Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY-JEAN SCHIENBEIN (158)
Inspection No. / No de l'inspection :	2013_140158_0001
Log No. / Registre no:	S-0791-12,S-0814,S-1194,S-0509
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 8, Feb 4, 2013
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE YORK 333 YORK STREET, SUDBURY, ON, P3E-5J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDRA MOROSO

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

Order # / Ordre no : 901 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all resident washrooms are kept clean and sanitary.

Grounds / Motifs :

1. On January 7, 2012, the Inspector toured four of the five resident care units in the home. The Inspector observed that the bathrooms shared by residents in seventeen rooms throughout the home were not clean and sanitary. The inspector observed that the majority of the bathrooms on one unit were littered with used paper products, sand and grit on the floors and debris behind the toilets. Resident # 01 told the Inspector that the cleaning staff only does a quick sweep and mop of the floor. The Inspector observed that there was obvious sand and grit in the corners of the bathroom, as well as, in the resident's bedroom. The Inspector observed that the toilet in their bathroom was not clean with obvious fecal material on the bowl. The Inspector observed that a plunger, which was on the floor in the corner of the bathroom of a resident's room required cleaning. The toilet seat was also not clean.
The Inspector observed Lysol wipes resting on the back of the toilet in another resident's bathroom. Resident # 02 family member told the Inspector that they brought in the wipes and instructed resident # 02 to wipe down the toilet before each use as the toilet is always dirty. The family member also stated that they had approached the staff regarding the lack of cleanliness and was informed that wipes are not supplied by the home.

A soiled urine collection container was observed by the Inspector to have been left to rest on the hand rail beside the toilet in the bathroom shared by four residents.
Two hand sanitizers outside the staff washroom and in a resident's room were found empty.
The Inspector observed that a gel pad, smelling of urine, was left in a heap on the bathroom floor in a resident's room. The Inspector observed that the bathrooms, which are shared by six residents on a second unit had sand and grit build up along the baseboards and sediment on the floor. The outside toilet bowls were also observed to be soiled and require cleaning.
The Inspector observed that a used plunger was left in the corner of the bathroom shared by four residents on a third unit. It was observed that the toilet and sink in this bathroom required cleaning and that personal care items (i.e open toothpaste tube and shaving cream) were left on the back of the toilet ledge. The Inspector also observed that 2 hand sanitizer containers for use by staff, residents and visitors, on the unit were empty. Staff # 01 told the inspector that they were the only housekeeper on the unit even though they were currently in respiratory outbreak.
The bathroom sink on the fourth unit was observed by the Inspector to be unclean with hard food debris scattered on it. Used gloves, used paper products and foul smelling brown residue were observed on the floor in the bathroom shared by four residents. The toilet was also observed to be unclean.
A respiratory outbreak was declared on Friday January 4, 2013. The ADOC identified that an initial outbreak meeting was held on the morning of January 4, 2013 as well as today. When the inspector conducted a tour of the home it was observed that one additional housekeeper was working in the home on the 3rd floor. On January 7, 2013, the Inspector spoke with the Environmental Services Manager who identified that he is calling in extra staff to increase the cleaning of the home. He told the inspector that the usual practice when the home is in outbreak is to bring in extra staff to work on the resident care units which are in outbreak. The Inspector reviewed the housekeeping schedule, which showed that there was a missing housekeeper on January 4, 2013 and that extra housekeeping staff were not brought in until January 7, 2012, three days after the outbreak was declared.
The licensee did not ensure that the home is kept clean and sanitary. (158)

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

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 and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
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 8th day of January, 2013

Signature of Inspector / Signature de l'inspecteur :

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

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

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**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
Direction de l'amélioration de la performance et de la conformité

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 8, Feb 4, 2013	2013_140158_0001	S-0791-12,S-0814,S-1194,S-0509	Complaint

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 YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 7-11, 2013

Logs S-000791-12, S-000814-12, S-001194-12, S-000509-12, S-001075-12, S-000950-12, S-001312-12, S-001288-12, S- 001204-12, S- 001218-12, S- 001219-12, S-001222-12 and S-001317-12 were reviewed during this Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (acting), the Director of Care (DOC), Assistant Directors of Care (ADOC), the Kinseologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, janitors, Residents and visitors.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, reviewed various home policies and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Continence Care and Bowel Management

Falls Prevention

Hospitalization and Death

Medication

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

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. 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 :

On January 7, 2012, the Inspector toured four of the five resident care units in the home. The Inspector observed that the bathrooms shared by residents in seventeen rooms throughout the home were not clean and sanitary. The inspector observed that the majority of the bathrooms on one unit were littered with used paper products, sand and grit on the floors and debris behind the toilets. Resident # 01 told the Inspector that the cleaning staff only does a quick sweep and mop of the floor. The Inspector observed that there was obvious sand and grit in the corners of the bathroom, as well as, in the resident's bedroom. The Inspector observed that the toilet in their bathroom was not clean with obvious fecal material on the bowl. The Inspector observed that a plunger, which was on the floor in the corner of the bathroom of a resident's room required cleaning. The toilet seat was also not clean.
The Inspector observed Lysol wipes resting on the back of the toilet in another resident's bathroom. Resident # 02 family member told the Inspector that they brought in the wipes and instructed resident # 02 to wipe down the toilet before each use as the toilet is always dirty. The family member also stated that they had approached the staff regarding the lack of cleanliness and was informed that wipes are not supplied by the home.
A soiled urine collection container was observed by the Inspector to have been left to rest on the hand rail beside the toilet in the bathroom shared by four residents.
Two hand sanitizers outside the staff washroom and in a resident's room were found empty.
The Inspector observed that a gel pad, smelling of urine, was left in a heap on the bathroom floor in a resident's room. The Inspector observed that the bathrooms, which are shared by six residents on a second unit had sand and grit build up along the baseboards and sediment on the floor. The outside toilet bowls were also observed to be soiled and require cleaning.
The Inspector observed that a used plunger was left in the corner of the bathroom shared by four residents on a third unit. It was observed that the toilet and sink in this bathroom required cleaning and that personal care items (i.e open toothpaste tube and shaving cream) were left on the back of the toilet ledge. The Inspector also observed that 2 hand sanitizer containers for use by staff, residents and visitors, on the unit were empty. Staff # 01 told the inspector that they were the only housekeeper on the unit even though they were currently in respiratory outbreak.
The bathroom sink on the fourth unit was observed by the Inspector to be unclean with hard food debris scattered on it. Used gloves, used paper products and foul smelling brown residue were observed on the floor in the bathroom shared by four residents. The toilet was also observed to be unclean.

A respiratory outbreak was declared on Friday January 4, 2013. The ADOC identified that an initial outbreak meeting was held on the morning of January 4, 2013 as well as today. When the inspector conducted a tour of the home it was observed that one additional housekeeper was working in the home on the 3rd floor. On January 7, 2013, the Inspector spoke with the Environmental Services Manager who identified that he is calling in extra staff to increase the cleaning of the home. He told the inspector that the usual practice when the home is in outbreak is to bring in extra staff to work on the resident care units which are in outbreak. The Inspector reviewed the housekeeping schedule, which showed that there was a missing housekeeper on January 4, 2013 and that extra housekeeping staff were not brought in until January 7, 2012, three days after the outbreak was declared.
The licensee did not ensure that the home is kept clean and sanitary.

Additional Required Actions:

CO # - 901 was 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. 6. Plan of care

Specifically failed to comply with the following:

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The Inspector reviewed resident # 04 health care record on January 9, 2013. The record showed that the physician had ordered a referral for an assessment by another discipline in November 2012. This order was processed by one registered staff member. A second signature, as per the home's processing of orders procedure was not found. There was no indication of the referral in the unit's day book or in resident # 04 progress notes. On January 9, 2013, the Inspector spoke with staff # S-108 who identified that no referral for resident # 04 was received. Staff failed to collaborate as per the home's policy, to ensure the physician's order was processed which thereby resulted in no referral and the resident not receiving the ordered services. The home did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

2. Resident # 04 progress notes were reviewed by the Inspector on January 7, 2013. The progress notes identified that on two occasions when the resident left the home to attend an appointment, the plans arranged by the resident's family member were not implemented, which caused the resident to be anxious and upset.
In June 2012, the staff sent resident # 04 for an appointment via handi-transit despite the resident's attestations that the appointment was the next day. The staff did not notify the family member who usually accompanies the resident. The resident arrived back at the home upset and crying as there had been no arrangement or money to ensure the resident's return to the home. The resident's appointment was in fact scheduled for the following day.
In September 2012, the handi-transit did not wait to pick up resident # 04 for their appointment as an ambulance was at the home's main entrance. The resident's family member, who was waiting for the resident at the destination, was called and they provided direction to the home to bring resident # 04 back to their room. The family member's direction was not heeded and the resident was later picked up by Handi-Transit and found by the family member sitting in a w/c outside the destination where the Handi-transit had delivered the resident. The home failed to ensure that the resident or SDM were given an opportunity to participate fully in the implementation of the resident's plan of care. [s. 6. (5)]

3. Resident # 09 fell in August 2012 and was transferred to the hospital for further assessment. Staff # 106 documented in resident # 09 progress notes that the resident's roommate witnessed resident # 09 fall when they were returning to their bed

after using the washroom and became dizzy. It is documented in resident # 09 plan of care that they could be left unattended on the toilet however; assistance with clothing adjustment, guidance with manoeuvring assistance was identified. The licensee did not ensure that the care set out in the plan of care was provided to resident # 10. [s. 6. (7)]

4. The health care record, including the home's internal fall incident report, care plan and the progress notes for resident # 13 were reviewed by the Inspector on January 10, 2013. The home's incident report identified that the resident had attempted to stand and called for help. The progress notes identified that the resident had rang for assistance and lost their balance when the staff member was assisting the resident. It was further documented, that the resident slid to the floor, sustained no injuries and that the brake of the wheel chair had not been applied.
The care plan identified that the resident required the assistance of two staff to pivot transfer onto the toilet and cuing to hold on to the bar during the transfer.
As well, it was identified under transferring, to ensure that the brakes are applied before transferring. The home did not ensure that the care set out in the plan of care was provided to resident # 13. [s. 6. (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 ensuring that the care set out in the plan of care, including the transferring assistance and transferring technique is provided to all residents, to be implemented voluntarily.

WN #3: 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. Resident # 08 had several pressure wounds which had specific wound care treatments ordered by the physician, despite the resident's palliative state. The home's wound care policy and medication policy were reviewed by the Inspector on January 11, 2012. The wound care policy identifies that the Registered staff are to document the completion of the treatment. The medication policy identifies the process of how physician's orders are processed and the codes to use, if a medication/treatment is not given. Resident # 08 health care record, including physician orders, progress notes and the resident's Treatment Administration Records (TAR) was reviewed by the Inspector. A specific month was reviewed and showed that, two out of five treatments for wound # 1 were documented, two out of ten treatments for wound # 2 were documented, and three out of 20 treatments for wound # 3 were documented. The licensee did not ensure that drugs/treatment are administered to residents in accordance with the directions for use specified by the prescriber. [O Reg 131 (2)] [s. 131. (2)]

2. Resident # 04 health care record, including the physician orders, the plan of care, the Treatment Administration Records (TAR) and the progress notes for resident # 4 was reviewed by the Inspector on January 10, 2013.
It was identified that the resident had an area with altered skin integrity for which the physician had ordered a specific wound care treatment. A review of resident # 04 monthly TAR showed missing signatures for the wound treatment on three occasions and that the wound treatment was held and not administered on four occasions. The progress notes were reviewed and there was nothing documented regarding the holding or non-administration of the prescribed wound care treatment. The progress notes also identified that there was a deterioration of the area with altered skin integrity. The home did not ensure that drugs/treatment are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (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 ensuring that drugs/treatments are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On January 7, 2013, the Inspector observed that a staff member was transferring resident # 03 onto the toilet at 1045hr. The bathroom door was open, which allowed the resident's roommate who was in bed, to view the process, including the resident's unclothed lower body. The licensee did not ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was provided. [s. 3. (1) 8.]

2. It was identified by resident # 05 Substitute Decision Maker that the resident, who was in a wheel chair, was not able to independently complete some parts of their personal hygiene without the aid of a mirror.
The Inspector toured the home and observed that majority of the bathrooms had mirrors mounted above the sink and were not at a level, in which a resident in a wheel chair would be able to see their reflection. The Inspector observed that there were no mirrors in the residents bedrooms unless brought in by the resident.
The Inspector observed on January 8, 2013, that resident # 116 hair was not combed, especially at the back. The resident who was wheel chair bound, identified that they were unable to see what their hair looked like after brushing, as they did not have a mirror and could not see the mirror in the bathroom. Resident # 116 plan of care did identify that the resident was independent and did not require assistance from staff regarding their personal hygiene.
The home did not ensure that residents receive care and assistance towards independence based on a restorative philosophy to maximize independence to the greatest extent possible. [s. 3. (1) 12.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The progress notes for resident # 07 identified that resident # 07 was exhibiting altered skin integrity in September 2012. It was documented by Staff # 104 that Staff # 110 offered to assess the resident as Staff # 104 was detained. The Inspector reviewed resident # 07 health care record and an assessment of the resident's skin integrity was not found completed. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The progress notes for resident # 07 identified that resident # 07 was exhibiting altered skin integrity in September 2012. The Inspector reviewed resident # 07 health care record and an assessment of the resident's skin integrity by the dietitian regarding the resident's wound was not completed. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian. [s. 50. (2) (b) (iii)]

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

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #901	2013_140158_0001	158

Issued on this 4th day of February, 2013

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