Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2015	2015_396103_0022	O-001881-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF FRONTENAC
2069 Battersea Road Glenburnie ON K0H 1S0

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

FAIRMOUNT HOME FOR THE AGED
2069 Battersea Road R. R. #1 Glenburnie ON K0H 1S0

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

DARLENE MURPHY (103), JESSICA PATTISON (197), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 7-10, 13, 2015

Log# O-001600-15 was included with this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of Resident Council, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Nurse Practitioners, Dietitian (RD), a Dietary Aide, Food Service Supervisor, RAI Coordinators, Executive Assistant, Manager of Environmental Services, Assistant Director of Care (ADOC), Director of Care (DOC) and Acting Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date, Resident #6 was being transported by a staff member in a wheelchair without foot pedals. The resident unexpectedly lowered their feet to the ground and as a result sustained a fall out of the wheelchair. The resident was assessed for injuries, returned to the wheelchair and within a short period of time, sustained a second fall.

Resident #6's health care record was reviewed. According to the resident's care plan, the resident could self propel in a wheelchair, and had a chair alarm in place as a fall prevention measure.

S#115 was interviewed and stated she was the Registered staff on duty at the time of the falls. She recalled assessing the resident for injuries following the first fall and within five to ten minutes recalled hearing a bang and found the resident on the floor for a second time. S#115 stated it was at that time she realized, the chair alarm had not sounded following either of the two falls. Upon examination of the alarm, it was noted the volume on the alarm was off/turned down and therefore not operational for the purpose of fall prevention at that time.

The DOC was interviewed and recalls being notified of the two falls. She stated the chair alarm was not functioning because the volume was turned down. The DOC agreed that all equipment used for the purposes of fall prevention needs to be checked on a regular basis to ensure in proper working order. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure Resident #6's fall prevention equipment, outlined in the resident plan of care, is in working order when being utilized, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b) in that they did not comply with their system to monitor food and fluid intake of residents identified at nutritional risk.

O. Reg. 79/10, s. 68(2)(d) states that every licensee of a long-term care home shall ensure that the organized programs of nutrition care and dietary services and hydration includes (d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Interviews with the Director of Care, the Assistant Director of Care and staff members #S116 and #S121 indicated that resident food and fluid intakes are documented in Point of Care (POC) in Mede-care. It was also confirmed that supplements for residents are documented in POC under nourishments.

Resident's #2, #6 and #29 were all noted to have significant weight changes within the first three months of 2015 and are all receiving nutritional supplements.

Resident's #2, 6 and 29's food and fluid intake documentation was reviewed from March 1 - April 8, 2015 (39 days).

The following intakes were not documented for Resident #2.
- 8 breakfast meals
- 8 lunch meals
- 10 supper meals
- 15 days of supplements

The following intakes were not documented for Resident #6.
- 19 days of supplements

The following intakes were not documented for Resident #29.
- 17 breakfast meals
- 17 lunch meals
- 5 supper meals
- 10 days of supplements [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's system to monitor food and fluid intake of residents with identified nutritional risks is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

On April 7/8, 2015 during stage one observations, the following was observed:

Room #134- Call bell was on floor behind bed, (197)

Room #126- Call bell in room not within reach when resident in wheelchair, (197)

Room #138- Call bell on floor behind night stand, (197)

Room #143- Call bell was underneath the bed. (197)

On April 10, 2015, the following call bells were found to be inaccessible to residents:

Room #113, #114- the call bells were found on the floor under the resident bed, (103)

Room #116 and #118- the resident's were observed lying in bed; the call bells were noted on top of the dresser well out of reach, (103)

Room #121A and B- both call bells were found on the floor behind the resident dressers, (103)

Room #122- call bell was observed tucked inside of top dresser drawer, (103)

Room #236- resident was observed sitting up in a wheelchair at the end of the bed; call bell was found non functional and pinned to the top of bed, (103)

Room #221-originally found by inspector to be non functioning is now working; the call bell was found behind the dresser on floor; the replacement call bell cord is very short and would not be able to reach beyond the head of the bed. (103)

The ADOC was interviewed and stated the home has received complaints from family in the past related to the inaccessibility of call bells. She stated the home's practice is to have all call bells accessible to all residents at all times despite the resident's ability to utilize it. [s. 17. (1) (a)]

Additional Required Actions:

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

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. The licensee has failed to ensure staff use safe transferring techniques when assisting residents.

On an identified date, Resident #6 was being transported by a staff member in the hallway. The resident was seated in a wheelchair without foot pedals and the resident was instructed to hold both feet off of the ground. The resident unexpectedly put their feet onto the floor and fell forward out of the wheelchair and sustained injuries.

According to PSW staff, at the time of this incident, the resident was capable of self propelling in a wheelchair and therefore the foot pedals were removed to facilitate the resident's mobility.

Resident #6's care plan, in effect at the time of the fall, was reviewed.

The care plan under "ADL Functional/Rehabilitation Potential" indicated:

-wheelchair to meals or in corridor, staff push wheelchair or resident can wheel self for short distances.

S#115 was interviewed and, on the date of this incident, recalled seeing the resident being transported by a PSW down the hall and noted the resident was holding both feet off the ground. The staff member stated Resident #6 saw her in the hallway, attempted to get her attention and immediately put their feet down. According to S#115, Resident #6 was transported by staff down the hall without foot pedals on a regular basis.

The DOC and ADOC were both interviewed and stated the home would expect all staff to utilize foot pedals when transporting residents to avoid injuries. Both agreed wheelchairs without foot pedals are acceptable for the purpose of residents self propelling and given this resident's status, the transfer without foot pedals was unsafe. [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 to ensure staff utilize safe transferring techniques for Resident #6, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 69 in that specified weight changes were not assessed using an interdisciplinary approach.

Resident #2 is assessed as high nutritional risk, and receives Boost 1.5 twice daily. Upon review of the resident's weight history, it was noted that in January 2015 the resident had a 5.13 per cent weight loss of body weight over one month. It was also noted that the resident has gradually lost approximately 10 kg in the past 12 months. Resident #2's progress notes were reviewed back to January 4, 2015 and no nutritional assessments were found related to the resident's January weight loss. The Registered Dietitian and Food Service Supervisor were unable to provide evidence that an assessment of the resident's January weight loss had occurred.

Resident #6 is assessed as moderate nutritional risk and receives polycose in juice three times daily to increase caloric intake. Upon review of the resident's weight history, it was noted that in March 2015 the resident had a 6.61 per cent weight loss of body weight

over one month and a 8.48 per cent weight loss of body weight over three months. Resident #6's progress notes were reviewed back to March 3, 2015 and no nutritional assessments were found related to the resident's weight loss. The Registered Dietitian and Food Service Supervisor were unable to provide evidence that an assessment of the resident's March weight loss had occurred.

Resident #29 is assessed as moderate nutritional risk and receives Boost 1.5 three times daily with meals. Upon review of the resident's weight history, it was noted that in January 2015 the resident had a 9.11 per cent weight gain over 3 months. In February 2015 the resident had a 16.16 per cent weight loss of body weight over one month, an 8.53 per cent weight loss over three months and a 10.44 per cent weight loss over six months. Resident #29's progress notes were reviewed back to Jan 1, 2015 and no nutritional assessments were found related to the resident's weight changes. The Registered Dietitian and Food Service Supervisor were unable to provide evidence that an assessment of the resident's January and February weight changes had occurred.

The home's policy "Nutritional Care - Significant Weight Change" last revised October 24, 2014 includes the following instructions:
A resident with significant weight change will be reassessed within 72 hours by nursing, the Dietitian and the Physician and a care plan will be developed and implemented accordingly.
A significant weight change refers to +/- 5% in 1 month, +/- 7.5% in 3 months and +/- 10% in 6 months.
At the same time each month each resident will be weighed, if the resident's weight has changed +/- 5% in 1 month, the resident will be reweighed to confirm the weight change.
The Dietitian or Food Service Supervisor will print off monthly weight reports to track significant weight changes.
A Dietary referral will be completed to provide the Dietitian with additional details regarding the resident's condition.
The RN, the Physician/NP and the Dietitian will assess the resident within 72 hours and record their findings and/or recommendations.

Inspector #103 conducted an interview with the ADOC and DOC on April 10, 2015 and both indicated that they would expect a significant weight change to be assessed right away, with a re-weigh first to confirm the weight change.

On April 13, 2015, the ADOC confirmed that referrals were not completed for Resident #2, #6 and #29 related their significant weight changes in 2015. [s. 69. 1.,s. 69. 2.,s. 69.

3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the weight changes specified in O. Reg. 79/10, s. 69 are assessed using an interdisciplinary approach, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)4 in that a resident who received tray service was not monitored during a lunch meal.

On April 7, 2015, the lunch meal was observed on an identified unit. Staff on the unit communicated that Resident #41 would be receiving a tray to their room and that it would be sent out after the lunch meal was served in the dining room.

At approximately 1213 hours, the lunch tray for Resident #41 was sent to the resident room. The inspector started observing the resident at 1217 hours and no staff were present. At this time, the resident was observed in bed with the head of the bed elevated to about 45 degrees and appeared to be sliding downward. Resident #41 started to cough at approximately 1220 hours. Inspector entered the room to ensure resident was

safe and it was noted at this time that the call bell was not within reach. Resident appeared fine and continued to eat. The resident was asked if they liked to eat lunch in their room but the resident was not able to answer the question.

Two staff members walked by Resident #41's room at 1221 hours but did not look in to check on the resident. Two more staff members were in the vicinity of the resident's room at 1224 but did not look in to check on the resident. At 1228 hours, staff were portering residents back to their rooms, but again did not look in to check on the resident. No staff were in the vicinity of the resident's room from 1230 - 1245 hours. At 1245, a staff member did look in the resident's room, but did not enter or ask the resident if they needed/wanted anything else.
At 1256 hours, the resident was noted to have finished the meal, 2 fluids, soup, sandwich and chocolate chip cookies - regular texture. No further staff entered or looked into the room after 1245 hours.

Review of Resident #41's current care plan dated March 27, 2015 states the following:
- the resident is on a minced diet (pureed prn) and at moderate nutritional risk
- resident requires limited assistance, lots of verbal cueing required and may need to be fed if resident will allow it
- staff to assist resident with eating and swallowing at all meals
- chewing difficulty; requires minced texture and pureed prn
- ensure resident is in proper upright position to eat
- monitor any coughing episodes and report to registered staff
- avoid serving foods that have a mixed texture
- provide food items that require little chewing

During a phone interview with the Food Service Supervisor on April 14, 2015, she stated that chocolate chip cookies are not appropriate for a resident on a minced diet and should not have been given to Resident #41.

An interview was conducted with staff member #S124 on April 13, 2015, regarding monitoring of Resident #41 while they are eating in their room. The staff member stated that their process is to look in on the resident approximately every 5 minutes while portering other residents back to their rooms after lunch. She confirmed that staff do not sit in the resident's room.

An interview was conducted with the Director of Care on April 13, 2015, who stated that for resident's at risk of choking, like Resident #41, the expectation would be for staff to sit

in the room with the resident in order to provide close monitoring. [s. 73. (1) 4.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73(2)(a) in that a staff member assisted more than two residents at the same time who required total feeding assistance.

On April 13, 2015, the lunch meal was observed on the secure unit, 1 North. Staff member #S124 was observed to be feeding three residents (#19, 20 and 23) their meals. On this date all three residents required total feeding assistance and did not appear able, nor did they attempt, to feed themselves.

Staff member #S124 was interviewed on April 13, 2015 after the meal and confirmed that she was feeding three residents who required total feeding assistance and that she has also had to do this in the past. She stated that the Registered Practical Nurse on duty is supposed to assist with feeding but did not and the Registered Nurse on duty will sometimes help as well, but was busy with the Doctor.

During an interview with the Director of Care and the Food Service Supervisor on April 13, 2015, both indicated that staff are to feed no more than two residents at a time who require total feeding assistance. [s. 73. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents receiving tray service to their rooms are monitored as per their assessed dietary needs and that staff assist no more that two residents who require total feeding assistance, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 15 (2) (c) whereby the home, furnishings and equipment were not maintained in a safe condition and good state of repair.

On April 7 and 8, 2015, the following was observed by inspectors:

Rm N102 Wall beneath window in bedroom was scarred, (197)

Rm S105 Large area on wall at end of bed where paint is scarred and numerous gouges in surface through the dry wall, (103)

Rm N116 Scarring on bedroom and bathroom walls, chunks out of drywall on corner upon exiting room, (197)

Rm N121 Scarring on wall, drywall coming off corners exposing metal corner beading, (197)

Rm N126 Chips missing from drywall around door out to hallway, corner bead exposed; door frame to bathroom has paint chipped off, linoleum floor coming apart at the seam, (197)

Rm N134 Large area of scarring on bedroom walls, especially beneath the window, paint chipped, (197)

Rm N136 Scarring on walls, chunks out of drywall, chipped paint, (197)

Rm N145 Some areas of drywall missing on corners when entering resident's area of semi-private room - metal corner bead exposed, (197)

Rm N221 Dry wall chipped and scraped (wheelchair level), door protector black scuff marks (wheelchair level), (601)

Rm N235 Small circular area in bathroom where dry wall is not intact/hole beginning; hole in wall behind bedroom door and an area of paint scarring beside dresser, (103)

Rm N238 Wall behind recliner has large area where wall surface is missing, (103)

Rm S239 Paint chipped in dry wall, scraped at wheelchair height. (601)

The following call bells were found to be non functional at the time of this inspection:

Rm N114 Call bell from end of the cord was not working; call bell could be activated from wall button only, (197)

Rm N138 Bathroom call bell detaching from quick release when attempted to activate, (197)

Rm N116 Call bell from end of the cord was not working; call bell could be activated from wall button only, (197)

Rm N236 Call bell from end of the cord was not working; call bell could be activated from wall button only. (103)

The Manager of Environmental Services was interviewed and indicated the home does a complete room cleaning and painting when residents are discharged. Stated otherwise repairs are identified by staff or by himself during room audits. The above noted areas had not been identified for repair at the time of this inspection. According to the Manager of Environmental Services, call bells are not currently audited for functionality at the home level. [s. 15. (2) (c)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 79 (3)(n) whereby the Resident Council meeting minutes are not posted.

During the review of the information posted by the home, it was determined the home has not been posting the minutes of the Resident Council. The home took action to post the minutes with the consent of the council. [s. 79. (3) (n)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 97 (1)(b) whereby the resident's substitute decision maker was not notified of an alleged incident of resident abuse/neglect.

The following is in regards to log #O-001600-15:

On an identified date, an allegation of resident abuse/neglect was reported to the DOC. The DOC was interviewed and stated at the time of the report, she had reason to believe the information constituted an allegation of resident abuse/neglect. The home immediately investigated the allegation, but failed to contact the resident's Power of Attorney (POA) at any time of the allegation as required by the legislation. [s. 97. (1) (b)]

Issued on this 15th day of April, 2015

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

Original report signed by the inspector.