Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 24, 2013	2013_108110_0014	T-288-13	Resident Quality Inspection

Licensee/Titulaire de permis

CHARTWELL MASTER CARE LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE GIBSON LONG TERM CARE CENTRE
1925 STEELES AVENUE EAST, NORTH YORK, ON, M2H-2H3

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

DIANE BROWN (110), BERNADETTE SUSNIK (120), NICOLE RANGER (189), SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 16-18, 22-26, 29-August 2nd, August 6-8, 12-16, 19, 2013

This inspection relates to LOG #T-288-13
Additional inspections related to the following LOG#'s were also completed during this inspection:
CIS-T-232-12, CIS-T-248-12, CIS-T-306-13, CIS-T-344-13, T-1345-12, T-270-12, T-183-13

During the course of the inspection, the inspector(s) spoke with Administrator, Physician , Director of Resident Services (DORS), Assistant Director of Care, Corporate Dietary Consultant, Corporate Environmental Consultant, Food Service Manager, Family Services Manager, Program Manager, Recreational Therapists, Business Manager, Registered Dietitian (RD), Spiritual Care Coordinator, RAI-MDS Coordinator, Physiotherapist(PT), Occupational Therapist (OT), Registered nurses (RN), Personal Support Workers (PSW), Registered Practical Nurse(RPN), Maintenance Persons, Environmental Services Supervisor, Staffing Clerk and Residents and Residents Families

During the course of the inspection, the inspector(s) observed resident care, home environment and meal service; reviewed resident and home records, policies and procedures and employee records; toured all homes areas including outdoor areas, measured illumination levels and reviewed service reports and policies and procedures.

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

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
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On an identified date, RN #1 was in the dining room feeding a resident at breakfast. Registered Nurse #1 revealed that out of her peripheral vision she observed, what she believed to be, a staff member pushing on the head of Resident #603 or pushing on him/her somehow to reposition him/her. Registered Nurse #1 stated she approached PSW #2 and stated "I'm not sure if I'm seeing what I think I am but don't do that". Throughout the meal, RN #1 stated she continued looking towards the resident and staff.

Registered Nurse #1 informed the inspector that after the meal ended she approached the Director of Resident Services to report her concerns. Both staff agreed to view the video surveillance of the dining room.
The RN reported to the inspectors that she viewed the video surveillance and observed PSW #2 using Resident #603's head to position him/her and that she was pushing on him/her so hard that the wheelchair was shaking.

An interview with the Administrator revealed that she also viewed the video surveillance and confirmed that PSW #2 pushed Resident#603's head up to reposition him/her at least 3-4 times in a very rough manner causing the wheelchair to shake violently, then at one point grabbed Resident #603's hair at the top of his/her head to reposition him/her. The PSW held Resident #603's head up in one hand then fed him with the other hand. The Administrator viewed the RN approaching the PSW #2 and resident confirming the RN's account of the incident. [s. 19. (1)]

2. Personal support worker #3 reported to the inspector that on an identified date, she was called by PSW #4 to help transfer Resident #389 off the toilet. Personal support worker #3 reported that PSW #4 informed her that the resident is aggressive and violent and will hit staff. Personal support worker #3 reported that they transferred the resident off of the toilet and into a wheelchair. Personal support worker #3 stated that while she was putting on the resident's shoes, she witnessed PSW #4, with a washcloth in her hand, take the resident's left earlobe then pull and twist it. Right after this, PSW #4 took the resident's hand and hit the resident's face with his/her own hand and stating "there, now you hit yourself and not us". Personal support worker #3 reported that the resident was not aggressive during this incident. Personal support worker #4 was charged with assault by police. [s. 19. (1)]

3. On an identified date, at 0345h, Resident # 503 was found on the floor by the staff. The resident was placed in his/her wheelchair and brought out to the nursing station

by the registered staff at 0410h. Resident was left alone by the nursing station for 90 minutes. The inspector viewed video surveillance which showed the resident rubbing his/her leg while at the nursing station. The registered staff returned to the resident at 0530h and did not assess the resident despite the resident's display of pain. Resident was later sent to the hospital at 0830h and was diagnosed with a fracture. The Administrator reported to the inspector that the home viewed this incident as neglect and the registered staff member was terminated. [s. 19. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. Personal support worker #3 reported to the inspector that she was hired in June 2013 and did not receive the following training during orientation or prior to performing her
responsibilities:
1. The long-term care home's mission statement.
2. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
3. The duty under section 24 to make mandatory reports.
4. The protections afforded by section 26.
5. Infection prevention and control.
6. Lifts and transfers. [s. 76. (2)]

2. The licensee failed to ensure that all staff at the home receive training as required prior to
performing their responsibilities.
The licensee utilizes a large number of agency staff to provide direct resident care. According
to the licensee, the agency staff are not provided with training in the areas mentioned in this
section prior to performing their duties. [s. 76. (2)]

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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as per regulation.

Resident #276 complained to the home numerous times in the past month about his/her roommate's offensive unhygienic habits and touching his/her personal possessions. Furthermore the resident called the Ministry of Health complaining that the home was not responding to his/her concerns about his/her roommate.

Personal support worker #5 confirmed that he/she reported the resident's concerns to the charge nurse. The charge nurse indicated that he/she reported the resident's concerns to the Director of Resident Services.
There was no response provided back to the resident regarding his/her complaint. [s. 101. (1)]

2. Resident #254 reported to the inspector that in an identified month and year,he/she complained to the staff that his/her wallet and an identified amount of money were missing. The resident reported to the inspector that he/she has not received a response from the home regarding his/her missing wallet and money.
Record review and staff interview confirmed there is no written record of response made to Resident #254 indicating what the licensee had done to resolve the complaint. [s. 101. (1) 1.]

3. Resident #502 reported to the inspector that in two identified months he/she made multiple complaints to the Social Worker, Director of Resident Services and Registered Staff regarding the care he/she was receiving from a PSW, specifically that he/she was left unattended on the toilet for 45 minutes without receiving assistance and that he/she received the wrong medication from an agency registered staff. A family member of Resident #502 confirmed Resident #502's complaints to the home and that no response was received from the home related to these complaints.

Record review and staff interview confirmed that there is no written record of a response made to Resident #502 indicating what the licensee had done to resolve the complaints and that two complaints were not investigated. [s. 101. (1) 1.]

4. A family member complained that Resident #604's eyeglasses were missing but no response was provided back to this identified family member and record review and

staff interview confirmed the homes process for investigating a complaint was not followed.
On an identified date, Resident #604's family was overheard by inspector asking staff if they have located the resident's eyeglasses, staff responded with no. Record review and staff interview confirmed that the resident's glasses had been missing since an identified date. Progress Notes stated "still could not find the glasses". Record review confirmed that a complaint form was not completed as per the home's policy. [s. 101. (1) 1.]

5. Record review of the home's complaint binder and excel complaints worksheet revealed that there is no documented record kept in the home that addresses the complaints of Resident #275, Resident #502, Resident #254 and Resident #604 made to the home. [s. 101. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
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. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The designated infection prevention and control co-ordinator for the home does not have education and has minimal experience with infectious diseases.

The current director of resident services (DORS) has not received any education or attended any courses within the last 30 years with respect to infectious diseases that may currently affect residents in long-term care homes. These diseases include but are not limited to enteric diseases such as Hepatitis A, Listeriosis, Campylobacteriosis, Clostridium difficile associate diseases, Shigellosis, E. coli, respiratory diseases such as pseudomonas, legionellosis, and blood borne diseases such as Hepatitis B. The DORS reported that she has not had experience in dealing with many of the reportable diseases under Ontario Regulation 559/91 under the Health Protection and Promotion Act. [s. 229. (3) (a)]

2. The designated infection prevention and control co-ordinator does not have education and experience with respect to cleaning and disinfection best practices in long-term care. The co-ordinator has not received any training or taken any courses covering the information found in a document developed by the Provincial Infectious Diseases Committee titled "Best Practices for Environmental Cleaning for Prevention and Control of Infections, May, 2012". [s. 229. (3) (b)]

3. The designated infection prevention and control co-ordinator does not have education and has minimal experience with respect to data collection and trend analysis. Data collection and trend analysis best practices can be found in a document developed by the Provincial Infectious Diseases Advisory Committee titled "Surveillance of health care-associated infections in patient and resident populations, October, 2011". The co-ordinator was not familiar with the document and therefore not familiar with current best practices with respect to how data needs to be collected and subsequently analyzed. Data that the home collects is analyzed by their corporate office monthly, but how it is analyzed was not known to the co-ordinator. [s. 229. (3) (c)]

4. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.
On an identified date, a registered staff member was observed to give medications to four different residents without performing hand hygiene. [s. 229. (4)]

5. On an identified date, the inspector observed improperly stored aerochambers in

identified medication carts. The aerochambers had been previously used to administer inhaled medications to different residents. The used aerochambers were observed to be stored in the medication carts with the mouthpieces touching each other, posing a risk of cross contamination among residents. [s. 229. (4)]

6. On an identified date, the inspector observed an isolation sign on an identified resident's room door. Inspector spoke with PSW #6 to inquire which resident was on isolation. Personal support worker #6 who was assigned to the identified resident was unaware that this resident was on isolation and was not able to identify the home's isolation procedures. [s. 229. (4)]

7. The licensee failed to ensure that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review and staff interview confirm that Resident #376, #344, #340, #389 and #243 were not offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

The Director of Resident Services confirmed that the home is currently not following the immunization schedule posted on the Ministry website because the home did not have the tetanus vaccine available in the home at the time of this inspection. [s. 229. (10) 3.]

8. The licensee failed to ensure that all staff have not all been screened for tuberculosis and other infectious diseases in accordance with prevailing practices. According to the Canadian Tuberculosis Standards (6th edition) all long term care facilities need to have an institutional TB infection prevention and control program in place and assess institutional risk and the risk for health care workers engaged in different activities.
At the time of hiring, all employees should have a two-step Tuberculin Skin Test (TST) unless they have documented results of a prior two-step test. If prior results are used, these should be transcribed into the employee's health record. The home could not provide documented evidence that all employees received a two-step TST. [s. 229. (10) 4.]

9. The licensee failed to ensure that 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.

The licensee failed to ensure that staff members #1 and #2 were screened for tuberculosis and other infectious diseases. An interview with Director of Resident Services confirmed the lack of screening for staff members #1 and #2. [s. 229. (10) 4.]

Additional Required Actions:

CO # - 004, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every residents right to be treated with courtesy and respect and in a way that fully recognize the resident's individuality and respects the resident's dignity is promoted and respected.
An interview with Resident #276 revealed that the licensee did not give notice to the resident before a change in roommate. Record review and staff interviews indicate that Resident #276 had numerous room mates within the last year.
The resident stated that the staff did not introduce him/her to any of his/her roommates in the last year and feels there is a lack of courtesy by the staff. Interviews with other residents, in the same room, confirmed Resident #276's statement. [s. 3. (1) 1.]

2. On an identified date, Resident #502 reported that after PSW #1 assisted him/her with toileting, she took the white disposable pads and flushed them down the toilet. Resident reported that the toilet became clogged and that he/she immediately proceeded to take a glove and unclog the toilet him/herself while PSW #1 held the garbage bag open for the resident. The resident reported that he/she felt humiliated and upset that he/she had to unclog the toilet him/herself.
Inspector spoke with PSW #1 who confirmed the resident's description of the incident. [s. 3. (1) 1.]

3. On an identified date, Resident #602 was observed being fed breakfast in an activity room. The confined activity space had 13 other residents engaged in an activity program whereby residents were clapping and counting while Resident #602 was at a nearby table being fed. An interview with the Registered Dietitian confirmed that Resident #602's dining needs are better met outside of the main dining room during regular mealtimes but his/her meal should not have occurred during an activity program. [s. 3. (1) 1.]

4. Resident #344 and #376 interviews revealed that staff are rough and impatient while providing care and address residents in an inappropriate tone and manner. Resident #376 told the inspector that the night PSWs are rude to him/her and he/she is afraid of them.
Resident #344 told inspector that the night PSWs are rough when they come in to assist him/her. The resident reported that the staff reposition him/her in a rough manner, are impatient and leave the impression that they do not want to assist him/her. [s. 3. (1) 1.]

5. On an identified date, Resident #267 and a witness reported that when Resident #267 was walking in the hallway towards his/her room he/she was stopped by a staff member who said "Hi" to the resident. Resident and witness reported that Resident #267 said "Hi" back but the staff member may not of heard the response. Resident and witness reported the staff member turned to the resident and said " I guess I don't deserve a hi back, oh, yeah, I should expect that from Resident #267". Resident reported that the staff member did not treat him/her with courtesy and respect. [s. 3. (1) 1.]

6. Resident #502 reported to the inspector that on an identified date, after dinner, he/she requested to use the toilet and called the PSW for assistance. Personal support worker #1 came to assist the resident and wheeled him/her into the bathroom then placing him/her onto the toilet. The resident reported that PSW #1 informed him/her that she had to deliver evening nourishments and left the resident on the toilet. Resident reported that he/she was left on the toilet for 45 minutes before PSW #1 returned to assist him/her off the toilet. Resident reported to the inspector that he/she was angry that he/she did not receive toileting assistance in a timely manner. Inspector interviewed PSW #1 who confirmed that she left the resident on the toilet and did not attend to the resident for 45 minutes. Furthermore, PSW #1 reported that there were no other staff available to assist her and confirmed that it was a long period of time to leave a resident on the toilet. [s. 3. (1) 3.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails are used, steps have not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The home had their bed systems evaluated by an external company on July 10, 2013. The results of the bed entrapment zone audit identified that approximately 70 beds did not pass one or more entrapment zones. On July 31, 2013, six identified residents were observed sleeping in bed with one or more bed rails in the raised position. Each of the beds were identified to have failed one or more entrapment zones. No interventions to mitigate the risks were apparent.

The identified resident's bed risk assessments were reviewed which revealed that registered staff completed a "bed rail assessment" on four out of the six residents in May and June 2013. The assessments were still in the process of being completed on all of the residents. In each of the four cases where an assessment was completed, the risks associated with any entrapment zone were dismissed as long as the resident or their substitute decision maker were made aware of them. Bed rail use was made based on whether or not the resident or the substitute decision maker wanted the bed rails in place, regardless of the assessed need. The form did not direct staff to identify what options were available to mitigate any entrapment zone (s) and it did not identify what entrapment zones were actually an issue. The process implemented to date does not satisfy the requirement for the licensee to prevent resident entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.
The home, specifically the outdoor courtyard area, was not a secure environment for its Residents between July 31, 2013 and August 2, 2013. A wooden fence that separated the long term care side from the retirement side was torn down on July 31, 2103 and replaced with a temporary mesh fence approximately 4.5 feet high and ran the length of the property (approximately 60 feet). The fence was observed on August 2, 2013 to have large gaps under it, large enough for a resident to crawl underneath it. It also had very flimsy sections where the fence could be pushed down and stepped over. Beyond the fence are two very busy streets. The outdoor courtyard was observed to be fully accessible to all residents from the dining room and activity rooms during the time of inspection. The acting Environmental Services Supervisor was shown the condition of the fence and he immediately requested that the fence be re-secured on August 2, 2013. The administrator also acted by having a staff member available to supervise the courtyard between August 3-6, 2013. An inspector confirmed that the fence was re-secured on August 3, 2013. The project was not adequately monitored to ensure that resident accessible areas were both safe and secure. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its Residents, to be implemented voluntarily.

WN #8: 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:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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 2007, c. 8, s. 6 (4).
(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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident sets out the planned care for the resident; the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident.

Resident #320 has been assessed as being at high risk for pressure ulcer development. The resident has previously experienced a pressure ulcer while living in the home. There is no written plan of care related to preventative skin care in place which describes the planned care for the resident, the intended goals of the care and clear directions for the staff.

An interview with the Director of Resident Services confirmed that there are no written plans of care for residents' assessed at high risk for pressure ulcer development contrary to the home's policy.[s.6.(1)(a)(b)(c)] [s. 6. (1)]

2. Staff interview and record review revealed that Resident #344 demonstrates behaviours of constant use of the call bell and verbal aggression towards staff. The written plan of care does not provide clear directions to staff and others who provide direct care to Resident #344 in relation to these behaviours.[s.6.(1)(c)] [s. 6. (1)]

3. Resident #376 has an identified medical medical condition. Staff interviews revealed that resident frequently obtains and consumes "junk" food. A record review revealed the resident's actions impedes the management of his medical condition. The homes' Dietitian has identified this risk however the written plan of care does not provide clear directions to staff and others who provide direct care to Resident #376 in relation to this behaviour.[s.6.(1)(a)(b)(c)] [s. 6. (1)]

4. Resident #344 requires assistance with mouth care on a daily basis. According to the staff, the resident requires the staff to put toothpaste onto the toothbrush for the resident to brush their teeth. There is no written plan of care in place outlining what the oral and dental care needs are for resident #344. [s. 6. (1) (a)]

5. Resident #376 is diagnosed with chronic back pain. The resident has been assessed by the nursing staff and identified as having pain in their lower back on a daily basis. The physiotherapy program is providing pain management interventions on a weekly basis.
Physiotherapy interventions have not been incorporated into the written plan of care. [s. 6. (1) (a)]

6. Resident #254's Minimum Data Set assessment, assessed the resident as being incontinent of bowel and bladder functions. Resident interview revealed resident's individualized continence care needs, however, residents written plan of care does not provide clear directions to staff and others who provide direct care to Resident #254 in relation to this resident's continence care needs. [s. 6. (1) (c)]

7. The licensee failed to ensure that Resident #344's plan of care is based on an assessment of the resident and the resident's needs and preferences. Resident #344 at low body weight and Body Mass Index (BMI) of 19.7 has experienced slow, progressive, unplanned weight loss. The resident's plan of care states weight maintenance is desirable.

Record review and staff interview reveal that resident has a fair appetite and often doesn't like the food. An interview with the resident's family revealed that resident finds the food lacks flavour and salt. The resident's preference for more flavour and salt have not been assessed. [s. 6. (2)]

8. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
Resident #601 has a low BMI with slow progressive weight loss. An interview with the resident's private sitter, record review and observations identified changes in resident's eating ability related to a lack of dentition. The resident was no longer taking a nutrition intervention and the private sitter was requesting a different diet texture than the resident's plan of care. Resident observation and staff interview confirmed that Resident #601 does not attend lunch.

An interview with the Registered Dietitian revealed that the RD was not informed of changes in Resident #601 eating ability and that Resident #601 was not being offered a lunch. [s. 6. (4) (a)]

9. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
Resident #602, at very high risk for malnutrition and dehydration related to barriers to oral feeding, was observed being fed by staff on two occasions. Staff interviews and

observations revealed a lack of awareness of feeding recommendations made by the Registered Dietitian and Occupational Therapist. Resident #602's care plan did not include the feeding interventions revealed through interview with the Registered Dietitian ie. food needs to go in the left side of residents mouth, avoid holding another spoonful in front of resident until resident had finished swallowing last spoonful. [s. 6. (4) (b)]

10. The licensee failed to ensure that the plan of care for safe transferring was provided to Resident #254 as specified in the plan of care.

The plan of care for Resident #254 states to use 2 staff for all transfers while the resident holds on to the transfer pole.

On an identified date, Resident #254 was transferred from the wheelchair to a shower chair by one staff member instead of 2 and no transfer pole was available. During the transfer the resident slid to the floor causing him/her discomfort. The DORS confirmed that the residents plan of care for a 2 person transfer and transfer pole was not followed. The PSW involved was relieved of her duties. [s. 6. (7)]

11. The licensee failed to ensure that the care set out in Resident #376's plan of care was provided.
The plan of care for Resident #376 directs the registered staff to evaluate the effectiveness and side effects of an identified medication. Staff interview and record reviews confirmed there is no evaluation of the effectiveness and side effects of an identified medication and staff are unaware of this process. [s. 6. (7)]

12. The licensee failed to ensure that the care set out in Resident #276's plan of care was provided.
Resident #276 who continues to show no interest in the home's activity programs and spends the majority of time in his/her room was identified at high risk for social isolation by the homes' program manager. The resident's plan of care states to provide one on one visits twice weekly for conversation. An interview with program staff confirmed that Resident #276 never refuses one to one visits. Record review and resident, staff interview confirm that Resident #276 typically receives one and sometimes less visits per week. Record review confirmed the following: 3 visits in June 2013; 5 visits in July 2013(with no visit between July 9th and July 23rd, 2013) and one visit between August 1-14th, 2013. [s. 6. (7)]

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

Resident #401 was identified in 2010 as being at a high risk for falls, experiencing several falls at the time. A restraint was applied in 2010 which prevented the resident from removing the restraint. The resident's physical and cognitive condition has deteriorated since this time.
Resident #401 had not be reassessed and the plan of care had not been reviewed and revised in response to the resident's deteriorating condition and resident's need for a restraint. Staff interviews revealed that the resident no longer resists the restraint, as had previously been identified, and the resident does not attempt to stand up or undo the restraint as had previously been identified. The resident continued to be restrained with the same type of restraint. An interview with the Director of Resident Services revealed that the resident restraint had not been reassessed and the plan of care revised in response to the resident's care needs changing. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out,(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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The resident-staff communication and response system could not be accessed and used by residents and staff in the 2nd floor tub/shower room between July 16 and August 2, 2013. The activation station located near one of the two tubs in the room was not functioning when tested by an inspector on July 22, 2013 and on August 2, 2013. Nursing staff were not aware of the non-functional switch on August 2, 2013, and a staff contacted the maintenance staff once they were made aware of the issue.

The activation station located in the television/lounge room on the 1st floor and the bathroom in an identified room did not have a pull cord attached to the switch on, July 22, July 31 and August 2, 2013. The activation station in the television/lounge room was located more than 5 feet above the floor and could not be reached by all residents if sitting in a wheelchair. Nursing staff were asked about the activation station pull cord for the television/lounge room on August 2, 2013 and immediately replaced it. [s. 17. (1) (a)]

2. The resident-staff communication and response system was not available in every area
accessible by residents. The spiritual room located inside of the television lounge/activity area on the first floor did not have an activation station. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the resident-staff communication and response system can be accessed and used by residents, staff and visitors and that it is available in every area accessible by residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table.

Findings/Faits saillants :

1. Lighting requirements were not being maintained as set out in the lighting table.

Corridors on the 1st, 2nd, 3rd and 4th floors did not provide consistent and continuous lighting of 215.28 lux. Fluorescent light fixtures were set 12 feet apart in the corridors and were measured using a light meter, held 4 feet above the floor. The lux between fixtures was 100 and the lux directly under each fixture was 1000.

Resident rooms did not all have general room lighting of 215.28 lux. Rooms with a small round frosted glass fixture were measured to emit 200 lux of illumination directly under the fixture. When the meter was moved away several feet, the level dropped to zero. Many rooms had no general room lighting at all and were measured to be zero lux in the centre of the room, with window coverings drawn.

The various resident ensuite bathrooms were noted to have several different types of lighting fixtures. Specifically in 6 identified bathrooms and others with a round, frosted glass hanging fixture, the lux was identified to be 90-100 lux. Other bathrooms, as identified, with a larger round glass fixture were 180-190 lux. The minimum requirement for resident bathrooms is 215.28 lux.

The licensee currently has a plan to have their home audited by an external company so that they are aware of what lighting upgrades will be required. According to the corporate environmental services consultant, the home will be audited within the next 3 years. [s. 18.]

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 lighting requirements in the lighting table are maintained, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the home had guaranteed access to a generator that was operational within three hours of the power outage and that could maintain the following;

(a) the heating system;

(b) dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks;

(c) the resident-staff communication and response system;

(d) elevators; and

(e) life support, safety and emergency equipment.

The home did not have a generator available on July 8, 2013 when a power outage affected a wide area in the city in which the home is situated. The home was without power between 1815h and 2330h and could not maintain all of the required essential services as identified above.

The home has 4 floors and two elevators that are heavily used by residents and staff. The majority of the residents cannot use the stairwells and no alternative transport methods were available to staff for residents who needed to be transferred either out of the home or within the home. During this power outage, several passengers became stranded inside of the elevator until emergency responders arrived.

According to the administrator, four residents were stranded on floors other than their own. These Residents were accommodated until power returned at 2330h.

According to the Food Services Supervisor, no perishable foods were affected during the outage and the outage occurred towards the end of the dinner meal.

The licensee has allocated funds to purchase an electrical transfer switch to accommodate a generator in December 2013 and funds for a generator for January 2014. [s. 19. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has guaranteed access to a generator that is operational within three hours of the power outage and that can maintain the heating system, dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snack, the resident-staff communication and response system, elevators and life support, safety and emergency equipment, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

On an identified date, at 0345h, Resident # 503 was found on the floor by the staff. The resident was placed in his/her wheelchair and brought out to the nursing station by the registered staff at 0410h. Resident was left alone by the nursing station for 90 minutes. The inspector viewed video surveillance which showed the resident rubbing his/her left leg while at the nursing station. Registered staff returned to the resident at 0530h and did not assess the resident despite the resident's display of pain. Resident was later sent to hospital in at 0830h and was diagnosed with a fracture. Administrator reported to the inspector that the home viewed this incident as neglect and the registered staff was terminated.
This incident occurred 10 days prior to the home reporting it to the Director. [s. 24. (1)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post -fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
Resident #254 was assessed by the home to be at moderate risk for falls, using the Morse Fall Risk Assessment Tool. The licensee uses a Post Fall Analysis Tool which is utilized for residents following a fall. Record review and interview with the Director of Resident Services confirmed that on an identified date, Resident #254 fell to the floor during a transfer with a PSW and that there was no post fall assessment completed on this resident after the fall. [s. 49. (2)]

2. Resident #263 fell on an identified date, and sustained a fractured then fell again three months later. A record review and registered staff interview confirmed that there was no post fall assessment completed for Resident #263 after each fall. [s. 49. (2)]

3. Resident #266 was assessed as being at high risk for falls and fell three consecutive months in 2013. A record review confirmed that there was no post fall assessment completed for any of the above identified falls. [s. 49. (2)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (7) The licensee shall ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 79/10, s. 71 (7).

Findings/Faits saillants :

1. The licensee failed to ensure each resident is offered a minimum of three meals daily. At lunch on an identified date, Resident #601 was observed sleeping in bed during the lunch meal. A record review indicated that Resident #601 has a private sitter for breakfast and does not eat lunch. Staff interview revealed that resident was not asked if he/she would like lunch as staff stated he/she eats a big breakfast. An interview with the Registered Dietitian revealed that this identified resident should have been awoken and asked if he/she would like to eat lunch. [s. 71. (3) (a)]

2. The licensee failed to ensure that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24 hour basis. On August 16, 2013, the inspector observed no food or beverages that are appropriate for the residents' diets in the first floor fridge. Staff reported to the inspector that there is no appropriate food or beverage available for residents after 2300h. Personal support worker #7 reported to the inspector that on August 15, 2013, a resident requested food late at night and there was no food available for the resident.
Inspector reviewed the nursing communication book on the 2nd floor. An entry on July 15, 2013 stated that staff reported to "leave snacks such as sandwiches, cookies or crackers as residents are hungry at night and there is nothing to eat". The staff on the 2nd floor confirmed to the inspector that there is no food available for residents after 2300h. [s. 71. (7)]

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 each resident is offered a minimum of three meals daily and that food and beverages that are appropriate for the residents' diets are accessible to staff and available to residents on a 24 hour basis, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

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

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the menu items were prepared according to the planned menu.
On two occasions the preparation of a meal was observed.
Observations and staff interview confirmed that standardized recipes were not followed with ingredients unavailable, omitted, substituted or reduced altering the flavour, nutrient value and appearance of the planned menu items.
Resident interviews revealed that the "food is not good" or "not properly prepared".
The 2013 Resident Satisfaction Survey included comments that the food quality needed to improve that food is very poor and bland. An interview with the Food Service Manager revealed that she was not consistently informed of missing ingredients or staff initiated menu substitutions, as is required and that staff are expected to follow standardized recipes. [s. 72. (2) (d)]

2. The licensee failed to ensure that all menu substitutions are communicated to the residents.
Observations and staff interview confirmed that on July 16, 2013, there were no condiments available as posted on the lunch menu and that on August 16, 2013, both dessert choices were substituted but the posted daily menu was not changed and changes were not communicated to residents. [s. 72. (2) (f)]

3. The licensee did not ensure that foods are prepared, stored and served using methods which preserve taste, nutritive value, appearance and food quality.
On two occasions the preparation of a meal was observed.
Observations and staff interview confirmed that Food Service Workers were adding unmeasured amounts of commercial thickener to a variety of foods with no direction to do so. Commercially prepared products were not cooked according to the recipe which states to follow manufacturer directions. The resulting product was soggy and lacked the expected appearance and texture.
Resident interviews revealed that the "food is not good" or "not properly prepared".
The 2013 Resident Satisfaction Survey included comments that the food quality needed to improve that food is very poor and bland. An interview with the Food Service Manager confirmed these practices were not acceptable.

Texture modified foods, minced and pureed, were prepared and hot held over 2.5 hrs in advance of meal service. The Food Service Manager (FSM) revealed through interview that this was not an acceptable practice and stated to the inspector the correct methods of preparing minced and pureed foods to preserve taste and nutritive

value.

The homes Food Production Policy # NHS-IV-15 Revision date July 2010 stated that "time to begin preparation" was to be included on production sheets. A review of production sheet and interview with FSM confirmed that this information was not available to staff. [s. 72. (3) (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 to ensure that the menu items were prepared according to the planned menu and that foods are prepared, stored and served using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.
On an identified date, Resident #602 was observed being fed by a PSW. Resident's head was flexed forward. Staff were observed spoon feeding Resident #602 soup while residents head was in this flexed position resulting in excessive spilling out of resident's mouth onto his/her apron. Staff involved in feeding Resident #602 expressed uncertainty about proper feeding techniques for this resident.
An interview with the Registered Dietitian and record review confirmed that the proper techniques to assist this resident according to the plan of care were not used at lunch on an identified date. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #17: 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:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(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; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. Staff interview and a review of the homes' admission package confirmed that the licensee failed to ensure that the admission package include following information: [s. 78. (2) (b)]

2. The home's mission statement. [s. 78. (2) (b)]

3. An explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident. [s. 78. (2) (d)]

4. The home's procedure for initiating complaints to the licensee. [s. 78. (2) (e)]

5. The home's policy on minimizing the restraining of residents and how a copy of the policy can be obtained. [s. 78. (2) (g)]

6. The name and telephone number of the licensee. [s. 78. (2) (h)]

7. 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. [s. 78. (2) (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 the required information, to be implemented voluntarily.

WN #18: 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:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. Observations and an interview with the Administrator confirmed the licensee failed to ensure that the following information was posted in the home: [s. 79. (3) (c)]

2. The policy to promote zero tolerance of abuse and neglect of residents. [s. 79. (3) (c)]

3. 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. [s. 79. (3) (f)]

4. 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. [s. 79. (3) (g)]

5. An explanation of evacuation procedures. [s. 79. (3) (j)]

6. An explanation of the protections afforded under section 26- whistle-blowing protection [s. 79. (3) (p)]

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 required information is posted in the home in a conspicuous and easily accessible location in a manner that complies with the requirements, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's procedures (LTCE-INF-B-01) which have been developed for cleaning and disinfection of resident care equipment have been implemented.

According to the home's policy which was developed in August 2012 and was noted to be written in accordance with best practices, the staff are required to clean and disinfect all used equipment as soon as possible after use and prior to use by or for another resident. It provides staff some guidance as to collection, cleaning and disinfecting tasks, but does not take into account how these tasks would be undertaken in the limited facilities provided in the home. Procedures lack specific steps as to how staff are to wash and disinfect the personal care devices.

The home's soiled utility rooms, which are not designed or set up appropriately to accommodate the processing of devices, would need to have appropriate sinks to accommodate the size of the various devices so they can be submerged if necessary. An area would need to be provided for appropriate drying which is not in a contamination zone and how to store the cleaned devices to prevent re-contamination.

During the inspection, washbasins with water in them were observed on resident's wardrobe tops and many were observed on towel bars in washrooms. Very dusty and some visibly soiled bed pans were noted in several soiled utility rooms on open shelving, above the hopper area. The hopper appeared to be the only location where a bed pan or washbasin could be rinsed, but no other sinks other than a hand sink was provided. Aero flush machines for bed pan or wash basin cleaning were noted in each utility room, however they were no longer functional.

A sign was posted on the wall next to the hopper that required staff to use everyday disinfectant (ED) spray bottles to apply the disinfectant onto the surface of the device and that two bottles of the ED should be located in each soiled utility room. However no disinfectant in bottles could be located in any of the 4 soiled utility rooms. ED was hooked up to the hopper and a dispensing hose was noted, however the purpose of the hose is unknown. No other instructions were provided as to cleaning, rinsing or drying procedures.

The procedures, although developed, are not specific to the home's current situation.

Management staff reported that they have not conducted any monitoring to determine if staff are following the procedures that can be implemented. [s. 87. (2) (b)]

2. Lingering offensive odours were not addressed on various floors during the inspection on July 31, August 1 and 2, 2013. Soiled laundry hampers were identified in corridors, just outside resident rooms. These hampers contained several compartments for soiled linens and one compartment was identified to have soiled briefs in it. The compartments are not designed to hold soiled and odourous briefs, made of mesh fabric without an air tight lid. The briefs were noted inside of clear bags, but the bags were not tied off. The hampers would sit in the corridors for a number of hours until the hampers were emptied. [s. 87. (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 procedures are developed and implemented for cleaning and disinfection of shower chairs, commodes, lift chairs and personal care devices such as bed pans and wash basins, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has not ensured that procedures are developed and implemented to ensure that the plumbing fixtures and sinks are maintained, specifically in non-resident areas.

The home has a quarterly preventive audit schedule to inspect plumbing fixtures (sinks, toilets, taps) in resident rooms but not soiled or clean utility areas. A policy has been developed that requires all staff to monitor and report to maintenance any disrepair issues of any equipment, fixture or surface.
Verification was made that a process was in place for staff to record maintenance issues.

On August 2, 2013, all 4 clean utility rooms were observed to have been converted into storage rooms. The sinks in 3 out of the 4 rooms were non-functional and had their faucets removed. The traps under the sinks were dried out (traps are designed to prevent sewer gases from traveling into
the room). In the 2nd floor clean utility room, the sink, counter and cabinets had been completely removed and the pipes were left exposed, with an opening for the drain covered in tape or paper.
The drainage for all four sinks was confirmed to be directly connected to a sanitary stack leading out to a main sanitary line, thereby allowing potential sewer gases from traveling up to each of the uncapped drainage lines of each sink. Each clean utility room did not have the drainage lines properly capped to prevent potential gases from traveling.

According to the maintenance person, the rooms have been in this state for approximately 10 years.

The aero flush bed pan and basin cleaning machines were non-functional in each of the 4 soiled utility rooms. Based on discussions with staff, the aero flush machines have not been used in many years. However, the cold water line to each machine was still connected and water was observed to be running down the aero flush drain. The fixtures have not been maintained in good condition. [s. 90. (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 policies and procedures are developed and implemented to ensure that the plumbing fixtures and sinks are maintained, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies.

During observations of the first floor medication pass on July 29, 2013, the inspector noted various non drug and non drug related items being stored in the medication carts and in double locked narcotics bins. These items included envelopes labeled with the names of various residents, containing items such as jewelery, keys, money. The inspector also observed four cans of coke and cheese and crackers in the medication fridge. [s. 129. (1) (a)]

2. Several non-medication items were noted to be stored in the narcotic drawer in the 4th floor medication cart. Hearing aides, cash/money in an envelope, jewelry. Treatment creams with an expiry date of January 2013 were found in the treatment cart on the 4th floor. Food items were observed to be stored in the medication fridge on the 4th floor. [s. 129. (1) (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 to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse which is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

The licensee's regular night shift RN was replaced by an agency RN on multiple occasions during the months of June, July and August, 2013.
Record review and an interview with the Director of Resident Services confirmed that an agency RN was the only RN on duty in the building on the following dates:
June 2, 6, 11, 12, 15, 16, 19, 22, 23, 28, 29, 2013.
July 5, 9, 23, 27, 30, 2013
August 1, 2, 3, 5, 8, 9, 12, 13, 2013. [s. 8. (3)]

WN #23: 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:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. Resident wheelchairs were not kept clean and sanitary between July 16, 2013, and August 2, 2013. Inspectors conducted a tour of the home on July 16, 2013, at which time they observed soiled wheelchairs belonging to identified residents. On July 31, 2013, two residents were seen sitting on very soiled wheelchairs from an identified. On August 2, 2013, the wheelchair in an identified room had been cleaned, however wheelchairs belonging to residents in other identified rooms were observed to be soiled. No cleaning schedule was available. According to the Assistant Director of Care, wheelchairs are required to be cleaned at a minimum once per week.

2. Wardrobe tops were very dusty in the majority of resident rooms on July 31, August 1 and 2, 2013.

3. An identified room was observed by inspectors on July 16, 2013, to have visibly soiled furnishings. When the room was checked on July 31, August 1 and August 2, the night table, foot board, rails and the wall behind the bed remained visibly soiled.

4. An overbed table was observed to be visibly soiled on July 31, 2013, and August 2, 2013, in an identified room. [s. 15. (2) (a)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of a physical abuse investigation, were reported to the Director. A staff interview and record review confirmed that the results related to this incident on an identified date, resulting in the termination of a staff member, were not reported to the Director. [s. 23. (2)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that a written record relating to each evaluation includes:

* a summary of the changes made, and
* the date that the changes were implemented

Record review confirmed that there was no written record related to the summary of the changes made to the Pain and Skin and Wound program and there was no date that the changes were implemented. [s. 30. (1) 4.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan for the home gets evaluated and updated at least annually in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices.
Record review and interviews with the Administrator and Director of Resident Services confirmed that there was no evaluation of the staffing plan for the home. [s. 31. (3)]

2. The licensee failed to ensure that continuity of care is promoted by minimizing the number of different staff members who provide nursing and personal support services to each resident.
Record review and staff interview confirmed that in the month of July 2013 there were 17 different personal support workers and 14 different registered staff from 3 different agencies filling vacant shifts throughout the home. Resident interviews revealed concerns related to the home's use of agency staff as agency staff were often unaware of their care needs. [s. 31. (3)]

3. The licensee failed to ensure that the staffing plan provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.
Resident interviews and the home's Resident Satisfaction Survey Results 2013 revealed concerns with staffing levels in the home.
General comments in the Resident Satisfaction Survey Results indicated that the home needs more staff for each floor; they need to hire more staff that really care about the residents and staff are too busy to help with toileting. Comments also included that the home is very short staffed on the weekends and the service is less than satisfactory. Resident interviews revealed comments such as "I have to wait a long time for assistance"; "many times I have to wait to be toileted and have wet myself because I had to wait so long for assistance". [s. 31. (3)]

WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee failed to ensure that no prohibited restraint devices are used on a resident. For the purposes of section 35 of the Act, regulation 112(3) states, every licensee of a long-term care home shall ensure that any device with locks that can only be released by a separate device, such as a key or magnet are not used in the home.

During the inspection period Resident #401 was observed to be using an identified type of restraining device which requires a separate device to unlock and open the restraint. [s. 35. (a)]

WN #28: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that if the Family Council has advised the licensee of concerns or recommendations the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

In the February 2013 minutes of the Family Council a concern was identified indicating that residents' laundry items were going missing.
Record review and an interview with the Family Council President confirmed that the licensee did not respond to this concern in writing within 10 days of receiving the February 2013 minutes from the Family Council Meeting. An interview with the Administrator confirmed that there was no written response to this concern. [s. 60. (2)]

WN #29: 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:

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; O. Reg. 79/10, s. 65 (2).
(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; O. Reg. 79/10, s. 65 (2).
(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; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(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. The licensee failed to ensure that the recreation program includes opportunities for residents and family to have input into the development and scheduling of recreation and social activities.
The first floor program calendar included a "internet program" that was "loved" by the residents according to staff and resident interviews. The program was not run as posted on July 14 and 28, 2013, and this program was not included in the August 2013 calendar. An interview with the program manager revealed that she was not aware that the program had not ran in July and to her knowledge there was no reason to not run the program. An interview with a program staff, new to the unit, revealed that changes to the August 2013 program calendar had been made with no input from the residents. [s. 65. (2) (d)]

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated as per regulation.

A staff interview and record review confirmed that a nutrition manager was not on site at the home, working in the capacity of nutrition manager, for the minimum number of hours of 64.6 hours per week for the 8 week period of April 1 to May 26, 2013. The actual on site hours of a nutrition manager ranged from 22.5 to 42.75 hours per week with an average of 35.2 hours per week. [s. 75. (3)]

WN #31: 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:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.
Record review and interviews with the Administrator and the President of Resident Council confirmed that Resident Council's advice was not obtained in the developing and carrying out of the satisfaction survey. [s. 85. (3)]

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of Residents identifies measures and strategies to prevent abuse and neglect and the training and retraining requirements for all staff including situations that may lead to abuse and neglect and how to avoid such situations.

Policy review and staff interview confirmed that the policy did not identify the following:

Measures and strategies to prevent abuse and neglect or [s. 96. (c)]

2. Situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #502 reported to the inspector that on an identified date, around 2200h, he/she requested his/her prescribed, as needed, medication from the agency registered staff. The resident reported that the agency nurse gave him/her the medication, he/she placed the medication in his mouth and realized that the medication felt smaller than what he/she normally receives. The resident reported that he/she spit out the medication and notice it was only one half of his prescribed dose. The resident reported that he/she told the nurse that it was the wrong medication.

The resident reported that he/she informed the evening RPN #1 and day RN #2 about the medication incident. The inspector spoke with RPN #1 and RN #2 who confirmed they were aware of the incident but did not document or complete a medication incident form for the incident. [s. 131. (2)]

WN #34: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. Resident # 502 reported that he/she informed the evening RPN #1 and day RN #2 about the medication incident that occurred on an identified date. Inspector spoke with RPN #1 and RN #2 who confirmed they were aware of the incident but did not document or complete a medication incident form for this incident. [s. 135. (1) (a)]

WN #35: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
4. The method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident's Notice of Assessment issued under the Income Tax Act (Canada) for the resident's most recent taxation year. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
6. The list of goods and services permitted under paragraph 3 of subsection 91 (1) of the Act that a resident may purchase from the licensee and the charges for those goods and services. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
7. The resident's ability to have money deposited in a trust account under section 241 of this Regulation. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
8. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the admission package includes the following information which was confirmed by reviewing the package and through a staff interview.

Information on the ability to retain a physician or RN (EC) to perform the required services. [s. 224. (1) 1.]

2. The Resident's obligation to pay accommodation charges during a medical, psychiatric, vacation or casual absence from the home. [s. 224. (1) 3.]

3. Information on how to apply for a reduction in the charge for basic accommodation, and the supporting documentation required. [s. 224. (1) 4.]

4. The list of goods and services that a Resident may purchase from the licensee and the charges for those goods and services. [s. 224. (1) 6.]

5. Trust account information. [s. 224. (1) 7.]

6. The Ministry's toll-free telephone number for making complaints about the home and its hours of service. [s. 224. (1) 8.]

WN #36: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 225 (1).
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. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
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 licensee failed to ensure that the home's license or approval, including any conditions or amendments is posted.
Home observations and an interview with the Administrator confirmed that the home's license or approval, including any conditions or amendments was not posted. [s. 225. (1) 2.]

WN #37: 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. The licensee failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.
Record review and interviews with the Administrator and President of Resident Council confirmed that improvements made through the quality improvement and utilization review system were not communicated to the Residents' Council. [s. 228. 3.]

2. Record review confirmed there was no written record setting out the improvements made to the quality of accommodation, care, service, program and good provided to the Residents. There was no written record of the name of persons who participated in the evaluations and the date the improvements were implemented. [s. 228. 4. i.]

WN #38: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
4. Identification of the community agencies, partner facilities and resources that will be involved in responding to the emergency. O. Reg. 79/10, s. 230 (4).

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's emergency plans comply with the regulations.

The home's "Loss of Utilities and Services" procedure was developed as a template by their corporate office. The template was not completed with the home's specific partner facilities, resources or agencies that would be involved in responding to the emergency. [s. 230. (4) 4.]

2. The home's "Loss of Utilities and Services" plan does not address the following components:
"Communications plan", "Specific staff roles and responsibilities" or "identify how the directions or information in the plan will be communicated to families, staff and residents".

The plan identifies the role of the maintenance staff when a loss of power occurs but it does not identify other staff roles and responsibilities in other departments. Roles and responsibilities would include very specific tasks related to a loss of power in the facility, involving activation, housekeeping, nursing, dietary and administrative staff. [s. 230. (5)]

3. The emergency plans for the home have not been evaluated and updated at least annually. The date on the "Loss of Utilities and Services" plans provided was September 2010 with no revision date. The plan provided was a corporate template where some of the key information specific to the home was not inserted. [s. 230. (6)]

4. According to the administrator, the home has not tested the emergency plans related to the loss of essential services on an annual basis. [s. 230. (7)]

Issued on this 13th day of December, 2013

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

Diane Brown

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), BERNADETTE SUSNIK (120), NICOLE RANGER (189), SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2013_108110_0014
Log No. / Registre no:	T-288-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 24, 2013
Licensee / Titulaire de permis :	CHARTWELL MASTER CARE LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	THE GIBSON LONG TERM CARE CENTRE 1925 STEELES AVENUE EAST, NORTH YORK, ON, M2H-2H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SOILI HELPPI

To CHARTWELL MASTER CARE LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.
This plan shall include but not limited to ensuring staff comply with the homes' policy to promote zero tolerance of abuse and neglect of residents.

The plan shall be submitted to Diane.Brown@ontario.ca on or before October 30, 2013

The licensee shall implement the plan by November 29, 2013

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and failed to ensure that residents are not neglected by the licensee or staff.
On an identified date, at 0345h, Resident # 503 was found on the floor by the staff. The resident was placed in his/her wheelchair and brought out to the nursing station by the registered staff at 0410h. Resident was left alone by the nursing station for 90 minutes. The inspector viewed video surveillance which showed the resident rubbing his/her leg while at the nursing station. The registered staff returned to the resident at 0530h and did not assess the resident despite the resident's display of pain. Resident was later sent to the hospital at 0830h and was diagnosed with a fracture. The Administrator reported to the inspector that the home viewed this incident as neglect and the registered staff member was terminated. [s. 19. (1)] (189)

2. Personal support worker #3 reported to the inspector that on an identified

date, she was called by PSW #4 to help transfer Resident #389 off the toilet. Personal support worker #3 reported that PSW #4 informed her that the resident is aggressive and violent and will hit staff. Personal support worker #3 reported that they transferred the resident off of the toilet and into a wheelchair. Personal support worker #3 stated that while she was putting on the resident's shoes, she witnessed PSW #4, with a washcloth in her hand, take the resident's left earlobe then pull and twist it. Right after this, PSW #4 took the resident's hand and hit the resident's face with his/her own hand and stating "there, now you hit yourself and not us". Personal support worker #3 reported that the resident was not aggressive during this incident. Personal support worker #4 was charged with assault by police. [s.19. (1)] (189)

3. On an identified date, RN #1 was in the dining room feeding a resident at breakfast. Registered Nurse #1 revealed that out of her peripheral vision she observed, what she believed to be, a staff member pushing on the head of Resident #603 or pushing on him/her somehow to reposition him/her. Registered nurse #1 stated she approached PSW #2 and stated "I'm not sure if I'm seeing what I think I am but don't do that". Throughout the meal, RN #1 stated she continued looking towards the resident and staff.Registered Nurse #1 informed the inspector that after the meal ended she approached the Director of Resident Services to report her concerns. Both staff agreed to view the video surveillance of the dining room. The RN reported to the inspectors that she viewed the video surveillance and observed PSW #2 using Resident #603's head to position him/her and that she was pushing on him/her so hard that the wheelchair was shaking.
An interview with the Administrator revealed that she also viewed the video surveillance and confirmed that PSW #2 pushed Residents #603's head up to reposition him/her at least 3-4 times in a very rough manner causing the wheelchair to shake violently, then at one point grabbed Resident #603's hair at the top of his/her head to reposition him/her. The PSW held Resident #603's head up in one hand then fed him/her with the other hand. The Administrator view the RN approaching the PSW #2 and resident confirming the RN's account of the incident. [s. 19. (1)] (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2013

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that no staff at the home, including agency staff, 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).

The plan shall be submitted to Diane.Brown@ontario.ca on or before October 30, 2013.

The licensee shall implement the plan by November 29, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that all staff at the home receive training as required prior to performing their responsibilities.

The licensee utilizes a large number of agency staff to provide direct resident care. According to the licensee, the agency staff are not provided with training in the areas mentioned in this section prior to performing their duties.

(109)

2. Personal support worker #3 reported to the inspector that she was hired in June 2013 and did not receive the following training during orientation or prior to performing her responsibilities:

1. The long-term care home's mission statement.
2. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
3. The duty under section 24 to make mandatory reports.
4. The protections afforded by section 26.
5. Infection prevention and control.
6. Lifts and transfers.

(189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2013

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Order / Ordre :

The licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Grounds / Motifs :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as per regulation.

Resident #276 complained to the home numerous times in the past month about his/her roommate's offensive unhygienic habits and touching his/her personal possessions. Furthermore the resident called the Ministry of Health complaining that the home was not responding to his/her concerns about his/her roommate.

Personal support worker #5 confirmed that she reported the resident's concerns to the charge nurse. The charge nurse indicated that she reported the resident's concerns to the Director of Resident Services.

There was no response provided back to the resident regarding his complaint. [s.101(3)] (109)

2. A family member complained that Resident #502's eyeglasses were missing but no response was provided back to this identified family member and record

review and staff interview confirmed the homes process for investigating a complaint was not followed.
On an identified date, Resident #604's family was overheard by an inspector asking staff if they have located the resident's eyeglasses, staff responded with no. Record review and staff interview confirmed that the resident's glasses had been missing since an identified date. Progress Notes stated "still could not find the glasses". Record review confirmed that a complaint form was not completed as per the home's policy.[s.101(3)]

(110)

3. Resident #254 reported to the inspector that in an identified month and year, he/ she complained to the staff that his/ her wallet and an identified amount of money were missing. The resident reported to the inspector that he/she has not received a response from the home regarding his/her missing wallet and money.

Record review and staff interview confirmed there is no written record of response made to Resident #254 indicating what the licensee had done to resolve the complaint.[s.101(3)] (189)

4. Resident #502 reported to the inspector that in two identified months he/she made multiple complaints to the Social Worker, Director of Resident Services and Registered Staff regarding the care he/she was receiving from a PSW, specifically that he/she was left unattended on the toilet for 45 minutes without receiving assistance and that he/she received the wrong medication from an agency registered staff. A family member of Resident #502 confirmed Resident #502's complaints to the home and that no response was received from the home related to these complaints.

Record review and staff interview confirmed that there is no written record of a response made to Resident #502 indicating what the licensee had done to resolve the complaints and that two complaints were not investigated.[s.101(1)(3)] (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2013

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure that all staff participate in the implementation of the infection prevention and control program.

The plan shall be submitted to Diane.Brown@ontario.ca on or before October 30, 2013.

The licensee shall implement the plan by November 29, 2013.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.
On an identified date, the inspector observed an isolation sign on an identified resident's room door. Inspector spoke with PSW #6 to inquire which resident was on isolation. Personal support worker #6 who was assigned to the identified resident was unaware that this resident was on isolation and was not able to identify the home's isolation procedures. (189)

2. On an identified date, the inspector observed improperly stored aerochambers in identified medication carts. The aerochambers had been previously used to administer inhaled medications to different residents. The used aerochambers were observed to be stored in the medication carts with the mouthpieces touching each other, posing a risk of cross contamination among residents. (109)

3. On an identified date, a registered staff member was observed to give medications to four different residents without performing hand hygiene. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2013

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the following residents right to be treated with courtesy and respect are fully respected and promoted:
Resident #344, #376, #267, #502, #276 and #602's .

Grounds / Motifs :

1. The licensee failed to ensure that every residents right to be treated with courtesy and respect and in a way that fully recognize the resident's individuality and respects the resident's dignity is promoted and respected.
On an identified date, Resident #267 and an witness reported that when Resident #267 was walking in the hallway towards his/her room he/she was stopped by a staff member who said "Hi" to the resident. Resident and witness reported that Resident #267 said "Hi" back but the staff member may not of heard the response. Resident and witness reported the staff member turned to the resident and said " I guess I don't deserve a hi back, oh, yeah, I should expect that from Resident # 267". Resident reported that the staff member did not treat him/her with courtesy and respect. [s.3(1)1.] (189)

2. Resident #344 and #376 interviews revealed that staff are rough and impatient while providing care and address residents in an inappropriate tone and manner. Resident #376 told the inspector that the night PSW's are rude to him/her and he/she is afraid of them.

Resident #344 told inspector that the night PSW's are rough when they come in to assist him/her. The resident reported that the staff reposition him/her in a rough manner, are impatient and leave the impression that they do not want to assist him/her. [s.3(1)1 (110)

3. On an identified date, Resident #602 was observed being fed breakfast in an activity room. The confined activity space had 13 other residents engaged in an activity program whereby residents were clapping and counting while Resident #602 was at a nearby table being fed. An interview with the Registered Dietitian confirmed that Resident #602's dining needs are better met outside of the main dining room during regular mealtimes but his/her meal should not have occurred during an activity program. [s.3(1)1.] (110)

4. On an identified date, Resident #502 reported that after PSW #1 assisted him/her with toileting, she took the white disposable pads and flushed them down the toilet. Resident reported that the toilet became clogged and that he/she immediately proceeded to take a glove and unclog the toilet him/herself while PSW#1 held the garbage bag open for the resident. The resident reported that he/she felt humiliated and upset that he had to unclog the toilet him/herself. Inspector spoke with PSW #1 who confirmed the resident's description of the incident.[s.3(1)1.] (189)

5. An interview with Resident #276 revealed that the licensee did not give notice to the resident before a change in roommate.
Record review and staff interviews indicate that Resident #276 had numerous room mates within the last year. The resident stated that the staff did not introduce him/her to any of his/her roommates in the last year and feels there is a lack of courtesy by the staff. Interviews with other residents, in the same room, confirmed Resident #276's statement. [s.3(1)1.]

Note: Finding #6 below does not apply to this Order (189)

6. Resident #502 reported to the inspector that on an identified date, after dinner, he/she requested to use the toilet and called the PSW for assistance. Personal support worker #1 came to assist the resident and wheeled him/her into the bathroom then placing him/her onto the toilet. The resident reported that PSW #1 informed him/her that he/she had to deliver evening nourishments and left the resident on the toilet. Resident reported that he/she was left on the toilet

for 45 minutes before PSW #1 returned to assist him/her off the toilet. Resident reported to the inspector that he/she was angry that he/she did not receive toileting assistance in a timely manner. Inspector interviewed PSW #1 who confirmed that she left the resident on the toilet and did not attend to the resident for 45 minutes. Furthermore, PSW #1 reported that there were no other staff available to assist her and confirmed that it was a long period of time to leave a resident on the toilet.[s.3(1)3]

(189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2013

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure that the following immunization and screening measures are in place:
Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.[r. 229. (10) 3.]

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.[r. 229. (10) 4.]

The plan shall be submitted to Diane.Brown@ontario.ca on or before November 7, 2013

The licensee shall implement the plan by December 5, 2013

Grounds / Motifs :

1. The licensee failed to ensure that Residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review and staff interview confirm that five identified residents were not offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

The Director of Resident Services confirmed that the home is currently not following the immunization schedule posted on the Ministry website because the home did not have the tetanus vaccine available in the home at the time of this inspection.
(109)

2. The licensee failed to ensure that 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.

The licensee failed to ensure that staff members #1 and #2 were screened for tuberculosis and other infectious diseases. An interview with Director of Resident Services confirmed the lack of screening for staff members #1 and #2.
(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 05, 2013

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare and submit a plan that summarizes the following:

1. Short term actions to mitigate risks to residents who are currently residing in a bed that has failed one or more entrapment zones, including residents who use a therapeutic surface.

2. Long term actions to ensure that each bed remains free of entrapment zones including a maintenance strategy to ensure that each bed is inspected as per manufacturer's instructions to maintain the bed in good condition.

The plan shall be emailed to Bernadette.susnik@ontario.ca by October 31, 2013.

The plan shall be implemented by December 31, 2013.

Grounds / Motifs :

1. The licensee failed to ensure where bed rails are used, steps have not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The home had their bed systems evaluated by an external company on July 10th, 2013. The results of the bed entrapment zone audit identified that approximately 70 beds did not pass one or more entrapment zones. On July 31, 2013, six identified residents were observed sleeping in bed with one or more bed rails in the raised position. Each of the beds were identified to have failed one or more entrapment zones. No interventions to mitigate the risks were apparent.

The identified resident's bed risk assessments were reviewed which revealed that registered staff completed a "bed rail assessment" on four out of the six residents in May and June 2013. The assessments were still in the process of being completed on all of the residents. In each of the four cases where an assessment was completed, the risks associated with any entrapment zone were dismissed as long as the resident or their substitute decision maker were made aware of them. Bed rail use was made based on whether or not the resident or the substitute decision maker wanted the bed rails in place, regardless of the assessed need. The form did not direct staff to identify what options were available to mitigate any entrapment zone(s) and it did not identify what entrapment zones were actually an issue. The process implemented to date does not satisfy the requirement for the licensee to prevent resident entrapment.[s.15. (1) (b)]

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

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

and the Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 24th day of October, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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