Ministry of Health and Long-Term Care

Ministére 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 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) :	MELISSA CHISHOLM (188), DIANA STENLUND (163), LAUREN TENHUNEN (196), ROSE-MARIE FARWELL (122)
Inspection No. / No de l'inspection :	2012_099188_0005-A
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	Jan 30, 31, Feb 1, 2, 3, 6, 7, 8, 9, 10, 12, 15, 16, 17, 2012
Licensee / Titulaire de permis :	F. J. DAVEY HOME 733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1
LTC Home / Foyer de SLD :	F. J. DAVEY HOME 733 Third Line East, Sault Ste Marie, ON, P6A-7C1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER J. MACLEAN

To F. J. DAVEY HOME, 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 :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall audit the resident-staff communication and response system within the home, including pull stations in resident rooms, resident washrooms, spa rooms and common areas to ensure they activate. The licensee shall audit all Versus badges to ensure they activate. The licensee shall ensure that the resident-staff communication and response system is on at all times.

Grounds / Motifs :

1. Inspector observed on January 31, 2012 at 11:40h in the spa room on Cedar Grove 3 that five of the five call bells did not activate when tested by the inspector. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (196)
2. Inspector observed on January 31, 2012 at 10:20h that the following call bells did not activate. Cedar Grove 319 and 311-B. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (196)
3. Inspector observed on February 1, 2012 at 10:00h in the spa room on Apple Orchard 2 that five of the five call bells did not activate when tested by the inspector. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (196)
4. Inspector observed on January 31, 2012 that the following call bells did not activate when tested by the inspector. Cedar Groove room 302-A and Birch Lane 319 washroom. Inspector observed on February 1, 2012 that the following call bells did not activate when tested by the inspector. Driftwood Beach 309-A, 315-A, Apple Orchard 321-A, Driftwood Beach 315 washroom, Apple Orchard 321 washroom and Apple Orchard 3 spa room (beside toilet). The licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (122)
5. Inspector observed on February 2, 2012 at 09:46h in the spa room on Birch Lane 1 that four of the five call bells did not activate when tested by the inspector and by a PSW. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (188)
6. Inspector observed on February 2, 2012 at 10:16h in the spa room on Birch Lane 2 that five of the five call bells did not activate when tested by the inspector and by a PSW. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (188)
7. Inspector observed on February 1, 2012 that a resident's Versus badge attached to their clothing did not activate when tested by the inspector. Inspector spoke with a RPN who confirmed that it was not functioning and required the batteries to be changed. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (163)
8. Inspector observed on February 1, 2012 that the following call bell in a resident room did not activate when tested by the inspector. Cedar Groove 121-A. The licensee failed to ensure the home is equipped with a resident -staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2012

Order # / Ordre no : 902 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall audit the resident-staff communication and response system within the home, including pull stations in resident rooms, resident washrooms, spa rooms and common areas to ensure they activate. The licensee shall audit all Versus badges to ensure they activate. The licensee shall ensure that the resident-staff communication and response system is on at all times.

Grounds / Motifs :

1. Inspector observed on January 31, 2012 at 11:40h in the spa room on Cedar Grove 3 that five of the five call bells did not activate when tested by the inspector. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (196)
2. Inspector observed on January 31, 2012 at 10:20h that the following call bells did not activate. Cedar Grove 319 and 311-B. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (196)
3. Inspector observed on February 1, 2012 at 10:00h in the spa room on Apple Orchard 2 that five of the five call bells did not activate when tested by the inspector. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (196)
4. Inspector observed on January 31, 2012 that the following call bells did not activate when tested by the inspector. Cedar Groove room 302-A and Birch Lane 319 washroom. Inspector observed on February 1, 2012 that the following call bells did not activate when tested by the inspector. Driftwood Beach 309-A, 315-A, Apple Orchard 321-A, Driftwood Beach 315 washroom, Apple Orchard 321 washroom and Apple Orchard 3 spa room (beside toilet). The licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (122)
5. Inspector observed on February 2, 2012 at 10:16h in the spa room on Birch Lane 2 that five of the five call bells did not activate when tested by the inspector and by a PSW. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (188)
6. Inspector observed on February 2, 2012 at 09:46h in the spa room on Birch Lane 1 that four of the five call bells did not activate when tested by the inspector and by a PSW. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (188)
7. Inspector observed on February 1, 2012 that a resident's Versus badge attached to their clothing did not activate when tested by the inspector. Inspector spoke with a RPN who confirmed that it was not functioning and required the batteries to be changed. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (163)
8. Inspector observed on February 1, 2012 that the following call bell in a resident room did not activate when tested by the inspector. Cedar Groove 121-A. The licensee failed to ensure the home is equipped with a resident -staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 17, 2012

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-A

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Four written notifications of non-compliance under s.36 have previously been issued, including a compliance order: CO-002, 2011_099188_0034.

The licensee shall prepare, submit and implement a plan for achieving compliance with s.36. The compliance plan shall include how the licensee will ensure staff use safe transferring and position devices or techniques when assisting all residents. Further, the plan shall address staff training to ensure policies and procedures are followed.

The plan is to be submitted in writing to Long Term Care Homes Inspector Melissa Chisholm, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, ON, P3E 6A5 by March 9, 2012. The plan must be fully implemented by May 25, 2012.

Grounds / Motifs :

1. Inspector reviewed the health care record of a resident. Inspector reviewed a progress note entry and the home's internal "unusual incident report" . Both describe the resident sustaining an injury following staff not following the established plan of care relating to transferring. Inspector spoke with a DON who confirmed the incident and provided a copy of the home's original "unusual incident report" to the inspector. The licensee failed to ensure that staff use safe transferring techniques when assisting residents. [O.Reg. 79/10, s.36] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : ~~Mar 23, 2012~~ ne. May 25, 2012

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure that the Director is immediately notified when a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, or 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. The licensee shall ensure that the Director is immediately notified of any requirements under s.24 of the Act.

Grounds / Motifs :

1. Inspector reviewed a Critical Incident Report in which a resident was abused by a staff. The Critical Incident identifies that the Director was not notified until almost 48 hours after the initial incident. The licensee failed to ensure the Director is immediately notified of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24 (1)] (163)
2. Inspector reviewed the health care record of a resident. Inspector reviewed a progress note entry and the home's internal "unusual incident report" . Both describe the resident sustaining an injury following staff failing to follow the established plan of care. Inspector spoke with a Director of Nursing (DON). The DON confirmed the incident and provided a copy of the home's original "unusual incident report" to the inspector. When asked by the inspector the DON identified that a Mandatory Report had not been submitted related this is incident of improper care. The licensee failed to report the improper care of a resident which resulted in a risk of harm. [LTCHA 2007, S.O. 2007, c.8, s.24(1)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 21, 2012

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. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Order / Ordre :

The licensee shall ensure that a resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. The licensee shall ensure that the resident's substitute decision-maker, if any, is notified of the results of the investigation, immediately upon the completion of the investigation.

Grounds / Motifs :

1. Inspector #188 interviewed a resident's SDM about an alleged abuse incident. The SDM reported to the inspector that they were not informed within 12 hours of the incident. The SDM identified that a phone call was received from the DON and that the DON informed them of the incident. The SDM identified that the DON had identified if the SDM wanted to pursue any further action that the Ministry and police would have to be notified. The SDM identified the DON was told that they wanted further action taken and to notify the Ministry and police. The licensee failed to ensure that the resident's SDM are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [O.Reg. 79/10, s. 97(1)(b)] (163)
2. Inspector reviewed the home's internal "unusual incident report" which identifies a incident in which a staff member identifies a second staff member failed to follow the resident's plan of care resulting in the resident sustaining an injury. The inspector spoke with the resident's SDM. The SDM identified the injury had been noticed during a visit to the resident but despite inquiries to the home staff notification of how the injury was sustain was not provided. Inspector spoke with a DON. The DON identified that the SDM was not made aware that the resident's injury was caused by a staff member failing to follow the resident's plan of care. The licensee failed to ensure that the resident's SDM is notified within 12 hours upon becoming aware of alleged, suspected or witnessed neglect of a resident. [O.Reg 79/10, s.97(1)(b)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 21, 2012

Order # / Ordre no : 004-A **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s.6. The compliance plan shall include how the licensee will ensure the written plans of care for four identified residents, and all residents of the home, are reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary and how the licensee will ensure the care set out in the plan will be provided to the residents.

The plan is to be submitted in writing to Long Term Care Homes Inspector, Melissa Chisholm, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, ON, P3E 6A5 by March 9, 2012. The plan shall be fully implemented by April 20, 2012.

Grounds / Motifs :

1. Inspector reviewed the health care record of a resident. Inspector noted the the resident had a foley catheter. Inspector reviewed the Kardex and care plan for the resident and noted it had not been updated to include the use of a foley catheter. Both the Kardex and care plan identified the resident on a toileting schedule. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)] (196)
2. Inspector reviewed the plan of care for a resident. Inspector noted an intervention under sections titled "Falls" and "Safety". Inspector observed on February 7, 2012 while the resident was in bed that the fall prevention interventions were not being followed. The licensee failed to ensure care was provided as per the plan of care. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)] (188)
3. Inspector reviewed the plan of care for a resident. Inspector noted an intervention under a section related to falls. Inspector observed the resident multiple times on February 7, 2012. Inspector noted that the interventions related to fall prevention were not followed during the observation. The licensee failed to ensure that care is provided as specified in the plan. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)] (188)
4. Inspector reviewed a residents printed plan of care located in the care plan binders at the nursing station. Inspector noted this resident's plan of care identified that the resident should receive a specific diet with several restrictions. Inspector reviewed the resident's most recent assessment completed by the Registered Dietitian and noted the diet was changed and the restrictions no longer in place. The plan of care was not updated to include the resident's new diet without restrictions. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)] (122)
5. Inspector reviewed the health care record of a resident. Inspector noted a physician's order to check the residents blood glucose twice daily. Inspector reviewed the plan of care including Kardex for the resident and noted it identifies that the resident is to have blood glucose monitoring seven times a day. The resident's plan of care has not been updated to include the new physician's order. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)] (196)
6. Inspector reviewed the health care record of a resident. Inspector noted a physician's order to discontinue the resource supplement as previously ordered. Inspector reviewed the plan of care for this resident and noted it included the administration of the resource supplement. Inspector spoke with a RPN who confirmed that the resident no longer receives resource supplement and acknowledged that the care plan in the PSW binder needed to be updated. Inspector noted the plan of care also identified the resident to be on contact isolation however the RPN confirmed to the inspector that isolation precautions are no longer being followed. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : ~~Mar 30, 2012~~ April 20, 2012

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005-A **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s.110. In particular this plan shall address how the licensee will ensure residents are monitored while restrained at least every hour, residents are released from the physical devices and repositioned at least once every two hours and the residents conditions are reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff at least every eight hours. Further, the plan shall include that every use of a physical device to restrain a resident under section 31 of the Act is documented, including all assessments, reassessments and monitoring, including the resident's response.

The plan is to be submitted in writing to Long Term Care Homes Inspector, Melissa Chisholm, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, ON, P3E 6A5 by March 9, 2012. The plan must be fully implemented by June 22, 2012.

Grounds / Motifs :

1. Inspector reviewed the health care record for a resident. Inspector noted that the resident has a physician's order for a physical restraint. Inspector reviewed the home's policy related to restraint use and noted the following under the procedure section for the Director of Nursing and RHA team leader, "The Team Leader reviews the need for continued use and the appropriateness of the type of restraint and initials the HCA Restraint Flow Sheet on each shift to indicate that this process has been done". Inspector reviewed the January 2012 Restraint Flow Sheet for this resident. Inspector noted no RPN signatures for any shifts in January 2012. Inspector spoke with a RPN who identified that she has never signed for this resident or any residents' restraints. The RPN identified the order for restraint is also included on the resident's medication administration record (MAR), but continued to identify that she does not sign for the reassessment of the residents' restraint on the MAR either. The licensee failed to ensure that the residents' condition has been reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff at least every eight hours. [O.Reg. 79/10, s.110(2)(6)] (188)
2. Inspector reviewed the health care record for a resident. Inspector noted that this resident has a physician's order for a physical restraint. Inspector reviewed the documentation, on the Restraint Flow Sheet, for this resident for the month of January 2012. Inspector noted that documentation was not completed for 16 of 31 day shifts in January 2012. Inspector noted that documentation was not completed for 4 of 31 evening shifts in January 2012. The licensee failed to ensure that documentation includes who applied the device and the time of application. [O.Reg. 79/10, s.110(7)(5)] (188)
3. Inspector reviewed the health care record for a resident. Inspector noted that this resident has a physician's order for a physical restraint. Inspector reviewed the documentation, on the Restraint Flow Sheet, for this resident for the month of January 2012. Inspector noted that no documentation was completed for 16 of 31 day shifts and 4 of 31 evening shifts in January 2012. Inspector reviewed the completed documentation and noted that 6 of the 14 documented day shifts does not include the resident's response, and 5 of the 27 documented evening shifts does not include the resident's response. The licensee failed to ensure that documentation includes all assessments, reassessments and monitoring, including the resident's response. [O.Reg. 79/10, s.110(7)(6)] (188)
4. Inspector reviewed the health care record for a resident. Inspector noted that this has a physician's order for a physical restraint. Inspector reviewed the documentation, on the Restraint Flow Sheet, for this resident for the month of January 2012. Inspector noted that no documentation was completed for 16 of 31 day shifts and 4 of 31

evening shifts in January 2012. The licensee failed to ensure that documentation includes every release of the device and repositioning. [O.Reg. 79/10, s.110(7)(7)] (188)
5. Inspector reviewed the health care record for a resident. Inspector noted that this resident has a physician's order for a physical restraint. Inspector reviewed the documentation, on the Restraint Flow Sheet, for this resident for the month of January 2012. Inspector noted that no documentation was completed for 16 of 31 day shifts and 4 of 31 evening shifts in January 2012. The licensee failed to ensure that documentation includes the removal of the device and post-restraining care. [O.Reg. 79/10, s.110(7)(8)] (188)
6. Inspector observed a resident on February 7, 2012 in the common area on a unit from 13:57h until 16:11h. The resident had a physical restraint applied during this time. Inspector observed that hourly checks of the resident were performed, however at no time over this observation period (greater than 2 hours) was the restraint released and repositioned. Inspector reviewed the January 2012 restraint flow sheet for the evening shift(14:00h-22:00h). 27 of 31 days were documented, of the 27 documented evening shifts it indicates the restraint was released and the resident repositioned every 2 hours only on 4 days. The remaining documented days indicate the resident was restrained between 3 and 5 hours without being repositioned or released. The licensee failed to ensure that staff release the restraint and reposition the resident at least every 2 hours. [O.Reg. 79/10, s.110(2)(4)] (188)
7. Inspector observed a resident had two long rails and was unable to release the physical device. Inspector interviewed an RPN who identified it was the resident's choice to have 2 rails thus the staff do not monitor the resident. On the same day, Inspector also interviewed a PSW. The PSW reported to the inspector that monitoring protocol are not used when the rails are in the up position. The licensee has not ensured the resident being restrained by a physical device is provided with monitoring at least every hour by a member of the nursing staff. [O. Reg. 79/10, s.110(2)(3)] (163)
8. Inspector reviewed a resident's health care record. The inspector was unable to locate documentation regarding the person who applied the device and the time of application. Inspector interviewed an RPN. The RPN confirmed that there is no documentation in this resident's health care record indicating the person who applied the device and the time of application. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act provides documentation as to the person who applied the device and the time of application.[O.Reg. 79/10, s.110 (7)(5)] (163)
9. Inspector reviewed a resident's health care record. The inspector was unable to locate documentation regarding the assessment, reassessment and monitoring, including the resident's response to the restraint. Inspector interviewed an RPN. The RPN confirmed that there is no documentation in this resident's health care record indicating assessment, reassessment and monitoring, including the resident's response to the restraint. 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 with regards to assessment, reassessment and monitoring, including the resident's response. [O.Reg. 79/10, s.110(7)(6)] (163)
10. Inspector reviewed a resident's health care record. The inspector was unable to locate documentation regarding every release of the device and all repositioning. Inspector interviewed a RPN. The RPN confirmed that there is no documentation in this resident's health care record indicating every release of the device and all repositioning. The licensee has failed to ensure the every use of a physical device to restrain a resident under section 31 of the Act is documented with regards to every release of the device and all repositioning. [O.Reg. 79/10, s.110(7)(7)] (163)
11. Inspector reviewed a resident's health care record. Inspector noted that the "restraint flow sheet" for use of two physical restraints for the month of February 2012 did not contain the initials of the RPN for February 1st through to February 8th, 2012 inclusive. The sheet did not contain the PSW initial or notation of resident response for for a total of five PSW shifts in that same time period. Interview conducted with an RPN who stated "the HCA had not documented as they should", in reference to area for RPN initials the RPN stated "last thing on my mind with the outbreak". The licensee failed to ensure that documentation includes all assessments, reassessments and monitoring, including the resident's response. [O.Reg. 79/10, s.110(7)(6)] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : ~~Apr 20, 2012~~ June 22, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of February, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 30, 31, Feb 1, 2, 3, 6, 7, 8, 9, 10, 12, 15, 16, 17, 2012	2012_099188_0005	Resident Quality Inspection

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1

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

F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

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

MELISSA CHISHOLM (188), DIANA STENLUND (163), LAUREN TENHUNEN (196), ROSE-MARIE FARWELL (122)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Executive Manager of Nursing Services, Executive Director of Finance and Corporate Services, Executive Director of Staff and Resident Services, Director of Food Services, Directors of Nursing, Director of Environmental Services, Assistant Director of Environmental Services, Director of Human Resources, Registered Nursing Staff, Personal Support Workers, Residents, Resident Council President, Families and Family Council President.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, observed meal service, reviewed resident's health care records, reviewed various 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

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system
Specifically failed to comply with the following subsections:

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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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. Inspector observed on February 1, 2012 that a resident's Versus badge attached to the resident's clothing did not activate when tested by the inspector. Inspector spoke with a RPN who confirmed that it was not functioning and required the batteries to be changed. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
2. Inspector observed on February 1, 2012 that the following call bell in a resident room did not activate when tested by the inspector. Cedar Groove 121-A. The licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
3. Inspector observed on February 2, 2012 at 10:16h in the spa room on Birch Lane 2 that five of the five call bells did not activate when tested by the inspector and by a PSW. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
4. Inspector observed on February 2, 2012 at 09:46h in the spa room on Birch Lane 1 that four of the five call bells did not activate when tested by the inspector and by a PSW. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
5. Inspector observed on January 31, 2012 that the following call bells did not activate when tested by the inspector. Cedar Groove room 302-A and Birch Lane 319 washroom. Inspector observed on February 1, 2012 that the following call bells did not activate when tested by the inspector. Driftwood Beach 309-A, 315-A, Apple Orchard 321-A, Driftwood Beach 315 washroom, Apple Orchard 321 washroom and Apple Orchard 3 spa room (beside toilet). The licensee failed to ensure the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
6. Inspector observed on January 31, 2012 at 11:40h in the spa room on Cedar Grove 3 that five of the five call bells did not activate when tested by the inspector. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
7. Inspector observed on January 31, 2012 at 10:20h that the following call bells did not activate. Cedar Grove 319 and 311-B. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
8. Inspector observed on February 1, 2012 at 10:00h in the spa room on Apple Orchard 2 that five of five call bells did not activate when tested by the inspector. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]

Additional Required Actions:

CO # - 901, 902 were served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector reviewed a progress note entry and the home's internal "unusual incident report" . Both describe the resident sustaining an injury following staff not following the established plan of care relating to transferring. Inspector spoke with a DON who confirmed the incident and provided a copy of the home's original "unusual incident report" to the inspector. The licensee failed to ensure that staff use safe transferring techniques when assisting residents. [O.Reg. 79/10, s.36]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector reviewed a progress note entry and the home's internal "unusual incident report". Both describe the resident sustaining an injury following staff failing to follow the established plan of care. Inspector spoke with a Director of Nursing (DON). The DON confirmed the incident and provided a copy of the home's original "unusual incident report" to the inspector. When asked by the inspector the DON identified that a Mandatory Report had not been submitted related this is incident of improper care. The licensee failed to report the improper care of a resident which resulted in a risk of harm. [LTCHA 2007, S.O. 2007, c.8, s.24(1)]
2. Inspector reviewed a Critical Incident Report in which a resident was abused by a staff. The Critical Incident identifies that the Director was not notified until almost 48 hours after the initial incident. The licensee failed to ensure the Director is immediately notified of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)]

Additional Required Actions:

CO # - 002 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. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's internal "unusual incident report" which identifies a incident in which a staff member identifies a second staff member failed to follow the resident's plan of care resulting in the resident sustaining an injury. Inspector spoke with the resident's SDM who identified that they had not been notified of any results of the home's investigation into the resident's injury. Inspector spoke with the DON who identified that the results of the investigation were not shared with the SDM and identified hesitation with sharing results of investigations with SDM's. The licensee failed to ensure the SDM was immediately notified of the results of the investigation upon the completion. [O.Reg. 79/10, s.97(2)]
2. Inspector reviewed the home's internal "unusual incident report" which identifies a incident in which a staff member identifies a second staff member failed to follow the resident's plan of care resulting in the resident sustaining an injury. The inspector spoke with the resident's SDM. The SDM identified the injury had been noticed during a visit to the resident but despite inquiries to the home staff notification of how the injury was sustain was not provided. Inspector spoke with a DON. The DON identified that the SDM was not made aware that the resident's injury was caused by a staff member failing to follow the resident's plan of care. The licensee failed to ensure that the resident's SDM is notified within 12 hours upon becoming aware of alleged, suspected or witnessed neglect of a resident. [O.Reg 79/10, s.97(1)(b)]
3. Inspector #188 interviewed a resident's SDM about an alleged abuse incident. The SDM reported to the inspector that they were not informed within 12 hours of the incident. The SDM identified that a phone call was received from the DON and that the DON informed them of the incident. The SDM identified that the DON had identified if the SDM wanted to pursue any further action that the Ministry and police would have to be notified. The SDM identified the DON was told that they wanted further action taken and to notify the Ministry and police. The licensee failed to ensure that the resident's SDM are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [O.Reg. 79/10, s. 97(1)(b)]

Additional Required Actions:

CO # - 003 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. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

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

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector noted a physician's order to discontinue the resource supplement as previously ordered. Inspector reviewed the plan of care for this resident and noted it included the administration of the resource supplement. Inspector spoke with a RPN who confirmed that the resident no longer receives resource supplement and acknowledged that the care plan in the PSW binder needed to be updated. Inspector noted the plan of care also identified this resident to be on contact isolation however the RPN confirmed to the inspector that the resident no longer requires isolation precautions. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)]
2. Inspector reviewed the health care record of a resident. Inspector noted a physician's order identifies the resident's blood glucose to be monitored twice daily. Inspector reviewed the plan of care including Kardex for this resident and noted it identifies that the resident should receive blood glucose monitoring seven times a day. The resident's plan of care has not been updated to include the new physician's order. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)]
3. Inspector reviewed a residents printed plan of care located in the care plan binders at the nursing station. Inspector noted this resident's plan of care identified that the resident should receive a specific diet with several restrictions. Inspector reviewed the resident's most recent assessment completed by the Registered Dietitian and noted the diet was changed and the restrictions no longer in place. The plan of care was not updated to include the resident's new diet without restrictions. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)]
4. Inspector reviewed the plan of care for a resident. Inspector noted an intervention under a section related to falls. Inspector observed the resident multiple times on February 7, 2012. Inspector noted that the interventions related to fall prevention were not followed during the observation. The licensee failed to ensure that care is provided as specified in the plan. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)]
5. Inspector reviewed the plan of care for a resident. Inspector noted an intervention under sections titled "Falls" and "Safety". Inspector observed on February 7, 2012 while the resident was in bed that the fall prevention interventions were not being followed. The licensee failed to ensure care was provided as per the plan of care. [LTCHA, 2007, S.O. 2007, c.8, s.6(7)]
6. Inspector reviewed the health care record of a resident. Inspector noted the the resident had a foley catheter. Inspector reviewed the Kardex and care plan for the resident and noted it had not been updated to include the use of a foley catheter. Both the Kardex and care plan identified the resident on a toileting schedule. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary. [LTCHA, 2007, S.O. 2007, c.8, s.6(10)(b)]

Additional Required Actions:

CO # - 004 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

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:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Inspector reviewed a resident's health care record. Inspector noted that the "restraint flow sheet" for use of two physical restraints for the month of February 2012 did not contain the initials of the RPN for February 1st through to February 8th, 2012 inclusive. The sheet did not contain the PSW initial or notation of resident response for for a total of five PSW shifts in that same time period. Interview conducted with a RPN who stated "the HCA had not documented as they should", in reference to area for RPN initials the RPN stated "last thing on my mind with the outbreak". The licensee failed to ensure that documentation includes all assessments, reassessments and monitoring, including the resident's response. [O.Reg. 79/10, s.110(7)(6)]
2. Inspector reviewed a resident's health care record. The inspector was unable to locate documentation regarding every release of the device and all repositioning. Inspector interviewed a RPN who confirmed that there is no documentation in the residents health care record indicating every release of the device and all repositioning. The licensee has failed to ensure the every use of a physical device to restrain a resident under section 31 of the Act is documented with regards to every release of the device and all repositioning. [O.Reg. 79/10, s.110(7)(7)]
3. Inspector reviewed a resident's health care record. The inspector was unable to locate documentation regarding the assessment, reassessment and monitoring, including the resident's response to the restraint. Inspector interviewed a RPN who confirmed that there is no documentation in the resident's health care record indicating assessment, reassessment and monitoring, including the resident's response to the restraint. 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 with regards to assessment, reassessment and monitoring, including the resident's response[O.Reg. 79/10, s.110(7)(6)]
4. Inspector reviewed a resident's health care record. The inspector was unable to locate documentation regarding the person who applied the device and the time of application. Inspector interviewed a RPN on who confirmed that there is no documentation in the resident's health care record indicating the person who applied the device and the time of application. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act provides documentation as to the person who applied the device and the time of application.[O.Reg. 79/10, s.110 (7)(5)]
5. Inspector observed a resident had two long rails and was unable to release the physical device. Inspector interviewed an RPN who identified it was the resident's choice to have 2 rails thus the staff do not monitor the resident. On the same day, Inspector also interviewed a PSW. The PSW reported to the inspector that monitoring protocol are not used when the rails are in the up position. The licensee has not ensured the resident being restrained by a physical device is provided with monitoring at least every hour by a member of the nursing staff. [O. Reg. 79/10, s.110(2)(3)]
6. Inspector observed a resident on February 7, 2012 in the common area from 13:57h until 16:11h. The resident had a physical restraint applied during this time. Inspector observed that hourly checks of the resident were performed, however at no time over this observation period (greater than 2 hours) was the restraint released and the resident repositioned. Inspector reviewed the January 2012 restraint flow sheet for this resident for the evening shift(14:00h-22:00h). 27 of 31 days were documented, of the 27 documented evening shifts it indicates the restraint was released and the resident repositioned every 2 hours only on 4 days. The remaining documented days indicate the resident was restrained between 3 and 5 hours without being repositioned or released. The licensee failed to ensure that staff release the restraint and reposition the resident at least every 2 hours. [O.Reg. 79/10, s.110(2)(4)]
7. Inspector reviewed the health care record for a resident. Inspector noted that this resident has a physicians order for a physical restraint. Inspector reviewed the documentation, on the Restraint Flow Sheet, for the month of January 2012. Inspector noted that no documentation was completed for 16 of 31 day shifts and 4 of 31 evening shifts in January 2012. The licensee failed to ensure that documentation includes the removal of the device and post-restraining care. [O.Reg. 79/10, s.110(7)(8)]
8. Inspector reviewed the health care record for a resident. Inspector noted that the resident has a physician's order for a physical restraint. Inspector reviewed the documentation, on the Restraint Flow Sheet, for this resident for the month of January 2012. Inspector noted that no documentation was completed for 16 of 31 day shifts and 4 of 31 evening shifts in January 2012. The licensee failed to ensure that documentation includes every release of the device and repositioning. [O.Reg. 79/10, s.110(7)(7)]
9. Inspector reviewed the health care record for a resident. Inspector noted that this resident has a physician's order for a physical restraint. Inspector reviewed the documentation, on the Restraint Flow Sheet, for this resident for the month of January 2012. Inspector noted that no documentation was completed for 16 of 31 day shifts and 4 of 31 evening shifts in January 2012. Inspector reviewed the completed documentation and noted that 6 of the 14 documented day shifts does not include the resident's response, and 5 of the 27 documented evening shifts does not include the resident's response. The licensee failed to ensure that documentation includes all assessments, reassessments and monitoring, including the resident's response. [O.Reg. 79/10, s.110(7)(6)]

10. Inspector reviewed the health care record for a resident. Inspector noted that the resident has a physician's order for a physical restraint. Inspector reviewed the documentation, on the Restraint Flow Sheet, for this resident for the month of January 2012. Inspector noted that documentation was not completed for 16 of 31 day shifts in January 2012. Inspector noted that documentation was not completed for 4 of 31 evening shifts in January 2012. The licensee failed to ensure that documentation includes who applied the device and the time of application. [O.Reg. 79/10, s.110(7)(5)]
11. Inspector reviewed the health care record for a resident. Inspector noted that this resident has a physician's order for a physical restraint. Inspector reviewed the home's policy related to restraint use and noted the following under the procedure section for the Director of Nursing and RHA team leader, "The Team Leader reviews the need for continued use and the appropriateness of the type of restraint and initials the HCA Restraint Flow Sheet on each shift to indicate that this process has been done". Inspector reviewed the January 2012 Restraint Flow Sheet for a resident. Inspector noted no RPN signatures for any shifts in January 2012. Inspector spoke with a RPN who identified that she has never signed for this resident's or any residents' restraints. The RPN identified the order for restraint is also included on the resident's medication administration record (MAR), but continued to identify that she does not sign for the reassessment of the residents' restraint on the MAR either. The licensee failed to ensure that the residents' condition has been reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff at least every eight hours. [O.Reg. 79/10, s.110(2)(6)]

Additional Required Actions:

CO # - 005 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. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record for a resident on February 8, 2012. The inspector was unable to locate consent signed by the resident for use of a restraint, two full bed rails. The licensee failed to ensure that restraining of a resident has been consented to by the resident. [LTCHA, 2007, S.O. 2007, c.8, s.31(2)(5)]
2. Inspector reviewed the health care record for a resident on February 8, 2012. The inspector was unable to locate an order or approval by a physician or registered nurse in the extended class for use of a restraint, two full bed rails. The licensee failed to ensure that a physician or registered nurse in the extended class has ordered or approved the restraint of two full bed rails for Plennevaux. [LTCHA, 2007, S.O. 2007, c.8, s.31(2)(4)]
3. Inspector reviewed the health care record for a resident on February 7, 2012. Inspector noted that this resident has a physician's order for a physical restraint. Inspector was unable to locate an assessment or any documentation which includes what alternatives to restraining were considered, and tried, but have not been effective in addressing the risk. Inspector spoke with a DON who identified that currently the home does not use a formal assessment or document alternatives to restraining. The DON reported that the home always uses the least restraining method and that with upcoming review of the restraint policy, alternatives to restraining will be documented. The licensee failed to ensure the restraint plan of care identifies what alternatives to restraining were considered, tried if appropriate, but would not be, or have not been, effective to address the risk the resident or another person would suffer. [LTCHA, 2007, S.O. 2007, c.8, s.31(2)(2)]
4. Inspector reviewed the health care record for a resident on February 7, 2012. Inspector noted that this resident has a physician's order for a physical restraint. Inspector was unable to locate an assessment or any documentation which identifies the significant risk this resident or another person would suffer serious bodily harm if the resident was not restrained. Inspector spoke with a DON who identified that currently the home does not use a formal assessment or document the risk the resident suffers but identified this would be considered when determining if a restraint would be appropriate. The licensee failed to ensure the restrain plan of care identifies the significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained. [LTCHA 2007, S.O. 2007, c.8, s.31(2)(1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring restraining of a resident by a physical device is included in the resident's plan of care only if all requirements under the Act are satisfied, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.

Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices;
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
(d) types of physical devices permitted to be used;
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. Inspector reviewed the home's policy titled "Residents requiring physical restraint" dated February 2010. Inspector noted this policy does not identify how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and the Regulations. The licensee failed to ensure the home's written policy under section 29 of the Act identifies how the home will evaluate to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and the Regulations. [O.Reg. 79/10, s.109(g)]
2. Inspector reviewed the home's policy titled "Residents requiring physical restraint" dated February 2010. Inspector noted this policy does not address alternative to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach. The licensee failed to ensure the home's written policy under section 29 of the Act identifies how alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach. [O.Reg. 79/10, s.109(f)]
3. Inspector reviewed the home's policy titled "Residents requiring physical restraint" dated February 2010. Inspector noted this policy does identify that consent is required when initiating a restraint but fails to identify the use of personal assistive service devices (PASD) and how consent is obtained and documented. The licensee failed to ensure the home's written policy under section 29 of the Act identifies how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented. [O.Reg. 79/10, s.109(e)]
4. Inspector reviewed the home's policy titled "Residents requiring physical restraint" dated February 2010. Inspector noted this policy does identify that "A physical restraint may be applied to a resident on the direction of Registered Nurse where there is an immediate risk of injury to the resident or to others". However the policy fails to identify the requirements of the Regulations related to restraining under the common lay duty as described in section 36 of the Act. The licensee failed to ensure the home's written policy under section 29 of the Act deals with restraining under the common law duty pursuant to subsection 36(1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others. [O.Reg. 79/10, s.109(c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the home's written policy to minimize restraining of residents includes all requirements identified in the regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. Inspector reviewed the health care record for a residenton February 7, 2011. Inspector noted the last documented medication review was completed September 30, 2011. Inspector spoke with a RPN on February 7, 2012 and confirmed that this was the most current quarterly medication review. The licensee failed to ensure that at least quarterly there is a documented reassessment of reach resident's drug regime. [O.Reg. 79/10, s.134(c)]
2. Inspector reviewed the health care record for a resident on February 7, 2012. Inspector noted the last documented medication review was completed on May 17, 2011. The licensee failed to ensure that at least quarterly there is documented reassessment of each resident's drug regime [O.Reg. 79/10, s.134(c)]
3. Inspector reviewed the health care record for a resident on February 7, 2012. Inspector noted the last documented medication review was completed on August 17, 2011. The licensee failed to ensure that at least quarterly there is a documented reassessment of reach resident's drug regime. [O.Reg. 79/10, s.134(c)]
4. Inspector reviewed the health care record for a resident on February 8, 2012. Inspector noted the last documented medication review was completed on September 9, 2011. Inspector spoke with the a RPN who spoke with the pharmacy service provider and confirmed that there has not been a quarterly medication review since September 2011. The licensee failed to ensure that at least quarterly there is a documented reassessment of each resident's drug regime. [O.Reg. 79/10, s.134(c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring there is, at least quarterly, a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following subsections:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The critical incident report that was submitted to the Ministry which identified that a resident failed to receive adequate oral hygiene as was assessed by a Registered Dental Hygienist. The licensee of a long-term care home failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures and physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth [O.Reg.79/10,r.34.(1)(a)].
2. Inspector reviewed the plan of care for a resident. The plan of care related to oral care identifies "mouth care standard in effect, to include cleaning of teeth after each meal, rinsing mouth and checking for any obvious deterioration of teeth and gums". Inspector observed the resident on February 7, 2012 at 10:46h. Inspector observed that this resident had food like particles in between teeth and plaque like build up along the gum line. Inspector observed the same resident at 14:01h (after lunch) and again at 16:03h. Inspector noted that during both follow-up observations that the resident continued to have food like particle in between teeth and plaque like build up along the gum line. The licensee failed to ensure that this resident received oral care to maintain the integrity of the oral tissue. [O.Reg. 79/10, s.34(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 ensuring each resident of the home receives oral care to maintain the integrity of the oral tissue, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey
Specifically failed to comply with the following subsections:

s. 85. (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. Inspector interviewed a member of the Family Council on February 9, 2012. It was identified to the inspector that the council has not had any involvement with the satisfaction survey, have not been asked for recommendations for the survey or been given the opportunity to give input regarding the survey. The licensee failed to seek the advice of the Family Council in developing and carrying out the survey, and in acting on its results. [LTCHA 2007, S.O. 2007, c.8, s.85 (3)].
2. Inspector interviewed the President of the Residents' Council on February 06, 2012. It was reported that the licensee has not sought the Residents' Council's advice in developing and carrying out the resident satisfaction survey and in acting on its results. 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.[2007, c.8,s.85(3)].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the licensee seeks the advice of Family and Residents' Councils in developing and carrying out the satisfaction survey and in acting on its results, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident on February 8, 2012. Inspector noted this resident is identified as incontinent. Inspector was unable to locate an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. Inspector interviewed the RAI coordinator on February 8, 2012 at 11:10h. The RAI coordinator stated "there is no incontinence assessment for bladder or bowel, we don't have one in place yet". The licensee failed to ensure that each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.[O.Reg. s.51(2)(a)]
2. Inspector reviewed the health care record of a resident on February 8, 2012. Inspector noted this resident is identified as incontinent. Inspector was unable to locate an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. Inspector interviewed the RAI coordinator on February 8, 2012 at 11:10h. The RAI coordinator stated "there is no incontinence assessment for bladder or bowel, we don't have one in place yet". The licensee failed to ensure that each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.[O.Reg. s.51(2)(a)]
3. Inspector reviewed the health care record for a resident on February 8, 2012. Inspector noted this resident is incontinent. Inspector was unable to locate a incontinence assessment using a clinically appropriate assessment instrument. The licensee failed to ensure that a resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [O.Reg. 79/10 s.51(2)(a)]
4. Inspector reviewed the health care record of a resident and was unable to locate an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. Inspector interviewed the RAI Co-ordinator about an incontinence assessment for this resident: "There is no incontinence assessment for bladder or bowel, we don't have one in place yet". The licensee failed to ensure that each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.[O.Reg. s.51(2)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program
Specifically failed to comply with the following subsections:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Inspector interviewed a Charge Nurse who is involved with resident immunizations on February 06, 2012. The nurse reviewed, with the inspector, immunization records for tetanus and diptheria for five residents. There was no evidence to show that any of these five residents were offered immunizations against tetanus and diptheria. The nurse added "we have not started offering tetanus and diptheria yet." The licensee failed to ensure that residents are offered immunizations against tetanus and diptheria. [O.Reg. 79/10, s.229(10)3]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring all residents are offered immunization against tetanus and diptheria, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector reviewed the home's medication policy #04-01-40 titled "Narcotic and Controlled Drugs" which identifies "Narcotic and controlled drugs must be stored in a double locked container in either the medication room or the medication care. Inspector observed on February 7, 2012 on Cedar Grove third floor, medication cards labeled with resident names containing Lorazepam (controlled substance), are not under double lock within the medication cart. The licensee of a long-term care home failed to ensure that 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)(b)]
2. Inspector observed on February 7, 2012 at 11:40h, that a blister pack of Lorazepam 0.5mg prn (controlled substance) ordered for a resident was stored in the drawer outside of the locked cabinet of the medication cart. A RPN was interviewed by the inspector and reported that only narcotics are stored in the locked cabinet of the medication cart. The licensee failed to ensure that 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)(b)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector noted this resident had been ordered a treatment cream four times daily and as required. The treatment administration record (TAR) has been signed by the registered staff indicating that the PSW has applied the cream. During an interview with the inspector, the PSW assigned to the resident stated "has not applied any creams to this resident's buttocks, no need for it". The licensee failed to ensure that the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. [O. Reg. 79/10, s. 131(4)(c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the staff member who administers the topical does so under the supervision of the member of the registered nursing staff, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident on February 12, 2012. Inspector noted this resident developed altered skin integrity at which time an initial assessment of the wound was completed. There have been no further documented assessments by a member of the registered staff since that time(two and a half weeks later). The licensee failed to ensure that, a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff. [O.Reg. 79/10 s.50(2)(b)(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 ensuring any resident who exhibits altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #17: 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 subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Inspector spoke with the a resident's substitute decision-maker (SDM). The SDM reported to the inspector concerns over an incident in which the resident sustained an injury approximately 2 months prior. The SDM reported that despite asking "management" what happened and expressing frustrations over the resident sustaining the injury a response from "management" has not yet been received.

Inspector reviewed a form titled "unusual incident report" which describes the incident which resulted in the resident sustaining the injury. The incident report identified that a staff member did not follow the resident's plan of care, which identifies a requirement of two staff member for transferring resulting in the injury during transfer. Inspector noted the incident report is signed by the RPN who completed it and the DON. Inspector spoke with the DON related to the incident. When asked by the inspector about the investigation the DON was unable to describe any investigation that took place following the incident. The licensee failed to ensure that every witnessed incident of neglect of a resident by staff is immediately investigated. [LTCHA 2007, S.O. 2007, c.8, s.23(1)]

2. Inspector spoke with DON on February 9, 2012 to discuss what actions were taken in response to an incident involving a resident sustaining an injury. The DON identified that herself and the Executive Manager of Nursing Services, had reviewed the resident's plan of care with staff to remind them that two people need to be present for all transfers. When asked by the inspector if the staff member involved had been followed up with the DON identified that "they did not want to single anyone out". The DON was unable to describe any additional action taken is response to the incident. The licensee failed to ensure that appropriate action is taken in response to every such incident. [LTCHA, 2007, S.O. 2007, c.8, s.23(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 ensuring every incident of alleged, suspected or witnessed incident of neglect of a resident by anyone is immediately investigated and appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. Interview conducted with a DON on February 9, 2012 at 12:00h. The DON stated that a staff member in the home has access to the government stock. According to the DON this staff member is not a registered staff member, is not the administrator and is not able to otherwise dispense medication. The licensee failed to ensure that access to medication storage areas is restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [O.Reg. 79/10, s.130(2)]
2. Inspector interviewed a RPN on February 7, 2012. The RPN reported that the unit clerks have access to the government stock room. The RPN reported that the clerks deliver the stock to the floors, but emphasized that the clerks do not have access to the medication rooms located on the home areas. The licensee failed to ensure that access to medication storage areas is restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [O.Reg. 79/10, s.130(2)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

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

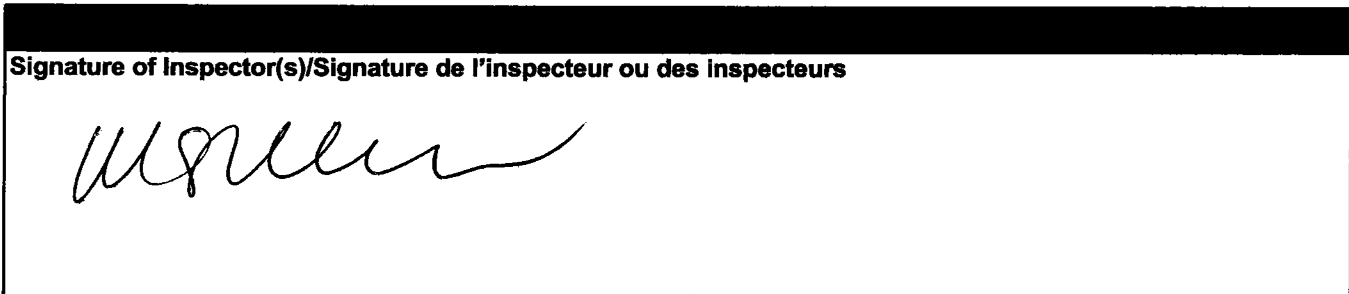
Findings/Faits saillants :

1. Inspector conducted a tour of the home on February 9, 2012 and did not observe a copy of the home's policy to minimize restraining of residents posted in the home. Inspector spoke with a DON and the Staff Services Clerk on February 9, 2012, both staff members reported that to the best of their knowledge a copy of the policy to minimize restraining of residents was not posted in the LTC home. The licensee failed to ensure that a copy of the home's policy to minimize restraining of residents is posted in the home. [LTCHA 2007, S.O. 2007, c.8, s.79(3)(g)]

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:

CORRECTED 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. 3.	CO #001	2011_054133_0030	163

Issued on this 19th day of March, 2012



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