfaction survey nor acting on its results.
The Administrator confirmed that Residents' Council was not involved in the development of the survey nor in acting on the results of the survey. She also confirmed that the home has not acted on the results of the October 2011 survey yet.
[LTCHA, 2007, S.O. 2007, c. 8, s. 85 (2) and (3)] (105)
2. An interview with a Residents' Council representative revealed that the Council has not been provided the results of the satisfaction survey.
The Residents' Council has not been provided the results of the satisfaction survey as verified by the Administrator.
[LTCHA, 2007, S.O. 2007, c.8, s. 85(4)(a)]

WN #20: 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).

Findings/Faits saillants :

1. Observations of the East tub room revealed the following maintenance concerns:
-both shelves used to hold towels have rust on the legs;
- tile near the garbage pail is cracked;
-wall near call bell light is peeling;
-wall behind the door has been repaired but has not been painted;
-paint on the door to the tub room is chipped; and
-there are stains on the ceiling above the sink.
The maintenance supervisor acknowledged that he was aware that these repairs needed to be done and they would be attended to in the near future.
[LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(c)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following subsections:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act.
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act.
3. The most recent audited report provided for in clause 243 (1) (a).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service.
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. Although the duty to make mandatory reports and the fundamental principle are posted in the home, there is no evidence to support that they have been communicated to residents.
The Administrator acknowledged that the duty to make mandatory reports and the fundamental principle have not been communicated to residents.
[O.Reg. 79/10, s.225(1)1 and 5] (105)
2. A review of posted information revealed that the most recent audited report is not posted in the home nor communicated to residents.
The Administrator acknowledged that the audited reports have never posted nor communicated.
[O.Reg. 79/10, s.225(1)3] (105)

WN #22: 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).

Findings/Faits saillants :

1. Observation of a group activity revealed that 14 of 15 residents were sleeping and not interested in &/or engaged while having the newspaper read aloud to them.
The Administrator also observed that 14 of 15 residents were sleeping and acknowledged that this definitely was not a meaningful activity.
[O. Reg. 79/10, s.65(2)(e)]

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 80. Regulated documents for resident

Specifically failed to comply with the following subsections:

s. 80. (1) Every licensee of a long-term care home shall ensure that no regulated document is presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident, unless,
(a) the regulated document complies with all the requirements of the regulations; and
(b) the compliance has been certified by a lawyer. 2007, c. 8, s. 80. (1).

Findings/Faits saillants :

1. There is no documented evidence to indicate that a lawyer certified that the Admission Agreement complies with all the requirements in the regulations.
The Administrator acknowledged that a lawyer has not certified all documents, presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident, comply with all the requirements of the regulations.
[LTCHA, 2007, S.O. 2007, c.8, s. 80(1)(a) and (b)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following subsections:

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
(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. A review of the Family Council binder revealed that the home has been conducting information meetings annually to advise residents' families and persons of importance to residents of their right to establish a Family Council. The last information session/Town Hall meeting was held in October 2011.
The Administrator confirmed that the licensee does not convene semi-annual meetings, as required.
[LTCHA, 2007, S.O. 2007, c.8, s. 59(7)(b)]

Issued on this 14th day of August, 2012

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

Ruth Hildebrand