Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA CHISHOLM (188), DIANA STENLUND (163)
Inspection No. / No de l'Inspection :	2012_099188_0027
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Jul 10, 11, 12, 13, 16, 17, 18, 19, 24, 25, 26, 30, 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:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2012_099188_0005, CO #902

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 ensure the home is equipped with a resident-staff communication and response system that is on at all times and clearly indicates when activated where the signal is coming from.

Grounds / Motifs :

1. Two written notifications of non-compliance under O.Reg. 79/10, s.17(1) have previously been issued. Including a voluntary plan of correction (VPC) issued in October 2011 during inspection # 2011_099188_0023 and compliance orders (CO) issued in February 2012 during inspection #2012_099188_0005, CO-901 and CO-902. (163)
2. Inspector observed on July 11, 2012 at 09:58h on the third floor Apple Orchard unit that the call bell above the bed in rooms A315A and A317 did not activate when tested by the inspector and staff member #102. Inspector noted the call lights outside the resident rooms did not activate, nor were the calls recorded on the computer at the nursing station. Inspector noted no page was received to the staff member's pager. The licensee failed to ensure that the home is equipped with a communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (188)
3. Inspector observed on July 12, 2012 at 08:39h on the third floor between Birch Lane and Cedar Grove units that the bathroom bell in room E303 was activated (light outside closed door was flashing). Inspector entered the Birch Lane unit and spoke with staff. It was identified that no page related to the activated bell had been received on the unit. It was identified by the Birch Lane staff that the page should have gone to the Cedar Grove unit. Inspector proceeded to Cedar Grove unit and spoke with staff who acknowledged they did not receive a page related to the activated bathroom bell and identified that the page should have been received on the Birch Lane unit. Inspector noted after discussing the communication-response system with staff #103 that the page should have been received on the Cedar Grove unit. Staff #103 identified that both pagers on Cedar Grove received the call, however staff thought the page was from the washroom on the unit (C303) and not the common area washroom (WC 303). The licensee failed to ensure that the home is equipped with a communication and response system clearly indicates when activated where the signal is coming from. [O.Reg. 79/10, s.17(1)(f)] (188)
4. Inspector observed on July 10, 2012 at 10:54h on the third floor Birch Lane unit that the call bell in the shared washroom in room B321 did not activate the staff pager when tested by the inspector. The licensee failed to ensure that the home is equipped with a communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (163)
5. Inspector observed on July 11, 2012 at 09:40h on the first floor Birch Lane unit that the call bell in the washroom in room B104 did not activate the call lights outside the room, nor did it activate the staff member's pager. The call bell above the bed in resident room B103 did not activate the staff member's pager when tested by the inspector. The licensee failed to ensure that the home is equipped with a communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)] (163)
6. Inspector observed on July 11, 2012 at 09:56h on the first floor Driftwood unit that the call bell in the washroom in room D104 did not activate the light outside the room when tested by the inspector. The licensee failed to ensure that the home is equipped with a 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 : Jul 30, 2012

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0005, CO #005

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all requirements are met with respect to the restraining of a resident by a physical device under section 31 of the Act.

Specifically the licensee shall,

- Ensure that when any resident, specifically residents #587 and #479, are restrained by a physical device, the device shall be applied according to the manufacturer's directions.
- Ensure that when any resident, specifically resident #479, is restrained by a physical device, staff shall apply the device in accordance with any instructions specified by the physician or registered nursing in the extended class.
- Ensure that when any resident, specifically resident #298, is restrained by a physical device, staff release and reposition the resident any other time when necessary based on the resident's condition or circumstances.
- Ensure that when any resident, specifically residents #298, 587, 479, are restrained by a physical device, the resident's condition is reassessed and the effectivesness of the restraining evaluation only by a physician, 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.

The licensee shall ensure that every use of a physical device to restrain a resident, specifically residents #298, 587 and 479, under section 31 of the Act is documented. Specifically, the licensee shall ensure that the following is documented:

- the person who applied the device and the time of application,
- all assessment, reassessment and monitoring, including the resident's response,
- every release of the device and all repositioning
- the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Grounds / Motifs :

1. Two previous written notifications (WN) of non-compliance under O.Reg. s.110 have been issued. Including a compliance order (CO) issued in February 2012 during inspection #2012_099188_0005. (188)
2. Inspector observed resident #298 on July 10, 2012 at 14:06h. Inspector noted the resident had a physical restraint. Inspector noted the resident was not properly positioned while the physical device was applied. Inspector noted staff complete the snack pass, however did not reposition the resident. The resident was not repositioned until 14:42h when the was finally repositioned to be seated properly. The licensee failed to ensure that resident is repositioned at any time based on the resident's condition or circumstances. [O.Reg. 79/10, s.110 (2)(5)] (188)
3. Inspector reviewed the health care record including plan of care for resident #298 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for June 2012 noting that 8 of 30 day shifts and 10 of 30 afternoon shifts had no documentation completed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)] (188)
4. Inspector reviewed the health care record including plan of care for resident #298 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for July 1-9, 2012 noting that 2 of 9 day shifts and 7 of 9 afternoon shifts had no documentation completed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)] (188)
5. Inspector reviewed the health care record including plan of care for resident #298 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the "physical restraint monitoring record" for June 2012 and July 1-9, 2012. Inspector noted that the section for the RPN to initial identifying assessment of the

resident was completely blank for both months. The licensee failed to ensure that a resident is assessed by a member of the registered nursing staff at least every 8 hours or at any other time based on the resident's condition. [O.Reg. 79/10, s.110(2)(6)] (188)

6. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted the resident has a physical restraint. Inspector observed on July 11, 2012 at 09:39h that the resident's physical device was incorrectly applied. Inspector observed on July 11 at 11:44h and 14:02h that the physical device remained incorrectly applied. Inspector spoke with staff #108 on July 11, 2012 at 14:07h who confirmed the physical device was incorrectly applied and proceeded to adjust it. The licensee failed to ensure that the physical device is applied in accordance with the manufacturer's directions. [O.Reg. 79/10, s.110(1)(1)] (188)

7. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for June 2012 noting that 6 of 30 day shifts and 2 of 30 afternoon shifts had no documentation completed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)] (188)

8. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for July 1-9, 2012 noting that 2 of 9 afternoon shifts had no documentation completed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)] (188)

9. Inspector reviewed the health care record including plan of care for resident #479 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector was unable to locate any documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for June 2012 or July 1-10, 2012. Inspector spoke with staff #107 who was also unable to locate the restraint documentation and was unable to articulate why the documentation was not available. A new documentation sheet for July 2012 following the conversation with the inspector was initiated by the staff member. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)] (188)

10. Inspector observed resident #298 on July 12, 2012 at 14:49h. Inspector noted the resident had a physical restraint. Inspector noted the resident was not properly positioned while the physical device was applied. The licensee failed to ensure that resident is repositioned at any time based on the resident's condition or circumstances. [O.Reg. 79/10, s.110(2)(5)] (188)

11. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the "physical restraint monitoring record" for June 2012. Inspector noted that the section for the RPN to initial identifying assessment of the resident was missing 13/30 day shift RPN initials and 19/30 evening/night shift RPN initials. The licensee failed to ensure that a resident is assessed by a member of the registered nursing staff at least every 8 hours or at any other time based on the resident's condition. [O.Reg. 79/10, s.110(2)(6)] (188)

12. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the "physical restraint monitoring record" for July 1-9, 2012. Inspector noted that the section for the RPN to initial identifying assessment of the resident was missing 8 of 9 day shift RPN initials and 5 of 9 evening/night shift RPN initials. The licensee failed to ensure that a resident is assessed by a member of the registered nursing staff at least every 8 hours or at any other time based on the resident's condition. [O.Reg. 79/10, s.110(2)(6)] (188)

13. Inspector reviewed the health care record including plan of care for resident #479. Inspector noted a physician's order for physical restraint. Inspector noted during breakfast and lunch on both July 12 and 13, 2012 that the resident's physical restraint was not removed as per the physician's direction. Inspector spoke with two staff members on the unit who identified they were not aware of the physician's direction related to the physical

device and care plan direction. The licensee failed to ensure that staff apply the physical device in accordance with any directions specified by the physician or registered nurse in the extended class. [O.Reg. 79/10, s.110(2)(2)] (188)
14. Inspector reviewed the health care record including plan of care for resident #479 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector observed during multiple observations on July 11, 12 and 13, 2012 that the physical device was not correctly applied. The licensee failed to ensure that the physical device is applied in accordance with the manufacturer's directions. [O.Reg. 79/10, s.110(1)(1)] (188)
15. Inspector reviewed a critical incident report. Inspector noted the report identifies resident #587 sustained a fall while sitting in a wheelchair. Inspector noted the resident has a physical restraint when in the wheelchair. The critical incident report identifies that the resident was able to "jiggle" the restraint loose resulting in the residents fall to the floor. The plan of care for the resident identifies interventions to prevent it from loosening, however these interventions had not been followed. The licensee failed to ensure that the physical device is applied in accordance with the manufacturer's directions. [O.Reg. 79/10, s.110(1)(1)] (188)

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

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0006, CO #001

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall provide resident #598's family member, who made a verbal complaint to the licensee, a response that indicates what the licensee has done to resolve the complaint or why the licensee believes the complaint to be unfounded and the reasons for the belief. A copy of this response, and any response made in turn by the complainant, shall be included in the home's monthly progress report to the Ministry.

The licensee shall ensure all verbal or written complaints made to the licensee or a staff member concerning the care of a resident or operation of the home are reported, responded to and documented in compliance with the requirements of the Long Term Care Homes Act and regulations. The licensee shall update their documented complaint record to include all verbal and written complaints, except those that have been resolved within 24 hours. Further, the licensee shall maintain an accurate record of complaints which includes all requirements identified in the regulations.

Grounds / Motifs :

1. Two previous written notifications (WN) of non-compliance have been issued under O.Reg. 79/10, s.101 including a compliance order (CO) issued in March 2012 during inspection 2012_099188_0006. (188)
2. Inspector reviewed the home's documented complaint record on July 16, 2012. Inspector noted that the record did not contain any complaints relating to resident #598. The inspector was aware of two complaints brought forward to the home related to resident #598's care. Inspector noted there was no documented record identifying these two complaints. Inspector spoke with staff #106 who confirmed receipt of these complaints and acknowledged they were not included in the home's documented complaint process. The licensee failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant. [O.Reg. 79/10, s.101(2)] (188)
3. Inspector noted a complaint was brought forward to staff #105. Inspector noted that resident #2629's family member expressed concerns. The resident's health care record identifies an unusual occurrence report was completed however staff #105 was unable to locate it during the inspection. This complaint was not included in the home's complaint record. Inspector spoke with staff #105 who received the complaint. When asked if the complaint was dealt with as per the home's written complaint process staff #105 identified she did not recognize it as a complaint. The licensee failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant. [O.Reg. 79/10, s.101(2)] (188)
4. Inspector was made aware of a complaint brought forward to staff #106 by a resident's family member. Inspector noted this complaint related to the care of a resident. Inspector spoke with staff #106 who confirmed receipt of the information and confirmed speaking with the parties involved following the discussion with the family member. Staff #106 however identified that the information was not represented as a complaint and thus not directed through the home's complaint process. No response was provided to the family following their complaint concerning the care of a resident. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint. [O. Reg. 79/10, s.101(1)] (188)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2012_099188_0005, CO #001

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting all residents, specifically residents #380, 303 and 740.

Grounds / Motifs :

1. Five written notifications (WN) of non-compliance under O.Reg. 79/10, s.36 have previously been issued. Including a voluntary plan of correction (VPC) in October 2011 during inspection #2011_099188_0024 and two compliance orders (CO) issued in December 2011 during inspection #2011_099188_00034 and in February 2012 during inspection #2012_099188_0005. (163)
2. Inspector reviewed a critical incident. It identifies that resident #380 fell during a transfer to the bathroom and sustained injuries resulting in transfer to hospital. Inspector interviewed staff #105 on July 16, 2012 about the incident. Staff #105 reported that resident #380 fell when staff were transferring the resident using a chorus lift. The plan of care outlines that for transfers, resident #380 requires a Maxi Lift x2 staff for transfers to the wheel chair. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O.Reg. 79/10, s.36] (163)
3. Inspector reviewed a critical incident. It identifies that staff #154 was observed taking resident #740 to the dining room in a wheel chair and the resident put their feet down thereby stopping the wheelchair. Inspector interviewed staff #107 on July 13, 2012 about the incident. Staff #107 reported that the resident was required to use foot rests and that the staff #154 who pushed the resident's wheelchair acknowledged that the staff did not use the foot rests on the wheel chair as required. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O.Reg. 79/10, s.36] (163)
4. Inspector reviewed a critical incident. It identifies that resident #303 was being transferred from bed. Resident #303 required an over bed lift to get in and out of bed however staff used a Sara lift (sit to stand) to transfer the resident. The report further identifies that the resident's arm hit the door when staff were bringing the resident to the toilet resulting in injury to the resident's arm. The resident's home area 24-Hour Nursing Report indicates for the date if the incident that the resident was transferred with a Sara lift, however the shift report adds that the care plan requires the use of an overhead lift when transferring in and out of bed. The licensee failed to ensure that staff use safe transferring and positioning devices or 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 : Jul 30, 2012

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant:

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to minimize the risk to the resident.

This plan is to be submitted in writing by August 10, 2012 to LTC Homes Inspector Melissa Chisholm, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603 Sudbury, Ontario P3E 6A5. Fax: 705-564-3133. The plan shall be fully implemented by August 31, 2012.

Grounds / Motifs :

1. Inspector reviewed a critical incident where resident #761 was found on the floor. The CI report indicates that resident #761 brought the resident's own bed into the home upon admission. The reports adds that following admission the home provided resident #761 with an alternating air mattress to go on the bed. Inspector reviewed the health care record for resident #761 and was unable to find any documentation that resident #761 bed system was evaluated upon admission or after the alternating air mattress was installed in the bed. Inspector interviewed staff #107 on July 18, 2012. Staff #107 confirmed resident #761's bed system was not evaluated upon the resident's admission to the home or after the home's alternating air mattress was installed on the resident's bed. It was further identified that the home does not currently have a process in place for the evaluation of bed systems when side rails are used in the home. The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [O.Reg. 79/10, s.15(1)a] (163)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant:

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if

appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that all the rights of residents are fully respected and promoted.

Grounds / Motifs :

1. Four previous written notifications (WN) of non-compliance have been issued. Including a voluntary plan of correction in December 2011 during inspection #2012-099188-0034 and a compliance order (CO) in December 2011 during inspection #2012_054133_0030. (188)
2. Inspector reviewed a critical incident. It was identified that staff #150 failed to provide appropriate and safe care to residents #1583, #2583 and #3583. Staff #150 failed to place the identified residents' beds in low positions, ensure that safety mats were on the floor, ensure that half rails were elevated and that call bells were pinned within the residents' reach. These three residents are each assessed at high risk for falls and as requiring these interventions for their own safety. The licensee failed to ensure that the resident's right to live in a safe environment was fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(5)] (188)
3. Inspector reviewed a critical incident. It was identified that at the start of a day shift that nine different residents were found saturated in urine, some with feces and one resident's window had been left open and the resident had been found to be trembling and cold. Through the home's investigation it was determined that appropriate care was not provided to these residents during the night shift. The licensee failed to ensure that during the night shift the residents right's to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(4)] (188)
4. Inspector reviewed a critical incident. It was identified that resident #223 did not receive care from the resident's assigned PSW. The investigation concluded that the resident did receive care from another PSW. It was determined that the resident was originally informed that staff #152 was assigned to the resident, however following communicating this to the resident staff #152 and staff #153 changed their assignments and staff #153 decided to provide care to resident #223. This switch was not communicated to the resident. The licensee failed to ensure that the resident's right to be told who is responsible for and who is providing the resident's direct care was fully promoted and respected. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(7)] (188)
5. Inspector reviewed a critical incident. It was identified that resident #671 had defecated in the tub during a bath and staff continued to bathe the resident in the soiled water. Inspector interviewed staff #107 on July 11, 2012. Staff #107 reported that the staff member involved in the incident acknowledged that resident #671 had defecated in the bath water after the resident was placed in the tub and that the resident remained in the soiled water for the duration of the bath. The licensee failed to ensure that the right's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(1)] (163)
6. Inspector reviewed a critical incident. It was identified that resident #171 requested to go to the bathroom and the staff member assigned refused to assist the resident and went on break. Shortly after, during a tub bath, the resident defecated in the tub leaving the resident emotionally distraught and humiliated. The licensee failed to ensure that the right's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(1)] (188)

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

Order # /
Ordre no : 007

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

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0005, CO #004

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall review and revise the written plan of care for residents #479 and 587. Their plans of care shall set out clear direction to staff and others who provide direct care to the residents and shall be reviewed and revised at any time their care needs change. The licensee shall ensure that all substitute-decision makers are given an opportunity to participate fully in the development and implementation of the plan of care, specifically the substitute-decision maker for resident #209. The licensee shall ensure that the care specified in the plan of care is provided to all residents, specifically resident #209. The licensee shall ensure that the plans of care for all residents in the home meet the requirements under s.6 of the Act.

Grounds / Motifs :

1. Eleven previous written notifications of non-compliance under LTCHA s.6 have been issued. Including one voluntary plan of correction (VPC) issued in October 2011 during inspection #2011_099188_0023 and three compliance orders (CO) issued in December 2011 during inspection #2011_099188_0034, in February 2012 during inspection #2012_099188_0005 and in April 2012 during inspection #2012_099188_0015. (188)
2. Inspector reviewed the health care record including plan of care for resident #479. Inspector noted an intervention related to the physical restraint was to remove it during meal times. Inspector noted on July 12 and 13, 2012 during breakfast and lunch meal services that this intervention was not followed. Inspector spoke with two staff members, on July 13, 2012, who were unaware of this intervention. Staff #104 spoke with a RAI coordinator who identified that the intervention does not provide the correct direction to staff. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)] (188)
3. Inspector reviewed the health care record including plan of care for resident #209. Inspector noted the plan of care contains a fall prevention intervention identifying staff are to ensure versus call bell string is clipped to resident #209 clothing when in bed. Inspector observed resident #209 on July 11th and 12th, 2012 in bed without the versus call bell string clipped to the resident's clothing. Inspector interviewed staff #109 and #107 on July 12, 2012. These staff members confirmed that resident #209 requires the versus call bell string attached to the resident's clothing when in bed. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)] (163)
4. Inspector reviewed the health care record for resident #209. The documentation indicates that resident #209 requires additional foot care treatment and to discuss the need with the resident's substitute decision-maker (SDM). Inspector was unable to locate documentation that confirmed that the resident's SDM was notified of the change in the resident's plan of care. Inspector interviewed staff #107 on July 12, 2012 who confirmed that there was no documentation in the resident's health care record to indicate that the substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care with regards to the resident requiring additional foot care treatment. The licensee failed to ensure the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)] (163)
5. Inspector reviewed a critical incident. It identifies that a staff member found resident #761 had fallen out of bed. The care plan document within the plan of care outlines that resident #761 was to have the bed in lowest position when not providing care. The licensee's documentation of the incident reports that the bed was found at the time of the incident to be at its "highest level". The licensee failed to ensured that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)] (163)
6. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted the plan of care and Kardex related to restraining with a physical device identified specific directions relating to the use of a physical restraint. Inspector observed on July 10 and 11, 2012 that these specific directions were not being followed. Inspector spoke with staff #108 on July 11, 2012 who identified that a change was made to the resident's plan of care and the interventions were. Staff #108 was unable to articulate when this change occurred however identified the plan of care had not been updated to reflect this change. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care in the plan is no longer necessary. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)] (188)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Order # /
Ordre no : 008

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

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0005, CO #002

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. Four previous written notifications of non-compliance have been issued under LTCHA s.24. Two voluntary plans of corrections (VPC) were issued in October 2011 during inspection #2011_099188_0023 and in December 2011 during inspection #2011_054133_0030. Two compliance orders were issued in February 2012 during inspection number 2012_099188_0005 and March 2012 during inspection number 2012_099188_0006. (188)
2. Inspector reviewed a critical incident. This Mandatory Report identifies improper/incompetent treatment of a resident that results in harm or risk to a resident. The incident was reported outside the immediate reporting time frame. The licensee failed to ensure the Director is immediately informed of improper or incompetent treatment of a resident that results in harm or risk to a resident. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(1)] (188)
3. Inspector reviewed a critical incident. This Mandatory Report identifies resident to resident verbal abuse. The incident was witnessed and was reported outside the immediate reporting time frame. The licensee failed to ensure the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)] (188)
4. Inspector reviewed a critical incident. This Mandatory Report identifies staff to resident abuse/neglect. The incident was reported to the Ministry outside the immediate reporting time frame. The licensee failed to ensure the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2) (188)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 009

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

Linked to Existing Order / Lien vers ordre existant:

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD 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.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Order / Ordre :

The licensee shall ensure that when a PASD is used under subsection (3) to assist a resident with a routine activity of living that it is included in the resident's plan of care only if all requirements are satisfied. Specifically, the PASD must have been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations. The licensee shall ensure the PASD 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.

Grounds / Motifs :

1. Inspector reviewed the health care record for resident #761 who was admitted with their own bed that included bed rails for assist. The care plan document in the plan of care identified the resident as requiring these two half rails while in bed. Inspector was unable to locate in the health care record any documentation that identifies the rails, being used as a PASD, had been approved by a physician, registered nurse, registered practical nurse, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations. Further, the inspector was unable to locate any documentation that indicates the use of the rails, as a PASD, were consented to by the resident, or a substitute decision-maker of the resident. The licensee failed to ensure that the use of a PASD to assist a resident with a routine activity of living is included in a resident's plan of care only if all of the following are satisfied: The use of the PASD has been approved by, a physician or, a registered nurse or, a registered practical nurse or, a member of the College of Occupational Therapists of Ontario or a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations, and the use of the PASD 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. [LTCHA 2007, S.O. 2007, c.8, s.33(4)(3)(4)]. (163)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board

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

and the

Director

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

Ontario

Ministry of Health and Long-Term Care

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

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 30th day of Juiy, 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

Ontario

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
Jul 10, 11, 12, 13, 16, 17, 18, 19, 24, 25, 26, 30, 2012	2012_099188_0027	Follow up

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)

Inspection Summary/Résumé de l'Inspection

The purpose of this Inspection was to conduct a Follow up 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, Director of Staff and Resident Services, Directors of Nursing (DON), Registered Nursing Staff (RN/RPN), Personal Support Workers (PSW), Residents and Families.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records, reviewed various policies and procedures, tested the home's communication and response system and reviewed the home's documented compiaint record.

The following previously issued Compliance Orders were reviewed as part of this follow-up inspection. CO#901_2012_099188_0005, CO#902_2012_099188_0005, CO#001_2012_099188_0005, CO#002_2012_099188_0005, CO#003_2012_099188_0005, CO#004_2012_099188_0005, CO#005_2012_099188_0005, CO#001_2012_099188_0006, CO#002_2012_099188_0006, CO#003_2012_099188_0006, CO#004_2012_099188_0006, CO#005_2012_099188_0006, CO#001_2012_099188_0015.

The following Inspection Protocols were used during this Inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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 July 10, 2012 at 10:54h on the third floor Birch Lane unit that the call bell in the shared washroom in room B321 did not activate the staff pager when tested by the inspector. The licensee failed to ensure that the home is equipped with a communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
2. Inspector observed on July 11, 2012 at 09:40h on the first floor Birch Lane unit that the call bell in the washroom in room B104 did not activate the call lights outside the room, nor did it activate the staff member's pager. The call bell above the bed in resident room B103 did not activate the staff member's pager when tested by the inspector. The licensee failed to ensure that the home is equipped with a communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
3. Inspector observed on July 12, 2012 at 08:39h on the third floor between Birch Lane and Cedar Grove units that the bathroom bell in room E303 was activated (light outside closed door was flashing). Inspector entered the Birch Lane unit and spoke with staff. It was identified that no page related to the activated bell had been received on the unit. It was identified by the Birch Lane staff that the page should have gone to the Cedar Grove unit. Inspector proceeded to Cedar Grove unit and spoke with staff who acknowledged they did not receive a page related to the activated bathroom bell and identified that the page should have been received on the Birch Lane unit. Inspector noted after discussing the communication-response system with staff #103 that the page should have been received on the Cedar Grove unit. Staff #103 identified that both pagers on Cedar Grove received the call, however staff thought the page was from the washroom on the unit (C303) and not the common area washroom (WC 303). The licensee failed to ensure that the home is equipped with a communication and response system clearly indicates when activated where the signal is coming from. [O.Reg. 79/10, s.17(1)(f)]
4. Inspector observed on July 11, 2012 at 09:58h on the third floor Apple Orchard unit that the call bell above the bed in rooms A315A and A317 did not activate when tested by the inspector and staff #102. inspector noted the call lights outside the resident rooms did not activate, nor was the calls recorded on the computer at the nursing station. Inspector noted no page was received to the staff member's pager. The licensee failed to ensure that the home is equipped with a communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]
5. Inspector observed on July 11, 2012 at 09:56h on the first floor Driftwood unit that the call bell in the washroom in room D104 did not activate the light outside the room when tested by the inspector. The licensee failed to ensure that the home is equipped with a communication and response system that is on at all times. [O.Reg. 79/10, s.17(1)(b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

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

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 critical incident report. Inspector noted the report identifies resident #587 sustained a fall while sitting in a wheelchair. Inspector noted the resident has a physical restraint while in the wheelchair. The critical incident report identifies that the resident was able to "jiggle" the restraint loose resulting in the resident's fall to the floor. The plan of care for the resident identifies interventions to prevent it from loosening, however these interventions were not followed. The licensee failed to ensure that the physical device is applied in accordance with the manufacturer's directions. [O.Reg. 79/10, s.110(1)(1)]
2. Inspector reviewed the health care record including plan of care for resident #479 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector observed during multiple observations on July 11, 12 and 13, 2012 that the physical device was incorrectly applied. The licensee failed to ensure that the physical device is applied in accordance with the manufacturer's directions. [O.Reg. 79/10, s.110(1)(1)]
3. Inspector reviewed the health care record including plan of care for resident #479. Inspector noted a physician's order for physical restraint. Inspector noted during breakfast and lunch on both July 12 and 13, 2012 that the resident's physical device was not removed as per the physician's direction. Inspector spoke with two staff members on the unit who identified they were not aware of the physician's direction related to the physical device and care plan direction. The licensee failed to ensure that staff apply the physical device in accordance with any directions specified by the physician or registered nurse in the extended class. [O.Reg. 79/10, s.110(2)(2)]
4. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the "physical restraint monitoring record" for July 1-9, 2012. Inspector noted that the section for the RPN to initial identifying assessment of the resident was missing 8 of 9 day shift RPN initials and 5 of 9 evening/night shift RPN initials. The licensee failed to ensure that a resident is assessed by a member of the registered nursing staff at least every 8 hours or at any other time based on the resident's condition. [O.Reg. 79/10, s.110(2)(6)]
5. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the "physical restraint monitoring record" for June 2012. Inspector noted that the section for the RPN to initial identifying assessment of the resident was missing 13/30 day shift RPN initials and 19/30 evening/night shift RPN initials. The licensee failed to ensure that a resident is assessed by a member of the registered nursing staff at least every 8 hours or at any other time based on the resident's condition. [O.Reg. 79/10, s.110(2)(6)]
6. Inspector observed resident #298 on July 12, 2012 at 14:49h. Inspector noted the resident had a physical restraint. Inspector noted the resident was not properly positioned while the physical device was applied. The licensee failed to ensure that resident is repositioned at any time based on the resident's condition or circumstances. [O.Reg. 79/10, s.110 (2)(5)]
7. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for July 1-9, 2012 noting that 2 of 9 afternoon shifts had no documentation completed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)]
8. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for June 2012 noting that 6 of 30 day shifts and 2 of 30 afternoon shifts had no documentation completed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)]
9. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted the resident has a physical restraint. Inspector observed on July 11, 2012 at 09:39h that the resident's physical device was incorrectly applied. Inspector observed on July 11 at 11:44h and 14:02h that the physical device remained incorrectly applied. Inspector spoke with staff #108 on July 11, 2012 at 14:07h who confirmed the physical device was incorrectly applied and proceeded to adjust it. The licensee failed to ensure that the physical device is applied in accordance with the manufacturer's directions. [O.Reg. 79/10, s.110(1)(1)]
10. Inspector reviewed the health care record including plan of care for resident #298 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the "physical restraint monitoring record" for June 2012 and July 1-9, 2012. Inspector noted that the section for the RPN to initial identifying assessment of the resident was completely blank for both months. The licensee failed to ensure that a resident is assessed by a member of the registered nursing

staff at least every 8 hours or at any other time based on the resident's condition. [O.Reg. 79/10, s.110(2)(6)]
11. Inspector reviewed the health care record including plan of care for resident #298 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for July 1-9, 2012 noting that 2 of 9 day shifts and 7 of 9 afternoon shifts had no documentation completed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)]
12. Inspector reviewed the health care record including plan of care for resident #298 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector reviewed the documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for June 2012 noting that 8 of 30 day shifts and 10 of 30 afternoon shifts had no documentation completed. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)]
13. Inspector observed resident #298 on July 10, 2012 at 14:06h. Inspector noted the resident had a physical restraint. Inspector noted the resident was not properly positioned while the physical device was applied. Inspector noted staff complete the snack pass, however did not reposition the resident. The resident was not repositioned until 14:42h when the resident was finally repositioned to be seated properly. The licensee failed to ensure that resident is repositioned at any time based on the resident's condition or circumstances. [O.Reg. 79/10, s.110(2)(5)]
14. Inspector reviewed the health care record including plan of care for resident #479 on July 10, 2012. Inspector noted this resident has a physical restraint. Inspector was unable to locate any documentation related to the application of the device, assessments, reassessments and monitoring including the residents response, every release of the device, all repositioning and removal or discontinuance of the device for June 2012 or July 1-10, 2012. Inspector spoke with staff #107 who was also unable to locate the restraint documentation and was unable to articulate why the documentation was not available. A new documentation sheet for July 2012 following the conversation with the inspector was initiated by staff #107. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented. [O.Reg. 79/10, s.110(7)(5)(6)(7)(8)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. Inspector noted a complaint was brought forward to staff #105. Inspector noted that resident #2629's family member expressed concerns. The resident's health care record identifies an unusual occurrence report was completed however staff #105 was unable to locate it during the inspection. This complaint was not included in the home's complaint record. Inspector spoke with staff #105 who received the complaint. When asked if the complaint was dealt with as per the home's written complaint process staff #105 identified she did not recognize it as a complaint. The licensee failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant. [O.Reg. 79/10, s.101(2)]
2. Inspector reviewed the home's documented complaint record on July 16, 2012. Inspector noted that the record did not contain any complaints relating to resident #598. The inspector was aware of two complaints brought forward to the home related to resident #598's care. Inspector noted there was no documented record identifying these two complaints. Inspector spoke with staff #106 who confirmed receipt of these complaints and acknowledged they were not included in the home's documented complaint process. The licensee failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant. [O.Reg. 79/10, s.101(2)]
3. Inspector was made aware of a complaint brought forward to staff #106. Inspector noted this complaint identified concerns relating to the care of a resident. Inspector spoke with staff #106 who confirmed receipt of the information and confirmed speaking with the parties involved following the discussion with the family member. Staff #106 however identified that the information was not represented as a complaint and thus not directed through the home's complaint process. No response was provided to the family following their complaint concerning the care of a resident. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint. [O. Reg. 79/10, s.101(1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 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 a critical incident. It identifies that staff #154 was observed taking resident #740 to the dining room in a wheel chair and the resident put their feet down thereby stopping the wheelchair. Inspector interviewed staff #107 on July 13, 2012 about the incident. Staff #107 reported that the resident was required to use foot rests and that the staff #154 had pushed the resident's wheelchair acknowledged that foot rests were not used as required. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O.Reg. 79/10, s.36]
2. Inspector reviewed a critical incident. It identifies that resident #380 fell during a transfer to the bathroom and sustained injuries resulting in transfer to hospital. Inspector interviewed staff #105 on July 16, 2012 about the incident. Staff #105 reported that resident #380 fell when staff were transferring the resident using a chorus lift. The plan of care outlines that for transfers, resident #380 requires a Maxi Lift x2 staff for transfers to the wheel chair. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O.Reg. 79/10, s.36]
3. Inspector reviewed a critical incident. It identifies that resident #303 was being transferred from bed. Resident #303 required an over bed lift to get in and out of bed however staff used a Sara lift (sit to stand) to transfer the resident. The report further identifies that the resident's arm hit the door when staff were bringing the resident to the toilet resulting in injury to the resident's arm. The resident's home area 24-Hour Nursing Report indicates for the date if the incident that the resident was transferred with a Sara lift, however the shift report adds that the care plan requires the use of an overhead lift when transferring in and out of bed. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O.Reg. 79/10, s.36]

Additional Required Actions:

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

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Inspector reviewed a critical incident where resident #761 was found on the floor. The CI report indicates that resident #761 brought the resident's own bed into the home upon admission. The reports adds that following admission the home provided resident #761 with an alternating air mattress to go on the bed. Inspector reviewed the health care record for resident #761 and was unable to find any documentation that resident #761 bed system was evaluated upon admission or after the alternating air mattress was installed in the bed. Inspector interviewed staff #107 on July 18, 2012. Staff #107 confirmed resident #761's bed system was not evaluated upon the resident's admission to the home or after the home's alternating air mattress was installed on the resident's bed. It was further identified that the home does not currently have a process in place for the evaluation of bed systems when side rails are used in the home. The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Additional Required Actions:

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

WN #6: The Licensee has failed to compiy with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector reviewed a critical incident. It was identified that resident #671 had defecated in the tub during a bath and staff continued to bathe the resident in the soiled water. Inspector interviewed staff #107 on July 11, 2012. Staff #107 reported that the staff member involved in the incident acknowledged that resident #671 had defecated in the bath water after the resident was placed in the tub and that the resident remained in the soiled water for the duration of the bath. The licensee failed to ensure that the right's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(1)]
2. Inspector reviewed a critical incident. It was identified that resident #223 did not receive care from the resident's assigned PSW. The investigation concluded that the resident did receive care from another PSW. It was determined that the resident was originally informed that staff #152 was assigned to the resident, however following communicating this to the resident staff #152 and staff #153 changed their assignments and staff #153 decided to provide care to resident #223. This switch was not communicated to the resident. The licensee failed to ensure that the resident's right to be told who is responsible for and who is providing the resident's direct care was fully promoted and respected. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(7)]
3. Inspector reviewed a critical incident. It was identified that at the start of a day shift that nine different residents were found saturated in urine, some with feces and one resident's window had been left open and the resident had been found to be trembling and cold. Through the home's investigation it was determined that appropriate care was not provided to these residents during the night shift. The licensee failed to ensure that during the night shift the residents right's to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(4)]
4. Inspector reviewed a critical incident. Inspector reviewed a critical incident. It was identified that staff #150 failed to provide appropriate and safe care to residents #1583, #2583 and #3583. Staff #150 failed to place the identified residents' beds in low positions, ensure that safety mats were on the floor, ensure that half rails were elevated and that call bells were pinned within the residents' reach. These three residents are each assessed at high risk for falls and as requiring these interventions for their own safety. The licensee failed to ensure that the resident's right to live in a safe environment was fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(5)]
5. Inspector reviewed a critical incident. It was identified that resident #171 requested to go to the bathroom and the staff member assigned refused to assist the resident and went on break. Shortly after, during a tub bath, the resident defecated in the tub leaving the resident emotionally distraught and humiliated. The licensee failed to ensure that the right's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(1)]

Additional Required Actions:

CO # - 006 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. 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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 a critical incident. It identifies that a staff member found resident #761 had fallen out of bed. The care plan document within the plan of care outlines that resident #761 was to have the bed in lowest position when not providing care. The licensee's documentation of the incident reports that the bed was found at the time of the incident to be at its "highest level". The licensee failed to ensured that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
2. Inspector reviewed the health care record for resident #209. The documentation indicates that resident #209 requires additional foot care treatment and to discuss the need with the resident's substitute decision-maker (SDM). Inspector was unable to locate documentation that confirmed that the resident's SDM was notified of the change in the resident's plan of care. Inspector interviewed staff #107 on July 12, 2012 who confirmed that there was no documentation in the resident's health care record to indicate that the substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care with regards to the resident requiring additional foot care treatment. The licensee failed to ensure the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)]
3. Inspector reviewed the health care record including plan of care for resident #209. Inspector noted the plan of care contains a fall prevention intervention identifying staff are to ensure versus call bell string is clipped to resident #209 clothing when in bed. Inspector observed resident #209 on July 11th and 12th, 2012 in bed without the versus call bell string clipped to the resident's clothing. Inspector interviewed staff #109 and #107 on July 12, 2012. These staff members confirmed that resident #209 requires the versus call bell string attached to the resident's clothing when in bed. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
4. Inspector reviewed the health care record including plan of care for resident #479. Inspector noted an intervention related to the physical restraint was to remove it during meal times. Inspector noted on July 12 and 13, 2012 during breakfast and lunch meal services that this intervention was not followed. Inspector spoke with two staff members, on July 13, 2012, who were unaware of this intervention. Staff #104 spoke with a RAI coordinator who identified that the intervention does not provide the correct direction to staff. The licensee failed to ensure the plan of care provides clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
5. Inspector reviewed the health care record including plan of care for resident #587 on July 10, 2012. Inspector noted the plan of care and Kardex related to restraining with a physical device identified specific directions relating to the use of a physical restraint. Inspector observed on July 10 and 11, 2012 that these specific directions were not being followed. Inspector spoke with staff #108 on July 11, 2012 who identified that a change was made to the resident's plan of care and the interventions were no longer required. Staff #108 was unable to articulate when this change occurred however identified the plan of care had not been updated to reflect this change. The licensee failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care in the plan is no longer necessary. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #8: 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 a critical incident. This Mandatory Report identifies resident to resident verbal abuse. The incident was witnessed and was reported outside the immediate reporting time frame. The licensee failed to ensure the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]
2. Inspector reviewed a critical incident. This Mandatory Report identifies improper/incompetent treatment of a resident that results in harm or risk to a resident. The incident was reported outside the immediate reporting time frame. The licensee failed to ensure the Director is immediately informed of improper or incompetent treatment of a resident that results in harm or risk to a resident. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(1)]
3. Inspector reviewed a critical incident. This Mandatory Report identifies staff to resident abuse/neglect. The incident was reported to the Ministry outside the immediate reporting time frame. The licensee failed to ensure the Director is immediately informed of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(1)(2)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following subsections:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD 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.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #761 who was admitted with their own bed that included bed rails for assist. The care plan document in the plan of care identified the resident as requiring these two half rails while in bed. Inspector was unable to locate in the health care record any documentation that identifies the rails, being used as a PASD, had been approved by a physician, registered nurse, registered practical nurse, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations. Further, the inspector was unable to locate any documentation that indicates the use of the rails, as a PASD, were consented to by the resident, or a substitute decision-maker of the resident. The licensee failed to ensure that the use of a PASD to assist a resident with a routine activity of living is included in a resident's plan of care only if all of the following are satisfied: The use of the PASD has been approved by, a physician or, a registered nurse or, a registered practical nurse or, a member of the College of Occupational Therapists of Ontario or a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations, and the use of the PASD 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. [LTCHA 2007, S.O. 2007, c.8, s.33(4)(3)(4)].

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: 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 including plan of care for resident #479 on July 11, 2012. Inspector noted the resident is at a high risk for skin breakdown. Inspector noted the plan of care identifies this high risk for skin breakdown. Inspector noted that plan of care directs staff to monitor the resident's skin during am and hs care however the home does not have a formal process to reassess this resident, who is at high risk for skin breakdown, weekly. It was identified to the inspector by three different registered staff members that if a resident has an open area then they are assessed weekly; however, those residents who do not have an open area, but are at risk for breakdown would only receive an assessment quarterly with MDS or upon return from an LOA or hospitalization. The licensee failed to ensure that resident's who exhibit altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [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 resident's who exhibit altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. Inspector reviewed a critical incident report which identifies an unexpected death. The incident was not reported until the following day. This is outside the immediate reporting time frame. The licensee failed ensure the Director is immediately informed, in as much detail as is possible of an unexpected or sudden death, including a death resulting from an accident or suicide. [O.Reg.79/10,s.107(1)(2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring the Director is immediately informed, in as much detail as possible of an unexpected or sudden death, including a death resulting from an accident or suicide, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. Inspector observed resident #209 on July 11, 2012 noting the resident's finger nails appeared untrimmed. The resident stated to the inspector that their finger nails required trimming. Inspector reviewed the health care record documentation for the month of June 2012 and July 1-10, 2012 noting that the documentation indicates the finger nails of resident #209 were not trimmed during that time period. Inspector accompanied staff #109 to observe the finger nails of resident #209 on July 11, 2012. Staff #109 confirmed that the finger nails of resident #209 were long and required trimming. The licensee failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails.[O.Reg. 79/10, s.35(2)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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. 20.	WN #1	2012_099188_0006	188
LTCHA, 2007 S.O. 2007, c.8 s. 20.	CO #002	2012_099188_0006	188
LTCHA, 2007 S.O. 2007, c.8 s. 23.	WN #1	2012_099188_0005	188
LTCHA, 2007 S.O. 2007, c.8 s. 23.	WN #2	2012_099188_0006	188
LTCHA, 2007 S.O. 2007, c.8 s. 23.	CO #003	2012_099188_0006	188
O.Reg 79/10 r. 97.	WN #1	2012_099188_0005	188
O.Reg 79/10 r. 97.	CO #003	2012_099188_0005	188
O.Reg 79/10 r. 97.	WN #2	2012_099188_0006	188
O.Reg 79/10 r. 97.	CO #005	2012_099188_0006	188

issued on this 8th day of August, 2012

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