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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 27, 28, 29, 30, Dec 30, 2011; Jan 3, 4, 10, 12, 2012	2011_056158_0006	Complaint

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the physiotherapist, physiotherapy aides, the dietitian, dietary aides, housekeeping staff, laundry staff, the Environmental Service Manager, residents and families.

During the course of the inspection, the inspector(s) observed staff interactions with residents, staff providing care to residents, staff administering medication to residents, reviewed several residents' health care records, the home's Fall Prevention and Management policy, the home's medication policy and procedures, the home's restraint policy, the home's Skin and Wound Care Program and protocols, reviewed the home's policy/protocols related to the transferring of residents with and without the use of a mechanical lift, the protocols related to provision of residents' oral care and toured the laundry department.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Medication

Minimizing of Restraining

Personal Support Services

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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director no later than one business day of an injury in respect of which a person is taken to the hospital.
An anonymous resident who fell in the home and sustained injury was transferred to hospital. The home informed the Director five days post incident, which does not meet the reporting time-line.
[O. Reg. 79/10, s. 107. (3)4]
2. A resident had a fall which resulted in transfer to hospital.
The home's internal incident report was completed, however, the home failed to ensure that a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and events leading up to the incident was reported to the Director within ten days of becoming aware of the incident.
[O. Reg. 79/10, s. 107. (4)1]
3. A resident had a fall which resulted in transfer to hospital.
The home's internal incident report was completed, however, the home failed to ensure that the Director was informed no later than one business day of an injury in respect of which a person is taken to the hospital.
[O. Reg. 79/10, s. 107. (3)4]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the Director is informed no later than one business day of an incident in the home where a person is injured and transferred to the hospital and that a written report is made to the Director within ten days of becoming aware of the incident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure that drugs are stored in an area that is secured and locked. On June 29/11 at 1745h and June 30/11 at 1230h, the inspector observed clear plastic bags containing several residents' "over the counter" vitamins, "over the counter" ointment such as polysporin, as well as, prescribed eye drops, and prescribed creams such as uremol 1%, sitting unattended on the counter on the nurse's desk in one resident care unit.
A RPN identified to the inspector on June 29/11 that direction was given from management on the evening of June 28/11 to remove from residents all hazardous materials including medication and creams which were not ordered for the resident's self use.
Other residents' prescribed creams which are applied by the PSWs, such as hydro-cortisone 1% were also observed by the inspector to be left on the nurse's desk and not stored in an area that is secure and locked.
[O. Reg. 79/10, s. 129. (1)(a)(ii)]

WN #3: 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. The home did not ensure that the staff used safe transferring and positioning techniques when transferring a resident on the evening of June 29/11.
The inspector observed two staff transfer a resident from a shower chair into a wheel chair in a rushed manner. The transfer sling used under the resident was placed crooked and pinched the resident's skin. The "strings" of the mechanical lift were not adjusted prior to the lifting of the resident. The resident was also not informed when the lifting process started causing the resident to jerk and look fearful.
There was a previous recorded incident in the resident's progress notes, which identified that the resident sustained bruising as a result of the staff transferring the resident with a mechanical lift and pinching the resident's skin.
[O. Reg. 79/10, s. 36]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all staff use safe transferring and positioning techniques when assisting all residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following subsections:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On June 29/11 at 0800, the inspector observed that a denture belonging to a resident was in a dry denture cup in the resident's bedside drawer. The denture was dry with food residue present on the back teeth. The home's policy regarding denture care was reviewed on June 29/11. The policy stated "using a denture brush and cleaning agent, gently brush all surfaces of the denture; rinse the dentures; dentures must be kept moist otherwise they may warp. If the dentures are out of the resident's mouth for several hours, make sure to store them in a labelled container of cool water". The licensee did not ensure that a resident's personal item such as dentures were cleaned as required.
[O. Reg. 79/10, s. 37 (1)(b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The inspector checked the medication cart on one resident care unit on June 28/11. The drugs for two different medication orders for a resident were contained in bottles which were not provided by nor labelled by the home's pharmacy provider.
The licensee did not ensure that drugs, which were received by the home, were provided by and labelled by the home's pharmacy provider.
[O. Reg. 79/10, s. 126]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (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. A resident with a history of falls was observed by the inspector on June 30/11 seated in a wheel chair with a rear buckling seat belt.
A RPN identified that the resident would crawl out of the wheel chair if not prevented and that the resident was not able to undo the buckle when positioned in the rear.
There was no documentation in the resident's health care record related to the application of the rear buckle seat belt.
The licensee did not ensure that the person who applied the device and the time of application was documented.
[O. Reg. 79/10, s. 110. (7)5]
2. A resident with a history of falls was observed by the inspector on June 30/11 seated in a wheel chair with a rear buckling seat belt.
A RPN identified that the resident would crawl out of the wheel chair if not prevented and that the resident was not able to undo the buckle when positioned in the rear.
There was no documentation in the resident's health care record related to the application of the rear buckle seat belt or repositioning when the resident is sitting in the wheel chair.
The licensee did not ensure that every release of the device and repositioning was documented.
[O. Reg. 79/10, s. 110. (7)7]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The home's medication administration policy was reviewed on June 28/11. The medication policy stated that the Registered Staff "initial" the Medication Administration Record(MAR) after the medication is administered to the resident.
The inspector reviewed a resident's June/11 MAR which showed several missing Registered Staff signatures for four different medications that were ordered by the physician.
The inspector reviewed a resident's April/11 Treatment Administration Record (TAR) which showed several missing Registered Staff's signatures for two different wound treatments that were ordered by the physician.
The licensee did not ensure that the home's written medication policy/protocol was implemented in accordance to prevailing practice with regards to medication administration.
[O. Reg. 79/10, s. 114 (3)(a)]

The inspector observed that a RPN administered a resident's four pills during meal time on June 28/11. The medication was placed on a napkin and set on the table by the resident's dinner plate. The RPN left to bring the medication cart back to the medication room and did not stay with the resident to ensure that the resident took the medication.
The home's medication policy did not identify that the medication could be left with a resident and taken at a later time.
The College of Nurses (CNO) standards identifies "the five rights of medication administration: the right medication, the right dose, the right route, the right time and the right client". The CNO standards also identifies that the nurse meets the standard when the nurse "ensures the client receives appropriate monitoring while administering the medication".
The licensee did not ensure that the administration of a resident's medication was implemented in accordance with prevailing practices.
[O. Reg. 79/10, s. 114. (3)(a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The Licensee did not ensure that the linen was maintained in a good state of repair.
On June 28/11 at 1230h, the inspector observed that the bottom bed sheets on two residents' beds in one unit were thread bare with holes. The inspector also observed that two additional resident beds were covered with thread bare sheets at 1830h.
[O Reg 79/10, s. 89 (1)(c)]

WN #9: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
The dietitian initially assessed a resident with impaired skin integrity as being a moderate nutritional risk with no open areas. The resident developed open areas a month later and was assessed only by the nursing staff. Specific interventions to reduce further skin breakdown such as turning, repositioning and a special mattress were added to the resident's plan of care. The dietitian's assessment a month after the nursing assessment did not identify the resident's open areas or any change to the resident's nutritional requirements. The resident's open areas deteriorated.
[LTCHA 2007, S. O. 2007, c.8, s. 6 (4)(a)]
2. The health care record of a resident with cognitive impairment and altered skin integrity was reviewed by the inspector on June 30/11. The resident's progress notes first identified the development of redness of the resident's skin in Feb/11. There was further documentation in the progress notes of the deterioration of the skin in April/11. The physician's orders identified that a wound protocol was ordered for the deterioration of the resident's skin areas in April/11.
The resident's April/11 Treatment Administration Records (TAR) identified that the wound protocol was administered.
A family member identified to the inspector on June 28/11 that the family was not made aware of the deterioration of the resident's skin areas until May/11. There was no documentation in the progress notes identifying that the family was notified of the resident's skin deterioration until May /11.
The home's Skin and Wound Care policy was reviewed and identified that the " RHA Team Leader will first call the resident's representative when a change in skin integrity is first discovered and the Primary Nurse will keep them informed weekly of the ongoing status of the wound."
The inspector spoke with a RPN on June 30/11 who identified that the family is usually called when the doctor orders a new treatment.
The licensee did not ensure that the resident's substitute decision maker was given the 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)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure that a physician or Registered Nurse in the Extended Class had ordered or approved the restraining of two residents.
A resident with a history of falls was observed by the inspector on June 29/11 seated in a wheel chair with the seat belt fastened at the back of the chair.
A RPN identified that the resident would crawl out of the wheel chair if not prevented and that the resident could not unfasten the buckle when placed at the back of the chair.
A physician's order dated December 2010 for a "rear seat belt" was found in the resident's health care record, however this order was not carried forward nor did it identify specific direction for when the belt was to be applied.
A RPN identified another resident who required a wheel chair with a rear buckling seat belt and who could not unfasten the belt. The resident was observed by the inspector on June 30/11 seated in a wheel chair fastened with a rear buckling seat belt plus a table top.
There were no physician orders found in the resident's health care record related to the wheel chair's rear buckling seat belt or the table top.
[LTCHA 2007, S. O. 2007, c.8, s. 31 (2)4]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The home did not ensure that the procedures for cleaning resident care equipment such as transfer slings were implemented.
The inspector observed that soiled transfer slings were used when residents were transferred with a chorus lift on June 29/11.
As well, the bottom steps of two chorus lifts were soiled with food particles and grit.
[O Reg 79/10, s. 87(2)(b)i]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following 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. The licensee did not ensure that the resident's right to keep personal possessions was respected.
The inspector observed that a female resident approached a staff member sitting at the nursing desk on June 29/11 inquiring why her lotions were removed from her room.
On June 29/11 at 1745h and June 30/11 at 1230h, the inspector observed several clear plastic bags containing residents' personal articles such as lotions, powder, lipstick, small scissors, tweezers, nail cutters and make up sitting on the counter outside the medication room at the nurses' desk of one unit.
A RPN identified to the inspector that direction was given from management on the evening of June 28/11 to remove all hazardous materials from the residents' rooms.
[LTCHA 2007, S. O. 2007, c.8, s. 3 (1)10]

Issued on this 13th day of January, 2012

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