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) :	KELLY-JEAN SCHIENBEIN (158), DIANA STENLUND (163), LAUREN TENHUNEN (196), MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2012_140158_0017
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Sep 24, 25, 26, 27, 28, Oct 1, 2, 3, 4, 5, 9, 10, 11, 22, 26, Nov 2, 2012
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE FALCONBRIDGE 281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JAMES R. FOREMAN

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall implement the plan as submitted on September 14, 2012 to ensure that plans of care for all residents provide clear directions regarding management of the residents' care needs to staff and others who provide direct care to residents.

Grounds / Motifs :

1. A previous compliance order was issued under s.6 (1) (c): 2012_140158_0010. A compliance date was extended from September 21/12 to October 14, 2012 at the request of the home. (158)
2. The health care record for resident # 03 was reviewed by the Inspector on September 26/12. It is documented by staff # S-128 in the initial assessment that the resident had a history of being non-compliant with eating their specific diet. In an interview on September 27/12, staff # S-128 confirmed that the resident continues to be non-compliant.
It is documented in the resident's plan of care that when the resident is non compliant, a specific intervention is used when "all other interventions fail. The specifics of what "other interventions" are, is not documented. Clear direction for staff and others who provide direct care to manage resident's refusal is not set out in the plan of care. [LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c)] (158)
3. The licensee has not ensured that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
Inspector 163 interviewed staff # S-114, staff # S-115 and staff # S-116 who reported that resident # 46209 requires dentures to be cleaned and removed after all meals and then put back into the resident's mouth prior to meal time. Inspector reviewed the care plan document within the plan of care which only identifies that resident # 46209 is to have dentures removed at bedtime to soak. [LTCHA 2007, S.O. 2007,c. 8, s. 6 (1) (c)]. (163)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that any resident requiring a mechanical lift for transferring is assessed for the sling size prior to use and that staff use safe transferring and positioning devices or techniques when assisting residents. [O. Reg. 79/10, s. 36.]

Grounds / Motifs :

1. Resident # 01 fell to the floor while being lifted using a specific mechanical lift. The resident was transferred to hospital for treatment. The documentation on the Critical Incident Report identified that the belt buckle on the lift broke and that this resulted in the resident falling to the floor. The Inspector spoke with staff # S-125 and staff # S-123 on October 2/12 and was shown the sling which they confirmed as being used by the 2 staff when the resident was transferred. The label on the sling clearly identified the number, size and a year was permanently marked on the label as well. The Inspector observed that the "stay clip" or "part on the harness of the belt that secures the belt from slipping" was missing and that the buckling clip (which was not attached) and the buckle were intact with no evidence of cracks or breakage. Staff # S-122, staff S-125 and staff # S-123 stated that when the resident was being transferred by the 2 staff, the resident leaned to the side causing the sling's strap to loosen and cause the belt buckle to let go.
The health care record including the plan of care for resident # 01 was reviewed by the Inspector on October 3/12 and the specific mechanical lift and sling size used when transferring resident # 01 is documented, however the size of sling which was used when the resident fell while being transferred differed than what was identified in the plan of care.
The Inspector spoke to staff # S-123 on October 2/12 and reviewed the home's process of inspecting slings and the home's policy regarding lifts and transfers. Staff # S-123 verified that a monthly sling Inspection is in place for the slings used with the mechanical lift used to transfer resident # 01 and that the Registered staff on the floor are responsible to assess the resident for the appropriate sling size.
The monthly Sling Inspection reports were reviewed by the Inspector and it is documented that the custom sling which was used in the transfer of resident # 01 was inspected in May, June, and July 2012. It was also documented that two other custom slings were also inspected in June and July 2012. There was no documentation identifying that any "Custom Sling" was inspected in August 2012. It is documented in the September 2012 Sling Inspection Report that a custom sling was inspected however there is "no number" identifying which sling was inspected.
The Inspector spoke to staff # S-123 on October 2/12 and reviewed the home's policy regarding lifts and transfers and the home's process of inspecting slings.
The Inspector observed that a year was permanently marked on the label of the sling used when the resident fell. Staff # S-123 confirmed that the year marked was the year that the sling was put into service. The Inspector reviewed the home's "Safe Lifting with Care" policy # 01-04 on October 2/12 and it is documented under the role and responsibility for DOC or delegate that "slings are to be removed from service after three years of service". The Inspector spoke with staff # S-123 who stated that depending on the condition, some slings, such as the sling used when the resident fell are kept in service beyond the three years.
Staff # S-122 confirmed on October 1/12 that all of the specific lifts were removed from service after the incident involving resident # 01. Resident # 01 plan of care was reviewed on October 5/12 by the Inspector and the plan of care still identified the use of the specific lift five days post incident. There was no documentation in the resident's plan of care, the progress notes, the 24-hr report or assessments that the resident was re-assessed after the incident when the specific lifts were removed and the transfer using a full mechanical lift was started for resident # 01. The size of the sling to use when transferring the resident using a full mechanical lift was not documented.
Staff # S-108 and # S-109 stated that resident # 01 is currently a "full lift". When questioned by the Inspector as to the sling size used with the full lift versus the specific lift removed from service, staff # S-109 stated that the slings used when transferring the resident in a full lift are different. Staff # S-108 stated "I think we are to use the medium size sling when transferring the resident in the full lift. The licensee did not ensure that staff use safe transferring or positioning techniques when assisting residents. [O. Reg. 79/10, s. 36.] (158)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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 Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
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.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 2nd day of November, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Sep 24, 25, 26, 27, 28, Oct 1, 2, 3, 4, 5, 9, 10, 11, 22, 26, Nov 2, 2012	2012_140158_0017	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4

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

KELLY-JEAN SCHIENBEIN (158), DIANA STENLUND (163), LAUREN TENHUNEN (196), MELISSA CHISHOLM (188)

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 Acting Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered staff, Personal Support Workers (PSWs), the Quality Assurance Co-ordinator, the RAI Co-ordinator, the Kinesiologist, the Activity Program Manager, the Activity aides, the Dietitian, the food service workers, the Support Services Manager, the Social Worker, residents and families.

During the course of the inspection, the inspector(s) walked through resident home areas, observed staff to resident interactions and care, reviewed residents' health care records, reviewed various policies and procedures and reviewed staff education/training records.

The following logs were reviewed during this RQI inspection: S- 1049-12, S-1111-12, S-1124-12 and S-1149-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

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

Findings/Faits saillants :

1. Resident # 01 fell to the floor while being lifted using a specific mechanical lift. The resident was transferred to hospital for treatment. Staff # S-122 confirmed on October 1/12 that all of the specific lifts were removed from service after this incident. Resident # 01 was among two other residents (resident # 04 and # 05) who were transferred solely with the specific lift. The plans of care for the residents were reviewed on October 5/12 by the inspector and all plans of care identify the use of the specific lift. There was no documentation in the residents' plans of care, the progress notes, the 24 -hr report or assessments that the residents were re-assessed after the incident when the specific lifts were removed and the transfer using a full mechanical lift was started for these residents. The size of the sling to use when transferring the resident using a full mechanical lift was not documented. The care set out in the plan of care was not based on an assessment of these resident and the needs of these residents. [LTCHA 2007, S.O. 2007,c. 8, s. 6 (2)]
2. Resident # 01 fell to the floor while being lifted using a specific lift and was transferred to hospital for treatment. The Inspector spoke with staff # S-125 and staff # S-123 on October 2/12 and was shown the sling which was used by the 2 staff when the resident was transferred. The label on the sling used, clearly identified the size of the sling. Inspector reviewed resident # 01 plan of care and the sling size documented in the resident's plan of care was not the sling size used when the resident fell during the transfer. The care set out in the plan of care was not provided to resident # 01. [LTCHA 2007, S.O. 2007,c. 8, s. 6 (7)]
3. The licensee has not ensured that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
Inspector # 163 interviewed Staff # S-114, # S-115, # S-116 who reported that resident # 46209 requires dentures to be cleaned and removed after all meals and then put back into the resident's mouth prior to meal time. Inspector reviewed the care plan document within the plan of care which only identifies that resident 46209 is to have dentures removed at bedtime to soak. [LTCHA 2007, S.O. 2007,c. 8, s. 6 (1) (c)].
4. The Inspector observed that resident # 46027 face was soiled with food debris after eating lunch on September 25, 26 and 27/12. The resident was observed to return to their room after eating lunch. The Inspector did not observe staff approach the resident to cue or encourage the resident to wash their face as documented in the resident's plan of care. The Inspector observed the resident at 16:00hr and the resident's face remained unwashed. The care set out in the plan of care was not provided to resident # 46027. [LTCHA 2007, S.O. 2007,c. 8, s. 6 (7)]
5. The Inspector observed that resident # 46027 did not participate in any activities on September 25, 26 and 27/12. The Inspector also observed that the resident was resting in bed when the staff entered the resident's room to assist other residents who were attending an activity at 11:00hr and at 13:45hr. The Inspector did not observe that resident # 46027 was approached or encouraged to attend either activity as stipulated in the resident's plan of care. The care that was set out in the plan of care for resident # 46027 was not provided. [LTCHA 2007, S.O. 2007,c. 8, s. 6 (7)]
6. The Inspector observed that resident # 46027 did not participate in any activities on September 25, 26 and 27/12. The health care record, including the RAI/MDS assessment for resident # 46027 was reviewed by the Inspector on September 28/12. Conflicting information was found documented between staff # S-117 and staff # S-124 regarding the resident's mood/level of interest/level of interaction. Staff # S-124 identified that they are responsible to complete a section related to a resident's psychosocial well being and a section related to the activity pursuits pattern of the RAI/MDS assessment. Staff # S-124 stated that nursing is responsible to complete the section related to mood and behaviour patterns. Staff # S-124 stated to the Inspector on September 28/12 that a collaborative approach was not done. The two departments did not collaborate with each other in the assessment of resident # 46027 so that their assessments were integrated, consistent and complement each other. [LTCHA 2007, S.O. 2007, c. 8, s. 6. (4)(a)]
7. The health care record for resident # 03 was reviewed by the Inspector on September 26/12. It is documented by staff # S-128 in the initial assessment that the resident had a history of being non-compliant with eating their specific diet. In an interview on September 27/12, staff # S-128 confirmed that the resident continues to be non-compliant.
It is documented in the resident's plan of care that when the resident is non compliant, a specific intervention is used when "all other interventions fail. The specifics of what "other interventions" are, is not documented. Clear direction for staff and others who provide direct care to manage resident's refusal is not set out in the plan of care. [LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c)]
8. The licensee has not ensured that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary; or care set out in the plan has not been effective.
Staff # S-118 reported to the Inspector that resident # 45958 has become increasingly incontinent of bowel. Review of the Point of Care documentation indicated that resident # 45958 was incontinent on 8 occasions in the past 14 days. The Care Plan document for resident # 45958 does not address the issue of bowel incontinence. [LTCHA, 2007, S.O. 2007, c.8.s6(10)(b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Resident # 01 fell to the floor while being lifted using a specific mechanical lift. The resident was transferred to hospital for treatment. The documentation on the Critical Incident Report identified that the belt buckle on the lift broke and that this resulted in the resident falling to the floor. The Inspector spoke with staff # S-125 and staff # S-123 on October 2/12 and was shown the sling which they confirmed as being used by the 2 staff when the resident was transferred. The label on the sling clearly identified the number, size and a year was permanently marked on the label as well. The Inspector observed that the "stay clip" or "part on the harness of the belt that secures the belt from slipping" was missing and that the buckling clip (which was not attached) and the buckle were intact with no evidence of cracks or breakage. Staff # S-122, staff S-125 and staff # S-123 stated that when the resident was being transferred by the 2 staff, the resident leaned to the side causing the sling's strap to loosen and cause the belt buckle to let go.
The health care record including the plan of care for resident # 01 was reviewed by the Inspector on October 3/12 and the specific mechanical lift and sling size used when transferring resident # 01 is documented, however the size of sling which was used when the resident fell while being transferred differed than what was identified in the plan of care.
The Inspector spoke to staff # S-123 on October 2/12 and reviewed the home's process of inspecting slings and the home's policy regarding lifts and transfers. Staff # S-123 verified that a monthly sling Inspection is in place for the slings used with the mechanical lift used to transfer resident # 01 and that the Registered staff on the floor are responsible to assess the resident for the appropriate sling size.
The monthly Sling Inspection reports were reviewed by the Inspector and it is documented that the custom sling which was used in the transfer of resident # 01 was inspected in May, June, and July 2012. It was also documented that two other custom slings were also inspected in June and July 2012. There was no documentation identifying that any "Custom Sling" was inspected in August 2012. It is documented in the September 2012 Sling Inspection Report that a custom sling was inspected however there is "no number" identifying which sling was inspected.
The Inspector spoke to staff # S-123 on October 2/12 and reviewed the home's policy regarding lifts and transfers and the home's process of inspecting slings.
The Inspector observed that a year was permanently marked on the label of the sling used when the resident fell. Staff # S-123 confirmed that the year marked was the year that the sling was put into service. The Inspector reviewed the home's "Safe Lifting with Care" policy # 01-04 on October 2/12 and it is documented under the role and responsibility for DOC or delegate that "slings are to be removed from service after three years of service". The Inspector spoke with staff # S-123 who stated that depending on the condition, some slings, such as the sling used when resident # 01 fell, are kept in service beyond the three years.
Staff # S-122 confirmed on October 1/12 that all of the specific lifts were removed from service after resident # 01 fell. Resident # 01 plan of care was reviewed on October 5/12 by the Inspector and the plan of care still identified the use of the specific lift five days post incident. There was no documentation in the resident's plan of care, the progress notes, the 24-hr report or assessments that the resident was re-assessed after the incident when the specific lifts were removed and the transfer using a full mechanical lift was started for resident # 01. The size of the sling to use when transferring the resident using a full mechanical lift was not documented.
Staff # S-108 and # S-109 stated that resident # 01 is currently a "full lift". When questioned by the Inspector as to the sling size used with the full lift versus the specific lift removed from service, staff # S-109 stated that the slings used when transferring the resident in a full lift are different. Staff # S-108 stated "I think we are to use the medium size sling when transferring the resident in the full lift. The licensee did not ensure that staff use safe transferring or positioning techniques when assisting residents. [O. Reg. 79/10, s. 36.]
2. On October 2/12, the Inspector observed that resident # 45988 who is unable to move their lower extremities and has poor skin integrity was sitting in their wheel chair (w/c) at the dining room table with their right foot dangling behind the back of the foot rest. Staff made no attempts to re-position the resident's foot. The licensee did not ensure that staff use safe transferring or positioning techniques when assisting residents. [O. Reg. 79/10, s. 36.]
3. On September 28/12, resident # 45988 who is unable to move their lower extremities and who is at risk for skin breakdown was observed by the Inspector sitting in their w/c at 09:45hr. The resident was sitting upright in their chair however the resident's left foot was observed to be dangling behind the foot rest.
Resident # 45988 was observed to be transferred into the tilt w/c by 2 staff on September 25/12 at 11:00hr. The resident was leaning to the right while sitting in the chair and the resident's feet were dangling and not placed on the foot board. The Inspector observed that the resident was in the same position at 14:30hr. The licensee did not ensure that staff use safe transferring or positioning techniques when assisting residents. [O. Reg. 79/10, s. 36.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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. On October 2, 2012, Inspector #196 observed the flooring in one of the tub/shower rooms, lifted, bubbled and "spongy" with black tinged liquid seeping out at the edge in the shower stall area. Inspector #196 observed that in a different floor tub/shower room, paint was peeling off of the heater on the lower part of the wall. The licensee has not maintained areas of the home in a good state of repair. The licensee failed to ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [LTCHA 2007, S.O.2007,c. 8, s. 15 (2)(c).]
2. Inspector #196 observed on October 2/12 that the cloth covered couches in one of the common areas have visible staining and soiling on the seat and arm surfaces and the side chairs have soiling on the arm rests. On October 3/12, Inspector #158 reported that in the one of the dining rooms there were three fabric covered dining chairs with stains on the seating surfaces. An interview was conducted with staff # S-126, on October 2/12 and it was reported that the particular floor's housekeeper would clean the fabric upholstery and "cleanliness audits" are conducted monthly for the common areas of the home. The home did not ensure furnishings in the common areas of the home were kept clean and sanitary.
The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary; [LTCHA 2007,S.O.2007,c.8,s.15.(2)(a).]

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 especially the flooring in the 3rd floor tub/shower room is in a good state of repair, to be implemented voluntarily.

WN #4: 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. The licensee has not ensured the programs include the 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.
Upon entry to the home at 08:20hr on October 03/12, Inspector # 158 and Inspector # 163 inspected the cutlery, cups and saucers in a dining room prior to breakfast meal service. Several mugs, cutlery and plastic glasses at several place settings were noted to have food particles and/or staining. Prior to breakfast on one of the floors on October 03/12, Inspector # 163 observed that both east and west end dining rooms had mugs and plastic glasses at several place settings with adhered food particles.
Staff # S-121 provided a copy of the home's dietary policy regarding dish-washing (Document number DIET-07-01-29) which outlines that staff are to check clean dishes for soiled particles. Staff # S-121 acknowledged during an interview with inspector 163 on October 03, 2012 that the issue of food particles and stained cutlery have recently been reported to the dietary department and that staff should be checking the dishes and cutlery prior to setting the tables. [O.Reg.68 (2)(a)]

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 enduring that the home's dietary policy regarding dish-washing is implemented, to be implemented voluntarily.

WN #5: 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. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. Resident # 03 who receives a specific treatment was observed on September 26, 28 and October 1/12 to be sleeping in bed when staff # S-112 was passing out fluids during the moming fluid pass. It was observed by the Inspector that staff # S-112 entered resident # 03 room but did not approach the resident nor offer the resident any fluids. The snack sheet located on the cart identified that the resident is to have a specific amount of fluid during this pass. Staff # S-112 did not look at the dietary list at any time during this pass. When questioned by the Inspector as to the process of passing out fluid/nourishment to the residents, the staff member identified that residents who are sleeping are not disturbed. Resident # 03 was not offered a between-meal beverage in the moming on Sept. 26, 28 and October 1/12. [O Reg 79/10, s. 71. (3) (b)]
2. Resident # 46027 who has a specific medical condition was observed at 11:10hr on September 27/12 to be sleeping in bed. Staff # S-113 was observed to offer coffee, tea, water, or fruit drink during this nourishment/fluid pass to some residents. Staff # 113 did enter resident # 46027 room but did not approach the resident nor offer the resident any fluids. The snack sheet located on the cart identified that the resident is to have a specific amount of fluid during this pass. Staff # 113 did not look at the dietary list at any time during this pass. When questioned by the Inspector as to the process of passing out nourishment to the residents, the staff member identified that residents who are sleeping are not disturbed. Resident # S-113 was not offered a between-meal beverage on the morning on Sept. 27/12. [O Reg 79/10, s. 71. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all residents are offered a between-meal beverage in the morning, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The Inspector observed on September 26 and 27/12 that there was a two to three foot gap between the privacy curtains in six resident's rooms and did not provide complete privacy for these residents. The Inspector also observed on September 26 and 27/12 that the privacy curtains in a 4-bed ward room, also had a three to four foot gap between the privacy curtains and did not provide complete privacy for resident # 02. The licensee did not ensure that every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy. [O Reg 79/10, s. 13]
2. The Inspector spoke with Staff # S-100 and Staff # S-101 who identified that when the privacy curtains are dirty, they are sent to laundry to be washed and are cleaned. The housekeeping staff hang the curtains upon return. Staff # S-100 identified that there has been an issue with not enough curtains since the home had to re-use the older curtains when the ceiling lifts were put in place. [O Reg 79/10, s. 13]

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 all residents have sufficient privacy curtains to provide full privacy, to be implemented voluntarily.

WN #7: 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. (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. The Inspector reviewed the health care record including the plan of care for resident #46176. The Inspector noted the resident's MDS assessment identifies the resident as frequently incontinent of bladder. Inspector spoke with S-110 who confirmed that the resident is incontinent of bladder. Inspector reviewed the health care record and was unable to find a completed continence assessment which includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. Inspector did note a copy of the home's assessment tool in the resident's chart; however this assessment was not completed. The licensee failed to ensure that a resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence of potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [O.Reg. 79/10, s.51(2)(a)]
2. The licensee has not ensured that 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.
Resident 46165 reported to Inspector 163 that they are incontinent of bladder. The plan of care for resident # 46165 indicates that this resident is incontinent of urine and requires an incontinent product. Staff S-111 reported to Inspector 163 that resident 46165 is incontinent and uses an incontinent product. Inspector 163 was unable to locate in either Point Click Care or in the resident's health care record that resident # 46165 received an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [O.Reg, 79/10,s.51(2)(a)]

WN #8: 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. The Inspector conducted a walk through of the home on September 28, 2012. The Inspector was unable to locate a copy of the home's most recent audited report. The Inspector spoke with staff # S-127 who confirmed it was not currently posted in the home. The licensee failed to ensure that the most recent audited report provided for in clause 243(1)(a) was posted in the home. [O. Reg. 79/10, s.225(1)(3)]

WN #9: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has 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.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The Inspector reviewed the health care records of five randomly selected residents. Inspector noted the following residents: #46176, #2291, #2292, #2293, #2294 all received TB skin testing, however four of the five resident's did not receive the testing within the 14 day time frame. Inspector noted that two of the residents: #46176 and #2292 received screening more than a year after admission to the home. The licensee failed to ensure that each resident admitted to the home is screen for tuberculosis within 14 days of admission, unless the resident has already been screened at some point in the previous 90 days prior to admission and the results of the screening are available to the licensee. [O. Reg. 79/10, s.229(10)(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 ensuring that each resident admitted to the home is screen for tuberculosis within 14 days of admission, unless the resident has already been screened at some point in the previous 90 days prior to admission and the results of the screening are available to the licensee, to be implemented voluntarily.

WN #10: 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. On October 2, 2012, Inspector #196 observed the bottom fitted sheet on a resident's bed on one floor to have holes and to be thread bare. Inspector # 158 observed during the stage one process, that the top linen sheets on two different resident's beds on a different floor had holes in them and to be thread bare. Inspector #196 conducted an interview on October 2, 2012 with staff # S-126 and it was reported that the laundry staff are responsible for removing thread bare linen from use. The licensee failed to maintain the home's linen in a good state of repair, specifically used thread bare linen sheets on resident beds. The licensee failed to ensure that, (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; [O.Reg.79/10,s.89.(1)(c).]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. On September 25/12, the Inspector observed that the table top restraint on resident # 46103 wheel chair (w/c) was loose and not secured. A family member stated in the family interview that "the table top was broken a while ago and that the home had removed the brackets which held it in place and were unable to repair the tray". The Inspector and staff # S-123 examined resident # 46103 w/c table tray on October 2/12 and it was found to be loose and ill fitting. Staff # S-123 stated that "the tray should be tight fitting and this tray's screws are loose."
Staff # S-123 stated that when a problem with the w/c is observed, the staff are to fill in the vendor's Activity Log Sheet with the following: resident's name, room #, the problem, staff initial and date.
The log book was reviewed by the Inspector and it is documented in July 2012 the following: " please check broke, screw missing" for resident # 46103 equipment. It is also documented in the log book that the brake was repaired but the identity of the technician and date it was fixed is not documented. The home did not ensure that the restraint was well maintained. [O Reg 79/10 s. 110.(1)2]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has not ensured that residents with the following weight change are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 5 per cent of body weight, or more, over one month.
Inspector # 163 reviewed the health care record including weights for resident #46209. The recorded weights for resident # 46209 revealed that there was a 7.7% weight loss between March and April 2012. In reviewing the health care documentation for resident # 46209, the weight changes were not assessed using an interdisciplinary approach and that actions were not taken and outcomes evaluated. Inspector 163 interviewed staff # S-128 about the weight change for resident # 46209. Staff # S-128 confirmed that the weight changes were not assessed using an interdisciplinary approach and that actions were not taken or outcomes evaluated. [O.Reg. 79/10,s.69]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. A resident's bathroom on one of the floors was noted by Inspector # 158 to have a lingering odour of urine at 10:00hrs and again at 11:45hrs on September 25/12. Inspector #196 noted a lingering musty, urine odour in a resident's room on a different floor on October 2/12 at 09:50hrs and again at 15:30hrs.
An interview was conducted with staff # S-126, on October 2, 2012 and it was identified that the home does have procedures developed to address lingering odours. The home did not implement their procedures to address incidents of lingering odours in both of the identified instances.
The licensee failed to ensure that procedures are developed and implemented for, (d) addressing incidents of lingering offensive odours. [O. Reg. 79/10, s. 87 (2)(d).]

WN #14: 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. The Inspector reviewed the home's admission package. The Inspector noted it did not contain a copy of the home's policy to promote zero tolerance of abuse and neglect of residents. The Inspector spoke with staff # S-119 who confirmed a copy of the home's policy is not included, instead the home has an explanation of the policy and a line stating "Please see the Administrator of Director of Care if you would like a copy of the policy". The licensee failed to ensure that the package of information includes a copy of the home's policy to promote zero tolerance of abuse and neglect of residents. [LTCHA 2007, S.O. 2007, c.8, s.78(2)(c)]
2. The Inspector reviewed the home's admission package. The Inspector noted it did not contain an explanation of the duty to make mandatory reports under section 24 of the Act. Inspector spoke with staff # S-119 who confirmed the information package did not include the required information. The licensee failed to ensure that the package of information includes an explanation of the duty under section 24 to make mandatory reports. [LTCHA 2007, S.O. 2007, c.8, s.78(2)(d)]

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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. Inspector # 158 observed that hand hygiene was not performed by a contracted service worker before, after and between providing care services to residents on the morning of September 28, 2012. Inspector noted that one resident was on isolation and the contracted service worker entered the room, provided the care and did not perform hand hygiene upon completion of the care or when exiting the room. When questioned by inspector # 158, the contracted service worker identified that they did not need to worry about washing their hands as they were not providing direct resident care. Inspector 188 spoke with staff # S-120 on October 3, 2012 who reported to Inspector 188 that no education related to infection control practices were provided to the contracted service worker. The licensee failed to ensure that no person mentioned in subsection 1 performs their responsibility before receiving training in infection prevention and control. [LTCHA 2007, S.O. 2007, c.8, s.76(2)(9)]

Issued on this 14th day of November, 2012

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