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

Division de la responsabilisation et de la performance du système de santé
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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 3, 2014	2014_216144_0044	L-001171-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

EXTENDICARE SOUTHWOOD LAKES
1255 NORTH TALBOT ROAD, WINDSOR, ON, N9G-3A4

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

CAROLEE MILLINER (144), ALISON FALKINGHAM (518), ROCHELLE SPICER (516)

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): September 2, 3, 4, 5, 8, 9, 10, 2014

During the course of the inspection, the inspector(s) spoke with 40 plus residents, three family members, the Administrator, Director of Care, Food Service Manager, Environmental Services Manager, Clinical Coordinator, Program Manager, the Physiotherapist, two Registered Nurses, eight Registered Practical Nurses, seventeen Personal Services Workers, three Health Care Aides and one Housekeeping Aide.

During the course of the inspection, the inspector(s) toured all resident home areas, one medication room, observed dining services, medication administration, provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices, reviewed residents clinical records, posting of required information, meeting minutes related to the inspection and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) 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. 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident's personal health information is kept confidential in accordance with the Act.

a) The computer program containing electronic clinical records on one resident home area, was observed open to the progress notes for resident #47. There were no staff in the vicinity of the computer.
b) The computer program containing electronic clinical records on a second resident home area, was observed open to the plan of care for resident #46. There were no staff in the vicinity of the computer.
c) Two registered staff confirmed the software program had been left open with resident confidential information revealed.
d) One management personnel and two registered staff confirmed the expectation that resident electronic clinical records will be closed when staff leave the area.
d) The home's policy related to confidentiality includes that each employee shall respect the privacy of each resident. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident's personal health information is kept confidential in accordance with the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. (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 has failed to ensure that there is a written plan of care for each resident that 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.

a) Through resident observations, staff interviews and progress notes, it was

confirmed that resident #25 uses three personal assistive safety devices (PASD).
b) Inspector #516 was unable to locate a plan of care within the resident's clinical records, indicating the use of the personal assistive devices.
c) The Director of Care (DOC) confirmed resident #25 does not have a plan of care in place that provides clear direction for the use of the personal assistive devices.. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide care to the resident.

a) Three staff interviews confirmed that one of resident #2's restraints is applied each morning when the resident is placed in the wheelchair, that they release the restraint every two hours and assist the resident to reposition, then reapply the restraint and document these actions on the resident flow sheet.
b) The restraint is not included in the resident's current written plan of care.
c) The DOC confirmed it is the expectation that the written plan of care provides clear directions to the staff and should include the restraint. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

a) The current quarterly assessment for resident #44 identifies that the resident requires a visual appliance.
b) The current written plan of care identifies the resident requires eyeglasses.
c) The resident was not wearing eye glasses on September 4, 5 and 8, 2014 when observed by Inspector #144.
d) At 10:00 am on September 8, 2014, the resident shared that they did not wear their glasses because they did not know where they were.
d) Two nursing personnel on September 8, 2014 confirmed the resident requires eye glasses, and that there were no eyeglasses found in the resident's room on this date. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

a) One resident experienced a fall resulting in hospitalization.
b) The physiotherapist reassessed the resident on readmission and documented in the progress notes that the wheelchair available for the resident was "very low and not

recommended unless it had a tilt mechanism."
c) A registered staff member documented in the progress notes that a physician's order was needed for a wheelchair assessment.
d) Two nursing personnel confirmed the resident is using a wheelchair with a tilt mechanism that was borrowed from within the home on the date of readmission.
e)One registered staff confirmed a physician's order for a wheelchair assessment was not obtained and should have been. [s. 6. (7)]

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

a) One resident experienced a fall [redacted]
b) Prior to the fall, the resident was ambulatory with a wheeled walker & supervision.
c) [redacted] the resident is no longer ambulatory and uses a wheelchair for mobility purposes.
d) The plan of care was reviewed [redacted] and the written plan of care revised to include the resident's high risk for falls.
e) The written plan of care was not revised to reflect the resident is no longer ambulatory and requires wheelchair transportation.
f) The current written plan of care continues to reflect the resident is ambulatory with a wheeled walker and supervision.
e) Four nursing personnel and the Physiotherapist confirmed the resident is no longer ambulatory and uses a wheelchair as her primary mode of locomotion. [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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system (b) is complied with. O. Reg. 79/10, s. 8 (1)(b)

a) The home Falls Prevention and Management Policy directs that an unwitnessed fall requires neuro vital signs to be taken and that follow-up documentation be completed every shift for 72 hours.
b) Resident #2 had an unwitnessed fall.
c) An initial nursing assessment and fall assessment were completed immediately post fall.
d) The clinical record does not include documentation of neuro vitals taken during the initial nursing assessment.
e) A nursing assessment was documented on the midnight shift.
f) The resident clinical record did not include further documentation during the following 72 hours.
g) This was confirmed by one Registered Practical Nurse.
h) The DOC confirmed that it is her expectation that the Falls Prevention and Management Policy is complied with. [s. 8. (1)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

a) The DOC, RAI Coordinator, a Registered Practical Nurse and a Health Care Aide confirmed resident #25 uses one full and one partial bed rail and a tilt wheelchair as PASD's.
b) The homes policy titled "Personal Assistance Service Devices" states the following documentation must be included in the residents health care record when a PASD is

used by a resident:
- Circumstances precipitating the application of the PASD
- An approval for the type of PASD
- Reason for the PASD
- A comprehensive interdisciplinary assessment of the resident prior to application of the PASD
- Assessment for the use of PASD's
- Interventions and other alternatives tried and evaluated
- Discussions with resident and/or SDM In regards to risks associated with PASD
- Signed consent
- Resident's reaction to PASD use
- Care plan to include any special care needs during PASD use
- The length of time the PASD will be used
- Conditions under which the PASD will be applied
- Frequency of monitoring checks

c) Inspector #516 was unable to locate any of the above listed required documentation for the use of the tilt wheel chair.
d) The inspector was able to locate a signed consent for the bed rail use.
e) The DOC confirmed the resident's clinical record did not include all required documentation for the use of resident #25's PASD's. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system the licensee is required to follow, is complied with.

a) The home policy related to the Continence Management Program identifies a continence assessment will be completed upon a resident's admission and with any deterioration in continence level.
b) One quarterly review identifies resident #44 as being continent of urine.
c) A second quarterly assessment identifies resident #44 as being frequently incontinent of urine.
d) One staff confirmed continent assessments are completed when there is a change in the resident's continence status and that a continence assessment was not completed for resident #44 when they became incontinent of urine.
d) One management personnel confirmed that continent assessments are completed on admission and when there is a deterioration in the resident's continence status. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure any plan, policy, protocol, procedure, strategy or system, the licensee is required to have, is complied with, to be implemented voluntarily.

WN #4: 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 has failed to ensure that where bed rails are used, 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.

Through review of resident #25's daily flow sheets, resident observation and staff interviews, it was determined that this resident uses two bed rails on a daily basis. The inspector was unable to locate a resident assessment in relation to the use of bed rails. The Director of Care and RAI Coordinator confirmed resident #25 was not assessed in relation to bed rail use.

Through review of resident #01's health record, resident observation and staff interviews, it was determined that this resident uses bed rails on a daily basis. Resident observation and record review revealed this resident has an air mattress. The inspector was unable to locate a resident assessment in relation to the use of bed rails. The Director of Care and RAI Coordinator confirmed resident was not assessed in relation to bed rail use.

It was determined through resident health record review, resident observation and staff interviews that resident #01 and #25 use bed rails daily. The Administrator confirmed the home had not completed bed entrapment assessments taking into account all potential entrapment zones for any bed within the home. [s. 15. (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 where bed rails are used, 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, to be implemented voluntarily.

WN #5: 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 licensee did not ensure that the home is equipped with a resident-staff communication and response system that, is on at all times.
a) Resident #27's bedroom call bell was not functioning when the call cord was pulled.
b) This was confirmed by a Personal Support Worker.
c) The Administrator, confirmed the call bell should have been functioning.
d) Resident #32's call bell located in the bathroom did not have a pull cord in place.
e) This was confirmed by one Health Care Aide.
f) The Maintenance Supervisor and Health Care Aide confirmed the pull cord should have been in place. [s. 17. (1) (a)]

2. a) On one identified date between 10:45 and 11:10 am, the call bell system over the beds of residents #329, 417 and 421 did not activate when the cords were pulled by Inspector #144.
b) Two staff were asked by the Inspector to initiate the call bell system in the above identified rooms.
c) Both personnel confirmed the call bell systems were not activated when the cords were pulled.
d) One management personnel confirmed the call bell cords should have activated when the cords were pulled. [s. 17. (1) (a)]

3. a) On one identified date, resident #27's bedroom call bell was not functioning when tested.
b) This was confirmed by a Personal Support Worker.
c) The Administrator, confirmed the call bell should have been functioning. [s. 17. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times and is on all the time, to be implemented voluntarily.

WN #6: 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).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the homes Skin and Wound Care program was evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices.

a)The Administrator confirmed the homes Skin and Wound Care program was not evaluated in 2013. [s. 30. (1) 3.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

a) The care plan for resident #11 includes the requirement for dental care twice a day.

b) Review of the resident's flow sheet by Inspector #518 confirmed dental care had not been documented as provided on the day, evening or night shifts.
c) Three PSW's confirmed the provision of dental care should be documented on the resident's flow sheet.
d) The Administrator confirmed that it is her expectation that all care interventions that are provided, is documented. [s. 30. (2)]

3. The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound program, including assessments were documented.

a) Inspector #516 observed bruising on resident #25.
b) One Registered Practical Nurse confirmed this resident had bruising as identified by the Inspector.
c) The inspector was unable to locate documentation of the bruising in the resident's clinical record.
d) The Administrator verified this resident currently has bruising and that the bruising had not been documented in the residents clinical record or in recent shift reports.
e) The Administrator further confirmed an assessment of the bruising should have been documented in the residents clinical record as per the homes established skin and wound care program requirements. [s. 30. (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 the homes Skin and Wound Care program was evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care includes an order by a physician.

a) Review of Resident #2's clinical record did not include a physician's order for restraints on the last three month physician medication and treatment review. The restraints were observed to be currently in use and have been in use for a prolonged period of time.
b) This was confirmed by one registered staff.
c) The DOC confirmed the expectation is that a physician will write an order for resident use of PASD's and restraints and that resident #2 did not have an order [redacted]. [s. 31. (2) 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 restraint plan of care includes an order by a physician., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

a) The Administrator provided documents related to the homes "Quality Program Evaluation"
b) The Quality Program Evaluation for "Resident Abuse" indicated an evaluation of the Resident Abuse Program did not occur in 2013.
c) The Administrator confirmed an evaluation of the homes resident abuse program did not occur in 2013. [s. 99. (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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,

(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes or improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis; (b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation; (c) that the results of the analysis undertaken under clause (a) are considered in the evaluation; (d) that the changes or improvements under clause (b) are promptly implemented; and (e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

a) Interview with the DOC revealed that there is no monthly analysis of restraining of residents by a physical device completed and that the policies have not been reviewed since November 2012.
b) The DOC also confirmed there were no written records of the previous policy review in November 2012 that included the date or names of persons who who participated in the evaluation.
c) The Director of Care stated that it is the expectation that a monthly analysis of the restraints is required and that the policies need to be evaluated on an annual basis. [s. 113. (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 to ensure that that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis and at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy and, that a written record of everything provided for, is prepared, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received annual retraining in falls management and prevention.

a) Falls management and prevention training records for 2013 were reviewed by Inspector #516. b) The Clinical Coordinator reported 140 employees required the above training in 2013.
c) Review of staff education attendance records for 2013, revealed 32/140 (23%) of the staff received annual retraining in falls management and prevention.
d) The Clinical Coordinator confirmed that 32/140 staff received annual retraining in falls management and prevention. [s. 221. (2)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is dressed in their own clean clothing and appropriate clean footwear[redacted]

a) Resident #44 was observed sitting in their wheelchair in stocking feet on two occasions during the inspection.
c) The current written plan of care identifies the resident is to wear shoes or slippers when not in bed.
d) One staff confirmed the resident should be wearing slippers when out of bed and in [redacted] wheelchair. [s. 40.]

WN #12: 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. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. a) The licensee has failed to ensure that the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly.
b) The Administrator confirmed that an analysis of complaints has not been done quarterly since February 2014.
c) The quarterly analysis of complaints received was due in May and August 2014. [s. 101. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

a) There were no assessments, reassessments, documentation of ongoing monitoring or documentation of residents responses in the clinical record for resident #2 regarding a restraint.
b) The DOC confirmed there has been no documentation regarding restraining with a physical device for this resident. [s. 110. (7) 6.]

WN #14: 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. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that pets visiting as part of a pet visitation program had up-to-date immunizations.

a) The home provided their visiting pet vaccinations records during the RQI.
b) Vaccination records on file for visiting dog #50, indicated their vaccination expired on September 21, 2013.
c) Vaccination records on file for visiting dog #51, indicated their vaccinations expired on April 06, 2013.
c) The Program Manager was unable to confirm that the above two identified visiting dogs had up-to-date vaccinations. [s. 229. (12)]

Issued on this 3rd day of October, 2014

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