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
Nov 7, 2014	2014_289550_0025	O-000810-14	Resident Quality Inspection

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

JOANNE HENRIE (550), ANGELE ALBERT-RITCHIE (545), HUMPHREY JACQUES (599), LINDA HARKINS (126), LISA KLUKE (547), MELANIE SARRAZIN (592)

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): September 2, 3, 4, 5, 8, 9, 10, 11 and 12, 2014.

During the course of this inspection Log # O-001038-13, # O-000883-13, and # O-000768-14 were also inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the RAI Coordinator/Infection Control Nurse and Staff Education Coordinator, the Food Service Supervisor (FSS), the Environmental Supervisor, the Activity Director, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Behavior Support Ontario staff (BSO), Cook, two Food Service Workers, Physiotherapist Assistant (PTA), housekeeping staff, Laundry Aide, the President of the Resident Council and the President of the Family COuncil.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **26 WN(s)**
- **9 VPC(s)**
- **6 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that the local Medical Officer of Health is invited to the Infection Prevention and Control team meetings.

During an interview the infection control nurse staff #S115 indicated to Inspector #550 that the infection control team meets on a quarterly basis. He/she indicated the Medical Office of Health is never invited to the infection control team meetings.

During an interview, the Director of Care indicated to Inspector #550 the Medical Office of Health is not always invited to the Infection control meetings. [s. 229. (2) (c)]

2. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an observation Inspector #545 and #550 observed a sign at the bedroom door entrance of two specific resident room indicating "Universal Precautions". During an interview, PSW #S116 indicated to Inspector that Resident #038 requires universal precautions because of being newly admitted to the home. He/she indicated when new residents are admitted they require universal precautions in place until the results of the MRSA swabs that are done on admission are received. He/she indicated Resident #037 requires universal precautions because he/she has MRSA in a wound on a sepcific body part and that universal precautions require staff to wear gloves when there is contact with body fluids. Staff #S116 indicated to Inspector #550 he/she was not aware that contact precautions should have been in place and he/she should wear a gown and gloves when providing direct care to those two residents.

During an interview RPN staff #S102 indicated to Inspector #550 he/she did not know why Resident #037 had a sign at the bedroom door entrance indicating ''Universal Precautions'' and that the resident had MRSA in a wound on a specific body part. He/she indicated to Inspector #550 he/she had to wear gloves when he/she is doing the dressing for the resident and that no other precautions are required. Staff #S102 indicated to Inspector #550 he/she was not aware that contact precautions should have been in place and that he/she should wear gloves and a gown when doing this resident's dressing to her wound.

Inspector #550 reviewed the written plan of care for Resident #037 dated a specific date in June 2014 and for Resident #038 dated a specific date in September 2014. There was no indication of the MRSA infection for either residents or precautions to be taken by staff when caring for these residents.

Inspector reviewed the home's MRSA and VRE screening policy, revised August 1, 2013. The policy indicated staff are to use ''universal precautions'' when caring for resident's who are MRSA+. Inspector reviewed the ''Politique des precautions universelles'' policy revised December 5, 2010. This policy indicated universal

precautions are applicable to blood and body fluids that contain blood, seminal fluid and vaginal secretions that contain occult blood, and liquids such as cerebrospinal, synovial, pleural, pericardial, amniotic and peritoneal. Universal precautions do not apply to feces, sputum, nasal secretions, sweat, tears, urine, vomiting and saliva unless they contain blood. Staffs are to wear a gown only when there is a possibility that blood can contaminate clothing and gloves are to be worn whenever there is direct contact with blood or bodily fluids, when performing capillary blood sugar and when the worker has cuts, scratches or other skin lesions and he judges his hands could be contaminated with blood.

The best practices from the Provincial Infectious Diseases Advisory Committee (PIDAC) indicate contact precautions have to be in place (wearing gloves and gown) when providing direct care for a resident infected with MRSA to prevent the transmission of the infection to other residents. As per the ‘’Routine Practices and Additional Precautions In All Health Care Settings’’, 3rd edition from PIDAC, direct care is defined as: providing hands-on care (e.g., bathing, washing, turning client/patient/resident, changing clothes, continence care, dressing changes, care of open wounds/lesions, toileting). Both staff were not aware that contact precautions include the use of a gown when providing direct care to an infected resident.

During an interview, the infection control nurse staff indicated to Inspector #550 the policies ''Politiques des précautions universelles'' and ''St-Viateur Nursing Home M.R.S.A. and V.R.E. screening policy'' are the only two policies the home has to guide staffs in dealing with MRSA positive residents. She has a ''Guidelines MRSA/VRE'' sheet posted on the bulletin board in her office but this sheet is not posted anywhere else, therefor not accessible to staffs. She indicated Resident #037 should not have had a sign for ''Universal precautions'' posted at the bedroom door; it should have been a ''Contact Precautions'' sign instead.

The Infection and Control program was not evaluated and updated in accordance with prevailing practices from the Provincial Infectious Diseases Advisory Committee (PIDAC) therefore cannot properly guide the staff in preventing the transmission of infections in the home.

This is an ongoing non-compliance as it was previously issued as a voluntary plan of correction during the Resident Quality Inspection that was conducted in May 2012. [s. 229. (2) (d)]

3. The licensee has failed to ensure that there is a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management

During an interview, the Infection Control Nurse indicated to Inspector #550 she did not receive formal education in infection prevention and control practices other than a 5.25 hour high level education session on different types of bacterias encountered in long term care and hand washing in May 2012.

The Director of Care indicated the Infection Control Nurse did not receive any education in infection prevention and control practices. [s. 229. (3)]

4. The licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

During an interview the Director of care indicated to Inspector #550 the home does not offer immunization against tetanus and diphtheria to the residents. She indicated the home does not have policies regarding these vaccines and that she is not aware the home has to offer these vaccines to the residents. She indicated they are meeting with the Health Unit in September 2014 to review their infection control policies. [s. 229. (10) 3.]

5. The licensee has failed to ensure that all pets visiting as part of a pet visitation program have up-to-date immunizations.

The Activity Coordinator indicated to Inspector #550 during an interview there is a volunteer who regularly visits with four dogs. She indicated it is the volunteer's responsibility to make sure the dogs have up-to-date immunizations and that there is no process in place by the home to ensure that all pets who visit have up-to-date immunizations.

The infection control nurse staff #S115 provided Inspector with a copy of the home's

"Politique des animaux domestiques dans l'établissement" policy. The policy indicates under bullet 1 and 2 that it is the owner's responsibility to ensure that the animal has up-to-date immunization and has to provide a copy of the immunization record. [s. 229. (12)]

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. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The Licensee failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg 79/10, s. 228.

During an interview, the Administrator indicated to Inspector #550 that the home is currently in the process of developing their quality improvement an utilization review system. They have not yet developed any goals, objectives, policies, procedures and protocols or a process to identify initiatives for review.

The Administrator indicated they have integrated the quality improvement system meetings with the management committee meetings and their last meeting was on January 9, 2014.

Non compliance was previously issued under LTCHA, c. 8, s. 84 as a written notification on May 31st, 2012.

If the home had implemented a quality improvement and utilization review system, they would have been able to identify the maintenance issues that are identified in WN#4 and policies not being followed as identified in WN#15. [s. 228.]

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

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to 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

Upon review of the health record, it was documented that Resident #010 is diagnosed with Mental Problems and was followed by the Psychogeriatric Services. A note from the registered nurse from this services indicated on a specific date in March 2014 he/she had discussed resident's behaviour with the home's behavioural support (BSO) staff. The last documented note from the psychogeriatric services physician was dated April 30, 2014 indicating that Resident would continue to be followed closely.

The Plan of Care dated a specific date in June 2014 indicated that Resident #010 was easily distracted, had episodes of disorganized speech, inconsistent mental functioning during the day, periods of restlessness, and periods of lethargy. It did not indicate that Resident #010 exhibited verbal abusive behaviour. When reassessed on a specific date in August 2014, Resident was exhibiting daily verbal abuse and was socially inappropriate with disruptive behaviour and it was indicated that both behaviours were

not easily altered. In a review of Resident #010's aggressive behaviour scale score, an increase from 1/12 to 9/12 over a period of 3 months (May 21 to August 6, 2014), indicated a significant increase in responsive behaviours.

During the inspection, Inspector #545 observed Resident #010 self-propelling his/her wheelchair throughout the home; and several times a day Resident was heard having angry outbursts, screaming very loudly at other residents to move out of her way, yelling that staff were not attending to his/her needs. On September 9, 2014 at 16:53 Inspector heard Resident swearing loudly to another resident to get out of her way, a staff member intervened and moved the other resident out of reach of Resident #010. On September 10, 2014 at 14:52, Resident #030 who was sitting in his/her wheelchair by the nursing station, touched Inspector #545's arm wanting attention; Resident #010 yelled out at Resident #030 to "stop listening right now on the conversation between the Inspector and the DOC". A PSW came by immediately, and directed Resident #010 to another area.

During interviews with PSW #S113, PSW #S111, RN #S112, Physiotherapy Assistant #S110 and the RAI Coordinator they identified the following responsive behaviours exhibited daily by Resident #010:
•Frequent daily outbursts at staff and visitors
•Yelling and swearing at other residents ordering them to move out of his/her way
•Displaying impatience and often screaming out that "no one helped him/her around here".
•Frequent outbursts at meal time demanding to be served first; indicating that Resident #010 was moved to the Main Dining Room because even though he/she was eating independently, Resident #010 required staff intervention to manage the behaviours

PSW #S113 indicated on September 8, 2014 that Resident #010 reacted with anger outbursts and identified the following triggers:
•Resident #010 couldn't pass in the hallways with his/her wheelchair or with the walker during the walking program,
•wandering Resident entered his/her room
•the food was not served as soon as resident arrived in the dining room
•resident rang the bell and staff didn't come fast enough
•staff pushed him/her to be independent like dressing or propelling own w/c when he/she didn't want

PSW #S111 indicated on September 8, 2014 that Resident #010 reacted in outbursts of yelling and screaming and becoming upset and identified the following triggers:

•not getting attention from staff, indicating that Resident reacted positively to one-on-one interaction with staff and enjoyed hugs as he/she got to know you
•not getting the assistance with care immediately when asked
•other residents won at Bingo while he/she didn't
•others are in his/her way in the corridor, added that Resident seem to own the corridor in the home, not want other residents in his/her space

RN #S112 indicated on September 8, 2014 that Resident #010 was verbally abusive on a daily basis, swearing at staff and residents when and identified the following triggers:
•pain in his/her legs
•high need of attention
•low intolerance to other Residents around him/her
•impatience, unable to wait, need to be served first

The RAI Coordinator indicated on September 9, 2014 some staff were a little rough with him/her, added that staff should not joke with Resident #010, and always approach him/her slowly and be attentive to his/her mood.

On September 10, 2014 BSO staff #117 indicated that the Behavioural Support staff were not involved with Resident #010 because resident was already followed by the psychogeriatric services and that the home's staff knew how to manage his/her responsive behaviours.

The RAI Coordinator indicated she was responsible in updating the plan of care, and to ensure it was printed and placed in the residents' paper chart as registered staff and direct care staff did not have access to the electronic records. She indicated that Resident #010's responsive behaviour plan of care dated a specific date in June 2014 did not include any mood and behaviour patterns, any identified responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day but that she would individualized resident's plan of care to reflect his/her responsive behaviour as identified by staff, including herself.

During an interview with the Director of Care on September 11, 2014 she indicated that she was aware that Resident's #10's plan of care needed some work in order to include any mood and behaviour patterns, any identified responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day. [s. 6. (1)]

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

The most recent care plan for Resident #001 dated a specific date in July 2014 indicates Resident #001 is incontinent of urine and wears incontinence products and skin integrity does not indicate a pressure ulcer to the coccyx.

During an interview, the Assistant Director of Care indicated to Inspector #550 Resident #001 is no longer incontinent of urine, resident now has a foley catheter in place because of a pressure ulcer. She indicated this resident has a stage 3 pressure ulcer to a specific body part and the treatment has been changed to a specific type of dressing to be change every three days and PRN. Tilting wheelchair, change position every 30-60 minutes, change degree of tilt when sitting.

PSW staff #S101 who was the PSW assigned to Resident #001 was aware that the resident had a foley catheter in place and the presence of a stage 3 ulcer on a specific body part. He/she indicated to inspector he/she has to reposition resident every two hours while the resident is in bed and that the resident should be up only for meals.

The Assistant Director of Care indicated to Inspector #550 being aware that the care provided to Resident #001 does not reflect what is in the written care plan. She indicated the care and interventions are updated in the written care plan only when the staffs complete the quarterly assessments. She indicated the care plan should be updated when the resident's care changes and they should not wait until the quarterly assessment is done. She indicated to inspector the changes in the care of a resident are communicated to staff at the report in the morning.

As such, Resident#001's written plan of care does not set out the planned care for the resident. [s. 6. (1) (a)]

3. On September 3rd, at 10:30 inspector #592 was doing an interview and an observation with a resident in room 102-4. Inspector #592 went to observe the bathroom area and found Resident #005 sitting on the toilet unattended, Resident #005 had the lift sling still under him/her and it was still attached to the lift that was in front of him/her. Inspector approached PSW #S102 who was walking down the corridor to inform him/her that Resident #005 was found sitting on the toilet unattended. PSW #102 indicated to Inspector #592 that he/she was coming to assist this resident. PSW#102 indicated to Inspector #592 that it was a regular practice for this resident to be left unattended on the

toilet with the lift. He/she indicated they put the brakes on the lift, they leave the resident alone for privacy and return to assist the resident later.

The Assistant Director of Care indicated to Inspector #592 during an interview that it is regular practice for staff to leave this resident unattended on the toilet with the sling and lift in front of him/her. This practice is done to ensure resident's privacy while on the toilet. Inspector #592 showed Resident #005's care plan to the Assistant Director of Care assistant. The care plan specified not to leave the resident unattended when on the toilet but to provide privacy. The Assistant Director of Care indicated that the care provided to this resident by staff was not reflecting the current plan of care. [s. 6. (1) (a)]

4. The most recent care plan for Resident #001 dated a specific date in July 2014 indicated this resident:
-is incontinent of urine and wears incontinence products.

During an interview, the Assistant Director of Care indicated to Inspector #550 Resident #001 is no longer incontinent of urine, the resident now has a foley catheter in place because of a pressure ulcer.

PSW staff #S101 who was the PSW assigned to Resident #001 was aware that the resident had a foley catheter in place.

The Assistant Director of Care indicated to Inspector #550 being aware that the care provided to Resident #001 does not reflect what is in the written care plan. She indicated the care and interventions are updated in the written care plan only when the staffs complete the quarterly assessments. She indicated the care plan should be updated when the resident's care changes and they should not wait until the quarterly assessment is done. She indicated to inspector the changes in the care of a resident are communicated to staff at the report in the morning. [s. 6. (1) (a)]

5. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

On September 12, 2014 the Director of Care provided Inspector #547 with a copy of the Resident #005's plan of care dated a specific date in December 2013. This plan of care only indicated that the resident requires a specific type of restraint when in bed. No indication of the resident's trunk restraint, or two specific type of limb restraint were noted in the resident's written care plan.

On September 12, 2014 staff #106 and staff#130 indicated that Resident #005 has a trunk restraint applied when seated in his/her chair. These same staff members also indicated that Resident #005 had two other specific type of limb restraint applied to a specific limb when staff were providing personal care or feeding also when the resident is seated in his/her chair when other residents are present. Staff #106 and Staff #130 confirmed that the resident cannot remove these restraints on his/her own.

On September 12, 2014 Staff #132 indicated to Inspector #547 he/she knows it is considered a restraint, but that it was not in the care plan. Both of the resident's limb restraints are also not in the care plan.

During an interview with Inspector #547 on September 12, 2014, the Director of Care indicated that all Resident #005's restraints should have been in the care plan and the restraint record should provide clear directions to staff and others who provide direct care to Resident #005 including the proper documentation and supervision of these restraints.

The Director of Care confirmed that the plan of care for Resident #005 did not set out clear directions to staff and others who provide direct care to this resident regarding his/her restraints.

The plan of care does not provide directions related to the application and monitoring of the two specific limb restraints. [s. 6. (1) (c)]

6. Resident #010 was reassessed on a specific date in August 2014, and it was documented that resident had inadequate bladder control with multiple daily episodes of incontinence, which was a change from his/her last assessment dated a specific date in May 2014. At that time Resident #010 had bladder incontinence two or more times per week but not daily.

Upon review of the Plan of Care dated a specific date in May 2014 it was indicated that Resident #010 was occasionally incontinent of bladder, two or more times per week, and interventions included provision of disposable/reusable diapers - small medium large, toileting every 2 hours or before and after meals and as needed. It was also documented that Resident had complete bowel control and needed to be toileted daily at the same time to prevent incontinence.

During interviews with PSW #S113 on September 8, 2014, he/she indicated that Resident used a specific type of incontinence product on days and evenings and another specific type of incontinence product at night time. He/she indicated that Resident required daily encouragement to be reminded he/she is capable of being continent, added that Resident was capable of ringing the call bell when needed to go to the bathroom. PSW #113 indicated that he/she needed to respond to the call bell quickly as Resident is not able to wait.

During interview with RN #S112 on September 8, 2014, he/she indicated that he/she was surprised that Resident was incontinent of bladder as Resident was capable of ringing the call bell for assistance, added that Resident regularly asked for assistance. The RN indicated that Resident was incontinent of bowels following administration of a laxative. The Plan of Care did not mention that Resident had frequent bowel incontinence following administration of laxative.

During an interview with the RAI Coordinator on September 9, 2014 she indicated that Resident #010's bladder and bowel continence was assessed as part of the completion of the RAI-MDS 2.0 assessment on a specific date in August 2014 but that she had not yet had time to revise and update the Resident's plan of care. She indicated that the printed plan of care last revised on a specific date in June 2014 was the only plan of care available and accessible to direct care staff and registered staff.

As such, Resident #010's plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

7. During the fall of 2014, Resident #004 was transferred to another Long Term Care Home. Resident #004's care plan dated a specific date in July 2014, was reviewed. It is noted in the care plan that Resident #004 will "maintain mobility and will exercise and prevent contractures. Resident #004 was to receive physical therapy 15 minutes total in 1 day per week, time 75 minutes".

On September 9, 2014, Inspector #126 interviewed Physiotherapy Assistant staff #S110. He/she indicated that resident #004 was not receiving any type of physiotherapy treatment since March 13, 2014. Staff #S110 is not aware of the criteria to ensure physiotherapy treatment continues or when to discharge a resident. Staff #S110 indicated he/she follows the instruction of the physiotherapist and usually discharge the resident after a visit from the physiotherapist. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 003, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 ensure that the home, furnishings and equipment are maintained in a good state of repair.

Inspector #547 interviewed the home's Environmental Supervisor on September 10, 2014 who indicated that the home does not have procedures or plans to ensure ongoing maintenance for preventative home repairs. The Environmental Supervisor indicated that staff will report any repair issues to him verbally or via the housekeeping/maintenance log book that he verifies daily. The Environmental Supervisor further indicated that he will repair any safety issues immediately as they are brought to his attention. The Environmental Supervisor does not keep any log of areas repaired, unless they were logged in the housekeeping/maintenance log book, as verbal items do not get added to this book.

The following observations were made by Inspectors #550, #592, #545 and #547 during the Resident Quality Inspection:

On September 4, 2014 Inspector #550 noted in a specific resident room:
-that the wall under the window was cracked exposing the dry wall beneath

-the bumper pads on each bed rail were noted to be ripped exposing the foam beneath
-the walls in this shared washroom were gouged with paint chipped exposing drywall. -screw holes observed above the soap dispenser and under the paper towel dispenser exposing the drywall beneath
-the bottom corner wall next to the sink is damaged, with paint chipped exposing the drywall

On September 2, 2014, Inspector #592 noted resident a specific resident room to have three broken floor tiles underneath the electric heater box to be broken exposing cement, 2 inches wide, 6 feet long. There were also three drywall patches in the bathroom walls and chipped paint exposing the drywall under the soap dispenser and three areas where caulking missing around the toilet exposing brownish and yellowish matter.

On September 3, 2014, Inspector #545 noted in a specific resident room shared bathroom that the caulking around the toilet covered with yellow/brownish matter and areas of caulking removed all together. Floor tiles around this toilet were stained with yellow/brownish colour. Paint on the bottom of the walls was noted to be chipped with black marks and the baseboards were unglued in 2 areas exposing the drywall behind with an accumulation of dust and debris

It was further noted on September 2nd to the 4th, 2014 these common areas in disrepair:
-On September 4, 2014 Inspector #550 observed TV lounge had indentations in the walls with chipped paint exposing the drywall as well as the wall under the window was damaged with chipped paint and drywall. Floor tiles under the baseboard heaters in this same area are damaged exposing the sub floor beneath

-On September 3, 2014 Inspector #545 observed in the small dining room (Rm 147) to have 8 metal chairs and 1 wooden chair with maroon leatherette exposing material beneath. Four white circular tables have lost painting on the edges exposing porous wood grain. The Lounge/TV room/Dining room area had 14/14 metal chairs with maroon leatherette where several slits exposed material. The wooden railing in the hallways had well worn varnish exposing the porous wood grain. Inspector # 545 also noted the Spa/Tub Room #113 (West Wing) had paint chips on walls/doors throughout exposing the porous drywall. Caulking was noted to be missing around toilet and covered with yellow/brownish matter with floor tiles stained around the toilet.

-On September 10, 2014 Inspector #547 observed a specific resident room had a bent baseboard heater box under the window, with paint chipped exposing a sharp edge in

this shared resident room. Floor tiles under this heater box was broken where the sub floor raises up exposing the cement sub floor, with dust and debris. Interview with the Janitor on this same date indicated that this floor was repaired 4-5 years ago and continues to crack as the cement sub floor has lowered in areas. they are unable to properly seal this area and they decided to not repair area again. No other solutions to seal this area under the baseboard heater to this date.

On September 11, 2014 Inspector #547 observed that the small dining room (RM147) had 3 baseboard heater boxes and the large dining/living room had 5 baseboard heater boxes that have been dented, with paint scuffed in several areas. The large dining/living room had 2/4 vinyl lazy boy chairs with ripped vinyl in several areas to each chair exposing the material and foam underneath. Both dining rooms had vinyl baseboard that has become unglued and broken in several areas, exposing the sub floor where dust and food debris has accumulated.

On September 10, 2014 Inspector #547 noted walls in 7/11 resident rooms in the West wing, and 6/14 resident rooms in the East wing, where the corner of walls near the resident's closets were gouged with paint and drywall removed exposing the metal drywall strapping beneath. Metal doorway to every resident room had paint scuffed exposing the metal base beneath.

On September 10, 2014 Inspector #547 interviewed the Administrator regarding the home and furnishings that have not been maintained in a good state of repair, and he indicated that the home has ongoing repairs required and will be rectified when the home rebuilds their new building. The Administrator indicated that the chairs could be recovered versus replaced to minimize costs, however they remain not done since the were also noted at the last Resident Quality Inspection in May 2012.

At this point and time, there is no building plans in place to rebuild the home.

Non compliance was previously issued as a voluntary plan of correction on May 31st, 2012. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

During a review of Resident #004's health record, Inspector # 126 observed that it was documented in the progress notes on a specific day in August 2014 that resident #004 was pinched by another resident which resulted in a small bruise to a specific body part. The incident was witnessed by RPN staff #S131 and it was documented by RN staff #S112. No other documentation in the progress notes was found related to that incident.

On September 11, 2014, Inspector #126 interviewed RN staff #S112 who was the RN in charge of the building when the incident of August 2014 occurred. RN staff #S112 indicated that he/she had not followed up on the incident because the resident who pinched Resident #004 does that occasionally to other residents in the home. RN staff #S112 also indicated that he/she did not complete an incident report, notify the resident's family of the incident or investigate the incident further as he/she had not perceived that incident as an incident of physical abuse.

The Director of Care was in the medication room when Inspector #126 interviewed RN staff #S112. The Director of Care asked Inspector #126 if the police needed to be called for such an incident. Inspector #126 indicated that the home is required to follow the legislation related to abuse. Inspector #126 asked both registered staff if they were aware of the abuse decision tree and they did not know what the Inspector was taking about.

There was no evidence that the alleged incidents of physical abuse involving the resident was immediately investigated as identified in WN #6.

The incident of physical abuse to Resident #004 was not reported to the Director as identified in WN #18.

Resident #004's substitute decision maker was not notified immediately upon the licensee becoming aware of the incident of abuse that resulted in a physical injury to the resident as indicated in WN #24.

The appropriate police force was not immediately notified of the witnessed incident of abuse to Resident #004 as indicated in WN #25.

During an interview, staff #S115 (RAI Coordinator and Educator) indicated to Inspector #126 that the home provided education in November 2013, on the home's policy ''Zero tolerance and non-abuse of residents & employees''. The attendance sheet dated November 2013 was reviewed and it was observed that out of 89 employees, 24 employees participated in the training on abuse. Staff #S112 indicated that he/she did not have training in the last year related to abuse.

The licensee has failed to ensure that all staff have receive retraining annually on Resident's Bill or Rights, duty to make mandatory reports under section 24 of the Act and the whistle blowing protection as identified in WN #20.

The home's package of information does not include an explanation of the duty under section 24 to make mandatory reports as identified in WN #21.

The home's "Zero tolerance non abuse of residents and employees" policy does not include all the requirements in the LTCHA, s. 20. (2) as identified in WN 17. [s. 19. (1)]

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 comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of or that is reported, is immediately investigated.

It was documented in the progress notes of Resident #004 dated a specific date in August 2014, that resident #004 was pinched by another resident that resulted in a small bruise to a specific body part. The incident was witnessed by RPN staff #S131 and it was documented by RN staff #S112. No other documentation in the progress notes was found related to that incident.

On September 11, 2014, Inspector #126 interviewed RN staff #S112 who was the RN in charge of the building when the incident of August 2014 occurred. RN staff #S112 indicated that he/she had not followed up on the incident because the resident who pinched Resident #004 does that occasionally to other residents in the home. RN staff #S 112 also indicated that he/she did not complete an incident report, notified the resident's family of the incident or investigate the incident further as he/she had not perceived that incident as an incident of physical abuse.

The Director of Care was in the medications room when Inspector #126 interviewed RN staff #S112. The DOC asked Inspector #126 if the police needed to be called for such an incident. Inspector #126 indicated that the home is required to follow the legislation related to abuse. Inspector #126 asked both registered staff if they were aware of the abuse decision tree and they did not know what the Inspector was taking about.

During an interview, staff #S115 (RAI Coordinator and Educator) indicated that the home provided education in November 2013, of the home's policy ''Zero tolerance and non-abuse of residents & employees''. The attendance sheet dated November 2013 was reviewed and it was observed that out of 89 employees, only 24 employees participated to the training on abuse. Staff #S112 indicted that he/she did not have training in the last year related to abuse. [s. 23. (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 in that all incidents of alleged, suspected or witnessed abuse of a resident by anyone is immediately investigated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

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:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

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:
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. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of restraints by physical devices to be included in the plan of care for Resident #005.

Resident #005 was diagnosed with two specific diagnosis. This resident is unable to walk and has limitation and partial loss of two limbs and can be physically aggressive towards staff and family when providing care or when they are feeding this resident.

Resident #005 was observed in his/her wheelchair in the television lounge at 10:30am by Inspector #592 on September 2, 2014 wearing a specific limb restraint. The limb restraint was attached to a specific body part and the other end of the restraint was attached to the bottom of the armrest. The restraint allowed the resident to move a specific limb but only allowed minimal movement.

Resident #005 was observed by Inspector #547 on September 12, 2014 sitting in his/her wheelchair alone in his/her room wearing two specific types of limb restraint to a specific body part. One end of a specific limb restraint was attached to the resident's specific limb but the restraint was not attached to the resident's chair at this time.

On September 12, 2014 the Director of Care provided Inspector #547 a copy of Resident #005's care plan dated a specific date in December 2013 as the most up to date care plan for this resident. This care plan only indicated that the resident requires a specific type of restraint when in bed. No indication of this Resident's two other types of restraints were noted in the resident's care plan.

On September 12, 2014 Staff #106 and Staff #130 both indicated to Inspector #547 that Resident #005 had a specific trunc restraint and that the resident cannot remove it on his/her own as it is a restraint to keep him/her safe in his chair. These same staff members indicated that the resident requires a specific limb restraint to be secured to the resident's chair and another specific limb restraint to a specific body part, to prevent the resident from being physically aggressive to staff/family during care and when they are assisting him/her with meals. Staff #132 also indicated that he/she signs this resident's restrictive devices monitoring/repositioning record for the resident's for the trunk restraint as this staff knows it is considered a restraint, but that it was not indicated at the top of this record, or is it in the care plan.

No indication from Staff #106, Staff #130 or Staff #132 that Resident #005's specified limb restraint should be signed for on the restraint record when in use.

On September 12, 2014 the Director of Care indicated during an interview with Inspector #547 that Resident #005's trunk restraint and a specific limb restraint should be indicated in the care plan and the restrictive devices monitoring/repositioning record. [s. 31. (1)]

2. The licensee has failed to ensure that the restraint plan of care include an order by the physician or the registered nurse in the extended class.

Resident #005 was observed in his/her wheelchair by Inspector #592 on September 2, 2014 wearing a specific type of trunk restraint and a specific limb restraint. The limb restraint was attached to the resident's specific limb and the other end of the restraint was attached to the bottom of the armrest.

Resident #005 was also observed by Inspector #547 on September 12, 2014 sitting in his/her wheelchair in his bedroom wearing a specific trunk restraint and two specific type of limb restraint. One end of the limb restraint was attached to the resident's specific body part but the other end was not attached to anything.

During an interview, PSWs staff #S116 and #S130 both indicated to inspector 547 the other end of the limb restraint is only attached to the wheelchair when they are providing care or feeding the resident, to prevent him/her from being aggressive with staffs. Inspector #547 observed that Resident #005 cannot remove any of the devices on his/her own.

Inspector #547 reviewed the resident's chart. The "Restrictive devices monitoring/repositioning record'' sheet signed by PSWs on a daily basis indicated the resident requires a specific type of restraint when in bed but it did not have any provision for the trunk restraint, the two specific limb restraints. It was further observed that PSWs sign on this sheet for the trunk restraint and the specific type to restraint when in bed but not for the two specific limb restraints. Inspector was unable to find a physician or registered nurse in the extended class' order for the trunk restraint.

During an interview the Director of Care indicated to Inspector #547 that no order by a physician or a registered nurse in the extended class had been obtained for the limb restraint. This is considered a restraint therefore a physician's order should have been obtained. [s. 31. (2) 4.]

3. The licensee has failed to ensure that the restraint plan of care include the consent by the resident or if the resident is incapable, by the Substitute Decision Maker (SDM).

As per documentation in the resident's chart, Resident #005 requires to have these restraints in place:
-a specific trunk restraint when in wheelchair
-two specific limb restraints when staff are providing care
-a specific type of restraint when in bed for safety

Inspector #547 reviewed the resident's chart and was unable to find that consent had been obtained for any of the above restraints. A blank restraint consent form was found in the chart but it was not signed by the resident or the resident's SDM.

During an interview, the Director of Care indicated to Inspector #547 that no consent had been obtained by the resident's SDM and that it should had been obtained for all restraints in place for Resident #005. [s. 31. (2) 5.]

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 all restraining devices for Resident #005 are:
-documented upon and included in the resident's written plan of care,
-are ordered by a physician or a nurse in the extended class, and,
-consent from the resident's substitute decision is obtained and documented., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or

cleaning of dentures.

During an interview with Resident #008's family member on September 2, 2014 the family member indicated that during a dental examination in the spring of 2014, the dentist repaired 7 cavities in the spring of 2014, added that he reported large amount of tarter, and requesting that staff brushed Resident's teeth twice daily.

Upon review of Resident #008's health record, it was documented that Resident was admitted to the home on a specific day in 2014 with several medical conditions. The most recent plan of care dated a specific day in June 2014 indicated that Resident #008 "had dentures and/or removable bridge, that he/she had broken, loose or carious teeth that daily cleaning of teeth or dentures, or daily mouth care by client or staff was required. It was also indicated that staff needed to remove and rinse dentures after each meal". In a letter signed by the dental surgeon in the spring of 2014 it was indicated that Resident had been seen in the spring of 2014 and that the hygienist had cleaned resident's teeth and that a deterioration in Resident #008's oral hygiene had been noted, and a total of seven cavities were being repaired. The dental surgeon recommended a specific mouth rinse and stated in his letter that it was important for Resident #008's teeth be brushed after each meal and especially at bedtime.

In a review of the quarterly medication review done on a specific day in August 2014, it was documented that a specific mouth rinse was prescribed for use at night after brushing Resident #008's teeth.

On September 12, 2014, Inspector #545 observed Resident #008's mouth and noted that his/her tongue was covered with a whitish film, and whitish debris and film over his/her teeth.

During an interview with PSW #S128 on September 12, 2014 PSW indicated that he/she had not provided Resident #008's mouth care this morning, added that he/she was too busy. PSW indicated he/she thought resident had a partial but was not sure if it was an upper or lower appliance. PSW indicated that he/she was not aware that he/she needed to brush Resident's teeth after each meal and was not aware of Resident's specific dental care needs. RPN S#102 indicated, after checking Resident's medical administration record that evening staff used a prescribed mouth rinse at 8pm, probably because Resident #008 had halitosis and some cavities.

The RAI Coordinator and the Director of Care, indicated during a discussion on

September 12, 2014 that Resident #008's did not receive dental care morning or evening and after each meals as recommended by the dental surgeon in the spring of 2014. [s. 34. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in that all residents who require assistance with oral care are provided with the care and assistance needed to maintain the integrity of the oral tissues, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On September 08, 2014, Inspector #550 observed in Resident #001's chart two "skin management - treatment and observation record" form with a first entry date of a specific date in July 2014 and the other one dated a specific date in August 2014. This form is is the tool the registered staff use to evaluate the wounds on a weekly basis as indicated by the Assistant Director of Care. The registered staff are to document the date and time the observation was made, the management and treatment, the observations, the weekly follow up assessment notes and the registered staff signature. It was observed that none of them had a weekly follow up assessment done. During an interview the Assistant Director of Care indicated to Inspector #550 there were no weekly follow up assessment done for the stage 3 wound of this resident. The management and treatment is documented but no weekly assessment is done. [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 in that Resident #001 who is exhibiting altered skin integrity or skin breakdown receive a weekly assessment by a member of the registered staff, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to comply in that the licensee did not ensure that the planned menu items are offered and available at each meal and snack.

On the 2014 spring and winter menu for residents it was documented that resident shall

be served tea and coffee with lunch and dinner.

An informant, lodged a complaint with the Ministry of Health and Long Term Care on a specific date in July 2014 and indicated that on several occasions tea and coffee were not served to residents at supper time on a sepcific date in July 2014 that menus served to residents are different from what was communicated to residents.

On September 10, 2014, Inspector # 126 interviewed Food Service Worker staff #S123 and #S124 regarding tea and coffee service at supper time. They indicated that if the home is short staffed and the (4pm-7pm) shift is not covered or replaced, the Dietary Staff do not prepare or offer tea or coffee at supper for the residents, because they are alone in the kitchen.

On September 11, 2014, Inspector #126, interviewed the Food Service Supervisor (FSS) regarding the coverage of the (4pm-7pm) shift. She indicated that she started her position at the beginning of August 2014. She was aware that several shift were not covered during the summer.

Inspector #126 reviewed the Dietary Staff Schedule for the period of June 29-September 11, 2014. It was noted that the home did not have anyone working those following (4pm-7pm) shifts on : June 12, 27, 28, 29, 30, July 2, 3, 5, 7 and 31, 2014. On most of these evenings, tea or coffee were not made available for the residents as planned in the menu.

The breakfast menu for September 11, 2014 indicated fried eggs and residents were observed to be eating scrambled eggs. Discussion held with FSS and two Dietary staff indicated that the cook does not have the same menu that is posted for residents. The FSS indicated that the fall/winter menu will be implemented shortly and the cook will use the same menu that is posted for the residents. [s. 71. (4)]

2. Observation of both dining rooms was done on September 2nd, 2014 by Inspectors #592 and #545 at 12:00pm. The "Regular Week at a Glance menu" (Spring/Summer 2014) posted on the bulletin board in both dining rooms for that specific day indicated for the lunch menu: garden quiche, chef salad with dressing, mandarin orange or tuna sandwich, red cabbage salad and strawberry mousse. The "Daily Menu" posted on the white Board located in the small dining room for that same specific day, the lunch menu indicated: Sheppard's pie and pickles, tuna sandwich with coleslaw and mandarin orange or ice cream. This was the menu provided in both dining rooms for lunch, therefore

Residents were not served the planned menu items indicated on the "Regular Week at a Glance menu".

During an interview, Staff PSW#S103 indicated to Inspector #592 he/she was not aware why the meal was not served as planned. He/she indicated the menu may have been changed because of the hot weather.

During an interview on September 2nd 2014, the Food Service Supervisor indicated to Inspector #545 she is newly hired (about one month). She explained that the posted menu was not served as planned because some ingredients were not available. She indicated staffs always make the corrections on the daily menu, handwritten on the white board.

An observation of both dining rooms was conducted on September 4th 2014 at 12:00pm by Inspector #592. The "Regular Week at a Glance menu" (Spring/Summer 2014) posted on the bulletin board indicated for lunch: grilled cheese sandwich, four bean salad or crunchy perch/tartar Sauce, hash browns and zucchini. The daily menu handwritten on the white board indicated: grilled cheese sandwich, four bean salad or Crunchy Perch, hash brown and veggies. When the meal was being served, Inspector #592 observed that there were no zucchini offered, they were replaced by carrot. The Food Support Worker staff #S104 indicated to inspector #592 that carrots were served for lunch and that he/she was not aware the Weekly Planned Menu indicated zucchini. The Food Support Worker indicated they probably ran out of zucchini and the staff forgot to change the daily and weekly menu.

During an interview, the Food Service Supervisor indicated to Inspector#592 she was not aware that carrots were served instead of zucchini at lunch time today. She indicated she is aware there are a lot of discrepancy between the Weekly planned menu and what is being served. She indicated she will have to focus more on the actual menu to ensure that items are available at each meal as per the planned weekly menu.

Interview was done with the Director of Care on September 5th, 2014. She indicated to Inspector #592 that the home's expectations is that the staff follow the Weekly Planned menu and if they can't provide what's on the menu, they should inform the Food Service Supervisor or the Director of Care so they could make the changes accordingly. She indicated that she was not aware of the changes on the menu for September 2nd and September 04th and that the Food Service Supervisor should have been aware of the changes because she was on site.

During an interview on September 5th, 2014 at 10:30am, the Cook staff #S105 indicated to Inspector #592 he/she is aware that the weekly menu is not in accordance with what is been served. He/she indicated having informed the Food Service Supervisor a long time ago of this and that nothing is being done. The Cook indicated the previous Food Service Supervisor was aware that the residents do not like zucchini; therefore no zucchini were available yesterday at lunch and was replaced with carrots. Staff #S105 also indicated that it's more convenient for them to write on the white board "veggies" instead of specifying which vegetable is served as it is easier to make changes. The Cook indicated he/she realize it would be best practice to identify which vegetable they are going to serve. [s. 71. (4)]

3. On September 4 2014 during an interview, a member of Resident #004's family indicated to Inspector #550 that often there is no tea or coffee offered to residents at supper because the home is short staffed and the 4-7pm shift in the kitchen is not covered. According to this family member this situation occurs regularly. [s. 71. (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 planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are schedules and procedures in place for routine, preventative and remedial maintenance in the home.

On September 10, 2014 Inspector #547 interviewed the Janitor for the home who indicated that he does not have any schedules and procedures in place for routine, preventative and remedial maintenance in the home, as he will repair or replace as they are broken or when he is informed they are broken. The Janitor also indicated that no records are kept of any repairs done in the home. The Janitor indicated that he is aware of repairs required in several rooms where the paint and drywall has been gauged exposing the metal drywall strapping as he does the sweeping and mopping of the home daily. He does not keep any record of rooms with damages, or has he created a plan for repairs at this time.

On September 10, 2014 Inspector #547 also interviewed the Administrator who also indicated that the home did not have any schedule or procedures in place for routine, preventative and remedial maintenance as the janitor has worked here for so long, that he is familiar with all the routines done and required in the home. He asks the Janitor to prioritize around resident risk, and knows that the Janitor will stop when staff ask him to fix something for a resident. The Janitor and the Administrator have an informal method of tracking what is required to be done in the home, and is verbal.

During the Resident Quality Inspection many issues were observed by several inspectors as identified in WN#3. [s. 90. (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 the home develops a preventative maintenance program, have schedules and routines in place to ensure that all repairs needing to be completed are done in a timely manner, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 129 (1).
(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 has failed to ensure that the drugs are stored in an area or a medication cart that is secure and locked.

On September 4, 2014 at 11:30, Inspector #545 observed a medication cart unlocked and unattended by the Nursing Station. No staff was around, and an insulin pen was on top of the cart. Inspector asked staff member #S110, sitting in the office behind the nursing station if he/she was the nurse responsible for the medication cart. Staff #S110 indicated he/she was a physiotherapy assistant and was not sure where the nurse was. At 11:35, RN #S100 came out of the Medication Room situated approximately 10 feet from where the medication cart was located in front of the Nursing Station. When asked what the home's expectation was in regards to leaving his/her medication cart unlocked and unattended the RN replied that the medication cart each medication drawers had plastic latches and that residents did not know how to open these drawers. RN #S100 indicated that it was not his/her practice to lock the medication cart when he/she moved away from it, if it was only for only a few minutes, even if he/she was unable to visualize the medication cart.

On September 9, 2014 during an interview with the Assistant Director of Care (ADOC) she indicated that some residents in the home would be able to open the plastic latches to open the drawers of the medication cart and easily access stored medications. The ADOC indicated that the home's expects that all nurses ensure that medications are stored in an area or a medication cart that is secure and locked at all times, even when the nurse leaves the medication cart for a few minutes. [s. 129. (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 that the medication cart is kept locked at all times when not supervised by a Registered Staff member, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's drug destruction and disposal policy include that drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

Upon review of the Disposal of Surplus prescribed drugs in the Nursing Home (Ministry of Health-Surplus Prescribed Drugs) policy, dated July 2013, surplus prescribed drugs was defined as "drugs remaining in containers which are labeled with the name of a

deceased, transferred or discharged resident, or where the use of the drug has been ordered discontinued by the Attending Physician". Information regarding drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs, was not found.

During an interview with the Director of Care (DOC) on September 11, 2014 she confirmed that the home stored safely and securely the drugs that were to be destroyed and disposed of, separately from drugs available for administration to a resident, until the destruction but that their policy did not include this information. She indicated that she would be updating her policy to meet legislation requirement. [s. 136. (2) 1.]

2. The licensee has failed to ensure that the that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the following in the drug record:

1. The date of removal of the drug from the drug storage area
2. The name of the resident for whom the drug was prescribed, where applicable
3. The prescription number of the drug, where applicable
4. The drug's name, strength and quantity
5. The reason for destruction
6. The date when the drug was destroyed
7. The names of the persons who destroyed the drug
8. The manner of destruction of the drug?

During an interview with the Assistant Director of Care on September 10, 2014 she indicated that the home stored safely and securely any controlled substance in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

During a discussion with the Assistant DOC on September 11, 2014, she indicated that the home did not have a policy providing the applicable team documentation as required per legislation.

On September 12, 2014 the DOC indicated that she would be updating the home's policy to meet legislation requirement indicating that the home did not have policy that provides the applicable team document the following in the drug record: (1) date of removal of the drug from the drug storage area, (2) name of the resident for whom the drug was

prescribed, where applicable, (3) prescription number of the drug, where applicable, (4) drug's name, strength and quantity, (5) reason for destruction, (6) date when the drug was destroyed, (7) names of the persons who destroyed the drug, and (8) manner of destruction of the drug. [s. 136. (4)]

3. The licensee has failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

During an interview with the Director of Care (DOC) on September 11, 2014, she indicated that every two months or sooner, the pharmacist comes to the home and together with the DOC or the Assistant DOC they separate each individual medication package called Dispill (clear plastic bubble sealed with a paper label indicating Resident's name, room number, name of medication, dosage, date and time of administration) from it's weekly Dispill card, leaving discontinued medications in their original packaging then placing them in a black plastic bag. The DOC indicated that the pharmacist then leaves the home with the black plastic bag with all the discontinued medications in its original packaging (Dispill) and that the pharmacist makes arrangements for destruction offsite.

The DOC indicated that she was not aware that all drugs, including controlled substances had to be altered or denatured to such an extent that its consumption is rendered impossible or improbable. [s. 136. (6)]

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 home's drug destruction policy is revised to include all the Legislation's requirements, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in skin and wound care as per LTCHA, 2007, c. 8. s.76 (7).

The Director of Care and the Staff Education Coordinator staff #S115 indicated to Inspector #550 the last education session on skin and wound management was done on June 5, 2013. At that time, 20 of 64 direct care staff received the education.

The home did not provide training in skin and wound care on an annual basis. [s. 221. (1) 2.]

2. The licensee has failed to ensure that all direct care staff receive the required annual training: Behaviour management.

In accordance with the O.Reg 79/10 s. 76 (7) 3 Additional training – direct care staff, every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: Behaviour management.

In discussion with the RAI Coordinator on September 10, 2014 she indicated that she attended the Gentle Persuasive Approach (GPA) training on behaviour management in 2011 and that only 10 to 15 staff attended GPA training yearly.

During an interview with the Director of Care on September 10, 2014 she indicated that behaviour management training was not provided yearly to all direct care staff. She confirmed that the home had a staff of 33 PSW, 16 registered staff. In reviewing the GPA Participant Information Collection Form, it was indicated that the following number of attendants participated in the GPA training:
-2013 (October 9): 11 staff attended GPA training
-2011: 6 direct care staff attended GPA
The DOC indicated that in 2012, GPA training was canceled due to an outbreak in the home. [s. 221. (2),s. 221. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that direct care staff receive training in skin and wound care and behaviour management, to be implemented voluntarily.

WN #15: 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 ensure that their policy titled "Policy for Skin Care Assessment and Management", revised February 13, 2008, is complied with.

The home' procedure indicates:
1. RN/RPN will use the Braden Scale for predicting pressure sore risk. The Braden Scale Form will be filed on the residents' chart and results documented in the Care Plan. He/she will also perform a "head to toe" (begin with the scalp and end with the toes, including the feet and nails) skin assessment and record the findings on the "Skin Assessment MDS Section M" form at the following times:
-Admission: within 8 hours of admission to the facility
-Post-admission: 6 week review when the resident has been identified as "at risk" with a score of 18 or less on the "Braden Scale"
-Quarterly review
-Change in health status: that affects skin integrity
-Return from hospital and/or leave(s) of absence: After an absence of more than 24

hours to be completed within 24 hours after return, for residents who are at risk for altered skin integrity.

It was documented in the progress notes Resident #001 developed a sore to a specific body part on a specific date in June 2014. During a review of the resident's health record, inspector observed there was no "Bradden Scale" assessment done. A skin assessment was done during the MDS evaluation period 7 specific days in June 2014, but none was not done after the resident had a change in the health status that affects the skin intergrity; when he/she developed a sore to a specific body part. Both the Director of Care and the Assistant Director of Care indicated this was not done as per their policy.

Inspector observed the chart of Resident #031 with the Director of Care. This resident was readmitted to the home following a hospital stay from in the summer of 2014. A skin assessment was done for the last MDS period evaluation 7 days in July 2014. This resident has a stage 2 stasis ulcer to a specific body part. No Braden scale assessment was observed in this resident's chart and no head to toe assessment was done within 24 hours of a return from a hospital stay for more than 24 hours.

Inspector reviewed the chart of Resident #023 with the Director of care. A skin assessment was done for last MDS period evaluation 7 days in July 2014. Last Braden scale was done a specific date in September 2013 where resident was identified at being at a moderate risk for pressure ulcer. No further skin assessment was done for this resident.

The Director of Care indicated to Inspector #550 these residents were not evaluated as per the home's "Skin Care Assessment and Management policy". [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

As per O.Reg 79/10 s.114 (3) (a) written policies and protocols for the Medication management system must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On September 11, 2014 the Director of Care provided Inspector #545 with two policies

regarding recording of narcotic medication which were reviewed, the following were noted:

#1: Controlled Drug Policy (Individual Patient's Narcotics Records) dated July 1, 2013 - on page 1 of 1, item 4 under Procedure indicated that "Inventory of the controlled drugs must be recorded on the "Narcotic and Controlled Medication Record" at the time of administration by the Registered Nurse on duty. [s. 8. (1)]

WN #16: 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 failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

For the purpose of this report, the communication and response system is referred to as a call bell system.

On September 4, 2014 while conducting the dining observation in the main dining room and the small dining room, Inspector #592 observed that both area were not equipped with a communication and response system accessible by residents.

During an interview, PSW staff #S103 indicated to Inspector #592 that there is no call bell system in the dining rooms and indicated that staff will shout for help when requesting assistance for any emergency.

During an interview the Director of Care (DOC) indicated to Inspector #592 that she was not aware that the dining room had to be equipped with a communication and response system. [s. 17. (1)]

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

Resident #020 was diagnosed with two specific diagnosis and was wheelchair bound, requiring total assistance of staff for transfers and for locomotion on the unit. On September 2 at 11:00 and September 5, 2014 at 13:20 the resident was observed sitting in a wheelchair watching TV in the resident's room. The resident-staff communication system panel for this resident was located on the wall between Resident's bed and his roommate's bed, and was not accessible to the resident due to bed placement. The call bell cord leading from the panel was tied to the bed post on the head of the bed and not accessible to the resident who was seated in his/her wheelchair nearest the foot of the bed. When asked by Inspector#545, how resident would call for assistance the resident indicated that he/she would call out to staff. The resident demonstrated that he/she would not be able to get to his call bell cord, but when presented with the call bell, he/she pressed the white button and stated that it worked well as he/she could hear that the alarm had went off. At the time of this observation, Resident #019 did not have access to his/her call bell.

Resident #019 was diagnosed with two specific diagnosis and was wheelchair bound, requiring extensive assistance of staff for transfers and for locomotion on the unit. On September 2, 2014 at 14:00 the resident was observed sitting in a wheelchair watching TV in the resident's room. The resident-staff communication system panel for this resident was located on the wall adjacent to the head of bed and was not accessible to the resident as due to bed placement. The call bell cord leading from the panel was tied to the bed rail nearest to the head of the bed and close to the floor as the bed rail was in

the down position and not visible as a blanket was covering it. The resident was seated in his/her wheelchair nearest the foot of the bed, and the call bell was not accessible to the resident. When asked by Inspector#545, how he/she would call for assistance the resident indicated the he/she would call out to staff, the resident demonstrated that he/she would not be able to get to the call bell cord. At the time of this observation, Resident #019 did not have access to the call bell.

On September 4, 2014 at 10:10, Resident #011 was observed lying in bed. The resident staff communication system was located on the wall adjacent to the bed, between Resident's bed and the roommate. The call bell cord leading from the wall was wrapped around the post of the bed's headboard and not accessible to the resident while he/she was resting in bed. When asked if he/she could access the call bell, Resident indicated that he/she didn't know where the call bell was as he/she could not see it. Upon review of the plan of care (dated a specific date in June 2014) it was documented "to provide Resident with the call bell when in bed and to place it within reach and encourage Resident to use it to call staff". On September 5, 2014, during an interview with RPN #S109 he/she indicated that the home's expectation was to ensure that the call bell was within reach at all times, he/she picked up the call bell that was hanging on the metal towel rack above the head of Resident's bed and moved it to the super pole by the bed so that it would be accessible to Resident #011.

On September 5, 2014 at 14:30 Resident #002 was observed lying in bed. The resident staff communication system was located on the wall adjacent to the bed. The call bell cord leading from the wall was tied to the post of the head of the bed and was not accessible to the resident while he/she was lying in the bed.

During an interview with PSW #S111, PSW indicated that the resident's son requested that the call bell be attached to Resident #002's pillow or clothing when in bed. At the time of this observation, the call bell was not accessible to Resident #002.

During interviews with PSW #S107, #S108 and #S111, they indicated that Residents were checked by staff regularly during the day therefore the call bells within reach were not required.

On September 5, 2014, the Director of Care indicated that she was aware that the resident-staff communication response system needed to be easily seen, accessed, and used by residents, staff and visitors at all times; but that this was not always put into practice into this home. [s. 17. (1) (a)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents included the following:
-clearly set out what constitutes abuse and neglect as per the legislation definitions
-provide for a program, that complies with the regulations, for preventing abuse and neglect
-contain an explanation of the duty under section 24 of the Act to make mandatory reports
-contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents
-set out the consequences for those who abuse or neglect residents
- comply with any legislative requirements

The Home "Zero-Tolerance non-abuse of residents and employees" policy was reviewed. It was observed that the policy was effective dated June 1998 and was reviewed in September 2013.

This policy was developed for residents and employees abuse. Some of the definitions of abuse in this policy does not reflect the Long Term Care Home Act's definitions. The abuse policy does not reflect legistlative requirements for:
Duty to protect (LTCHA s.19)
Reporting to Director (LTCHA s.24)
Reporting notification, (O. Reg 79/10 s.97. &s.98)
Evaluation of incident of abuse(O. Reg 79/10 s.99)

The education on this policy was done in November 2013. The attendance sheet dated November 2013 included 89 employees but only 24 staffs signed as having been a participant to this training.

The Full Time Evening RN S#112 indicated that the Incident of August 2014 was not perceived as a physical incident of abuse. This incident was witnessed by RPN S#131 and resident resulted in having a small bruise to a specific body part. [s. 20. (2)]

WN #18: 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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, abuse of a resident by another resident.

Upon a review of Resident #004's health record, Inspector #126 observed an entry in the progress notes dated a specific date in August 2014 that indicated Resident #004 was pinched by another resident and as a result of this, Resident #004 sustained a small bruise to a specific body part. The incident was witnessed by RPN staff #S131 and was documented by RN staff #S112. No other documentation in the progress notes was found related to that incident.

During an interview, the Full Time Evening Registered Nurse staff #S112 indicated that this incident was not perceived as a physical abuse incident, therefore no one was notified of the incident. [s. 24. (1)]

WN #19: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During the observation of the small dining room at lunch time by inspector #545 on September 2nd at 12:25, it was observed that staff started to serve dessert (mandarin pieces and ice cream sandwiches) to resident even if many of them were not done eating their main course. It was also observed that several residents stopped eating their main course to eat their dessert.

During the observation of the main dining room at lunch time by inspector#592 on September 4th 2014 at 12:45, it was noted that one staff was distributing desserts starting at table #8, 4, 3, 2, 7, 6, 5, and 1, while the main course meal was not finished. Dessert plates were put beside main plate for all residents.

During an interview with Food Service Supervisor on September 4th 2014, she indicated to inspector #592 that she was not aware of the legislation for the course by course meal service.

During an interview with the Director of Care on September 5th 2014 by inspector #592 she indicated that she was aware of this practice and it should not be done this way. She indicated she is planning to revise staff assignment in the dining room. [s. 73. (1) 8.]

2. The licensee failed to ensure that no resident who requires assistance with eating or

drinking is served a meal until someone is available to provide the assistance required by the resident.

During an observation of the main dining room on September 02, 2014 at 12:27pm, Inspector #592 observed that at table #5 three residents were sitting with their main course served in front of them and that only one resident was being assisted by a staff member. At 12:33pm, 6 minutes later, Inspector #592 asked RPN staff #S102 if Residents # 014 and # 015 were going to be assisted with their meals. Staff #S102 indicated that another staff will come but in the meantime residents had to wait to be fed. Staff #S102 then immediately started to feed those two residents.

The most recent written plan of care for Resident #014 dated a specific date in August 2014 indicated this resident is on high nutritional risk. The most recent written plan of care for Resident #015 dated a specific date in December 2013 indicated this resident is at moderate nutritional risk.

During an observation on September 03, 2014 at 12:29pm, Inspector #592 observed at table #5 that Residents #016 and #003 were served their main course but no staff were present to assist them. At 12:36pm, 7 minutes later, a PSW came to feed both residents. PSW #S103 who was providing assistance to other residents at table #5 indicated to inspector that both residents like their food at room temperature and that is the reason their meal is served in advance. PSW indicated that all staff were aware of this but she is unsure if it is specified in the care plan.

It is documented in Resident #003's most recent written plan of care dated a specific date in June 2014 that this resident is at high nutritional risk. It is documented in Resident #016's most recent written plan of care dated a specific date in November 2013 that this resident is at moderate nutritional risk.

During an observation on September 04, 2014 Inspector #592 observed that Residents #017 and #018 at table #8 received their main course at 12:30pm but there were no staff present to assist those residents. A PSW came at table #8 at 12:45 to assist both residents, 15 minutes later.

The most recent written plan of care for Resident #017 dated a specific date in July 2014 indicated this resident is on high nutritional risk. The most recent written plan of care for Resident #018 dated a specific date in June 2013 indicated this resident is at moderate nutritional risk.

Inspector #592 reviewed the care plan of Residents #003 and #017. There was no specification for both residents regarding their preference to be served their meals at room temperature and that both residents' decision making was severely impaired.

During an interview with the Food Service Supervisor on September 04, 2014, she indicated to Inspector #592 that staffs are expected to serve residents who require assistance only when there are staffs available to feed the residents. Their meal should not be served to prevent them to eat the food and risk of chocking with no supervision. The Food Service Supervisor indicated to Inspector #592 that she was not aware of the Legislation because she has been recently hired and she was unsure of the home's expectation.

During an interview with the Director of Care on September 05, 2014, she indicated to Inspector#592 that the home's expectations is that there is one PSW assisting one table. She indicated she was not aware that some residents were served their meal without staffs' presence to assist them and that they had to wait to be fed. She indicated that it is not an appropriate practice and that she is planning in the near future to re-organize the dining room department. [s. 73. (2) (b)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that that all staff have receive retraining annually on Residents' Bill of Rights,duty to make mandatory reports under section 24 and the whistle-blowing protections.

The educator binder was reviewed by Inspector #126. It was noted that the Residents' Bill of Rights, duty to make mandatory reports under Section 24 and whistle-blowing protection was not part of the annual retraining.

Discussion with DOC indicated that they have not provided annual retraining on Residents' Bill of Rights,duty to make mandatory reports under section 24 and the whistle-blowing protection. [s. 76. (4)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(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. 78 (2)
(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. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)

(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to ensure the package of information shall include, at a minimum, (b) the long-term care home's mission statement; (d) an explanation of the duty under section 24 to make mandatory reports; (e) the long-term care home's procedure for initiating complaints to the licensee; (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; (n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; (o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; (q) an explanation of the protections afforded by section 26.

Inspector reviewed the admission package that is provided to residents upon admission. The package failed to include:
-the long-term care home's mission statement
-an explanation of the duty under section 24 to make mandatory reports
-the long-term care home's procedure for initiating complaints to the licensee
-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
-a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents
-information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package
-an explanation of the protections afforded by section 26

During an interview with Inspector #550, the Administrator indicated the above was not part of the Resident's Admission package. [s. 78. (2)]

WN #22: 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 failed to ensure the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements. The required information for the purposes of subsections (1) and (2) is, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; (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; (q) any other information provided for in the regulations.

In accordance with O. Reg 79/10, s. 225 (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to resident under section 79 of the Act includes the following: 3. The most recent audited report provided for in clause 243 (1) (a).

During a tour of the home, Inspector #550 observed that the following information was not posted in the home:

-the long-term care home's policy to promote zero tolerance of abuse and neglect of residents
-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
-the most recent audited reconciliation report

During an interview with Inspector #550, the Administrator indicated the above information was not posted in the home. [s. 79. (3)]

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Family Council in developing and carrying out the annual satisfaction survey.

S#113, President of the Family Council, stated that he/she has been participating in the Family Council for over four years and does not remember the council being asked for advice in developing and carrying out the satisfaction survey during that time.

Director of Care indicated that there is a satisfaction survey conducted annually in the home, and the Administrator is the lead on that project and is not aware of the home specifically seeking the advice of the Family Council in developing and carrying out the survey

During an interview with the Administrator he indicated that the same survey is used every year and there is no formal process to seek advice from the Family Council in developing the survey. [s. 85. (3)]

2. The licensee has failed to ensure the results of the survey are made available to the Family Council in acting on its results.

S#113, President of the Family Council, indicated during an interview that he/she has been participating in the Family Council for over four years and does not remember the council being presented with the results of the survey and advice in acting on the survey results during that time.

Director of Care indicated that there is a satisfaction survey conducted annually in the home, and the Administrator is the lead on that project and is not aware of the home specifically presenting the results of the survey and seeking the advice of the Family Council in acting of the survey results.

The Administrator has indicated to the Team Lead and indicated on the Quality Improvement check list that the Home does not make available to families the results of the annual survey and actions taken.

During an interview with the Administrator he indicated that the same survey is used every year and the survey results and actions are not made available to the Family Council [s. 85. (4) (a)]

WN #24: 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 ensure that he resident's Substitute Decision Maker and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury.

Upon a review of Resident #004's health record, Inspector #126 observed an entry in the progress notes dated a specific date in August 2014 that indicated Resident #004 was pinched by another resident and as a result of this, Resident #004 sustained a small bruise to a specific body part. The incident was witnessed by RPN staff #S131 and was it documented by RN staff #S112. No other documentation in the progress notes was found related to that incident.

During an interview, the Full Time Evening Registered Nurse staff #S112 indicated that this incident was not perceived as a physical abuse incident, therefore he/she did not notify the resident's substitute decision maker of the incident. [s. 97. (1) (a)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of witnessed incident of abuse that the licensee suspects may constitute a criminal offence.

Upon a review of Resident #004's health record, Inspector #126 observed an entry in the progress notes dated a specific date in August 2014 that indicated Resident #004 was pinched by another resident and as a result of this, Resident #004 sustained a small bruise to a specific body part. The incident was witnessed by RPN staff #S131 and was it documented by RN staff #S112. No other documentation in the progress notes was found related to that incident.

During an interview, the Full Time Evening Registered Nurse staff #S112 indicated that this incident was not perceived as a physical abuse incident, therefore he/she did not notify the appropriate police force. [s. 98.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home who maintains an emergency drug supply for the home keep only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and the Administrator.

On September 11, 2014 Inspector #545 did an observation of the home's Emergency Drug Box, kept locked in the medication cupboard in the locked Medication Room. The following medications were found in the Emergency Drug Box:
-Resident #033 - a specific phenothiazines, 4 ampoules, ordered November 13, 2013
-Resident #034 - a specific phenothiazines, 3 ampoules, ordered Aug 7, 2014
-Resident #035 - a specific anticholinergic drug, 1 inhaler, ordered March 5, 2013

In reviewing the "Drugs Used From Medication (Emergency Box) Control Sheet" available in the Emergency Drug Box, it was documented that Resident #035 had received 4 doses of a specific phenothiazines injectable, taken from the Emergency Drug Box on the following dates:

-April 25, 2014
-April 26, 2014
-April 27, 2014
-April 28, 2014

During an interview with the Director of Care on September 11, 2014 she indicated that Residents #033, #034 and #035 were no longer Residents in the home, added that all 3 had passed away. The DOC then indicated that on a specific date in April 2014 the physician prescribed a specific phenothiazines injectable every 6 hours as needed for Resident #035 who is no longer a Resident in the home. The DOC indicated that registered staff probably used one of the ampoules of discontinued specific phenothiazines that had been moved into the Emergency Drug Box when Resident #033 had passed away.

On September 11, 2014, the Assistant Director of Care indicated to Inspector #545 that she felt that it would be wasteful to destroy the specific phenothiazines when Residents were discharged or passed away and felt it was acceptable to keep this medication in the Emergency Drub Box for use for other Residents as required in an emergency situation.

In a discussion with the DOC she indicated that the Resident specific prescribed medications would be removed immediately from the home's Emergency Drug Box and placed in the locked Drug Destruction cupboard because neither the specific phenothiazines nor the specific anticholinergic drug inhaler had been approved or prescribed for the purpose of Emergency Stock. [s. 123. (a)]

2. The licensee has failed to ensure that the home who maintains an emergency drug supply for the home has a written policy is in place to address:
-the location of the supply,
-procedures and timing for reordering drugs,
-access to the supply,
-use of drugs in the supply, and
-tracking and documentation with respect to the drugs maintained in the supply.

On September 11, 2014, Inspector #545 reviewed the content of the home's locked Emergency Drug Box located in the locked Medication Room.

During an interview with the Director of Care (DOC) on September 11, 2014 she indicated that the home maintained an Emergency Box, supplied with a list of

medications provided by Shoppers Drug Mart. When asked for a written policy regarding location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply, and tracking and documentation with respect to the drugs maintained in the supply, the DOC provided Inspector #545 with a Memo. Upon review of the memo sent to all registered staff on September 21, 2007 (provided by the DOC), it was documented that "whenever staff need to contact the on-call physician for a new medication order please verify list of medications available in emergency box to assure that the medication was in stock so treatment could be started promptly before delivery from pharmacy" and that "the reordering of non-urgent medications should be done 3-5 days ahead and not on weekends because regular staff were not available and delivery could be delayed". In further discussion with the DOC, she confirmed that the home did not have a written policy in place. [s. 123. (b)]

Issued on this 9th day of January, 2015

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

Original report signed by the inspector.

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) :	JOANNE HENRIE (550), ANGELE ALBERT-RITCHIE (545), HUMPHREY JACQUES (599), LINDA HARKINS (126), LISA KLUKE (547), MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2014_289550_0025
Log No. / Registre no:	O-000810-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 7, 2014
Licensee / Titulaire de permis :	GENESIS GARDENS INC 438 PRESLAND ROAD, OTTAWA, ON, K1K-2B5
LTC Home / Foyer de SLD :	FOYER ST-VIATEUR NURSING HOME 1003 Limoges Road South, Limoges, ON, K0A-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To GENESIS GARDENS INC, 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

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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:

A process to ensure that the infection control program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices from the Provincial Infectious Diseases Advisory Committee (PIDAC)

A monitoring process to the ensure that:
-every resident with an infection has their written plan of care revised to include the type of infection identified and the precautions to be in place to guide staff when caring for the resident.
-communication is enhanced with proper signage at the resident's bedroom entrance to guide staff and visitors with the precautions in place.
-all staff are applying proper precautions at the appropriate time when caring for a resident with a specific infection.

The home shall have a process for revision of their policies and procedures for all antibiotic resistant organism present in the home be revised to include prevailing practices as per the Provincial Infectious Diseases Advisory Committee (PIDAC).

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Joanne Henrie by November 21, 2014 via e-mail to joanne.henrie@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that the local Medical Officer of Health is invited to the Infection Prevention and Control team meetings.

During an interview the infection control nurse staff #S115 indicated to Inspector #550 that the infection control team meets on a quarterly basis. She indicated the Medical Office of Health is never invited to the infection control team meetings.

During an interview, the Director of Care indicated to Inspector #550 the Medical Office of Health is not always invited to the Infection control meetings. (550)

2. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an observation Inspector #545 and #550 observed a sign at the bedroom door entrance of two specific resident's rooms indicating "Universal Precautions". During an interview, PSW #S116 indicated to Inspector that Resident #038 requires universal precautions because of being newly admitted to the home. He/she indicated when new residents are admitted they require universal precautions in place until the results of the MRSA swabs that are done on admission are received. PSW indicated Resident #037 requires universal precautions because he/she has MRSA in a wound on a specific body part and that universal precautions require staff to wear gloves when there is contact with body fluids. Staff #S116 indicated to Inspector #550 he/she was not aware that contact precautions should have been in place and he/she should wear a gown and gloves when providing direct care to those two residents.

During an interview RPN staff #S102 indicated to Inspector #550 he/she did not know why Resident #037 had a sign at the bedroom door entrance indicating ''Universal Precautions'' and that the resident had MRSA in a wound on a specific body part. RPN indicated to Inspector #550 he/she had to wear gloves when he/she is doing the dressing for the resident and that no other precautions are required. Staff #S102 indicated to Inspector #550 he/she was not aware that contact precautions should have been in place and that he/she should wear gloves and a gown when doing this resident's dressing to his/her wound.

Inspector #550 reviewed the home's MRSA and VRE screening policy, revised August 1, 2013. The policy indicated staff are to use ''universal precautions'' when caring for resident's who are MRSA+. Inspector reviewed the ''Politique des precautions universelles'' policy revised December 5, 2010. This policy indicated universal precautions are applicable to blood and body fluids that contain blood, seminal fluid and vaginal secretions that contain occult blood, and liquids such as cerebrospinal, synovial, pleural, pericardial, amniotic and peritoneal. Universal precautions do not apply to feces, sputum, nasal secretions, sweat, tears, urine, vomiting and saliva unless they contain blood. Staffs are to wear a gown only when there is a possibility that blood can contaminate clothing and gloves are to be worn whenever there is direct contact

with blood or bodily fluids, when performing capillary blood sugar and when the worker has cuts, scratches or other skin lesions and he judges his hands could be contaminated with blood.

The best practices from the Provincial Infectious Diseases Advisory Committee (PIDAC) indicate contact precautions have to be in place (wearing gloves and gown) when providing direct care for a resident infected with MRSA to prevent the transmission of the infection to other residents. As per the ‘’Routine Practices and Additional Precautions In All Health Care Settings’’, 3rd edition from PIDAC, direct care is defined as: providing hands-on care (e.g., bathing, washing, turning client/patient/resident, changing clothes, continence care, dressing changes, care of open wounds/lesions, toileting). Both staff were not aware that contact precautions include the use of a gown when providing direct care to an infected resident.

During an interview, the infection control nurse staff #S115 indicated to Inspector #550 the policies ''Politiques des précautions universelles'' and ''St-Viateur Nursing Home M.R.S.A. and V.R.E. screening policy'' are the only two policies the home has to guide staffs in dealing with MRSA positive residents. She has a ''Guidelines MRSA/VRE'' sheet posted on the bulletin board in her office but this sheet is not posted anywhere else, therefor not accessible to staffs. She indicated Resident #037 should not have had a sign for ''Universal precautions'' posted at the bedroom door; it should have been a ''Contact Precautions'' sign instead.

The Infection and Control program was not evaluated and updated in accordance with prevailing practices from the Provincial Infectious Diseases Advisory Committee (PIDAC) therefore cannot properly guide the staff in preventing the transmission of infections in the home.

This is an ongoing non-compliance as it was previously issued as a voluntary plan of correction during the Resident Quality Inspection that was conducted in May 2012.
(550)

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 : Jan 31, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 228. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:

Development and implementation of a quality improvement and utilization review system that includes all requirements as per LTCHA s. 84 and O. Reg. 79/10 s. 228.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Joanne Henrie by November 21, 2014 via e-mail to joanne.henrie@ontario.ca and to submit a progress report by January 31st, 2015 to Joanne Henrie via e-mail.

Grounds / Motifs :

1. The Licensee failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg 79/10, s. 228.

During an interview, the Administrator indicated to Inspector #550 that the home is currently in the process of developing their quality improvement an utilization review system. They have not yet developed any goals, objectives, policies, procedures and protocols or a process to identify initiatives for review.

The Administrator indicated they have integrated the quality improvement system meetings with the management committee meetings and their last meeting was on January 9, 2014.

A quality improvement and utilization review system would have identified maintenance issues identified in WN #4 and policies not being followed as identified in WN #15.

Non compliance was previously issued under LTCHA, c. 8, s. 84 as a written notification on May 31st, 2012. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that:

The changes to a resident's condition are reflected in the written plan of care of each resident, specific to high risk areas such as:
-responsive behaviours,
-continence care,
-restraint use,

in order to provide clear directions to staff and others who provide direct care to residents.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (a) (b) (c) in that the licensee did not 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

Upon review of the health record, it was documented that Resident #010 is diagnosed with Mental Problems and was followed by the Psychogeriatric Services. A note from the registered nurse from this services indicated on a specific date in March 2014 he/she had discussed resident's behaviour with the home's behavioural support (BSO) staff. The last documented note from the

psychogeriatric services physician was dated a specific date in April 2014 indicating that Resident would continue to be followed closely.

The Plan of Care dated a specific date in June 2014 indicated that Resident #010 was easily distracted, had episodes of disorganized speech, inconsistent mental functioning during the day, periods of restlessness, and periods of lethargy. It did not indicate that Resident #010 exhibited verbal abusive behaviour. When reassessed on a specific date in August 2014, Resident was exhibiting daily verbal abuse and was socially inappropriate with disruptive behaviour and it was indicated that both behaviours were not easily altered. In a review of Resident #010's aggressive behaviour scale score, an increase from 1/12 to 9/12 over a period of 3 specific months indicated a significant increase in responsive behaviours.

During the inspection, Inspector #545 observed Resident #010 self-propelling his/her wheelchair throughout the home; and several times a day Resident was heard having anger outbursts, screaming very loudly at other residents to move out of the way, yelling that staff were not attending to his/her needs. On September 9, 2014 at 16:53 Inspector heard Resident swearing loudly to another resident to get out of the way, a staff member intervened and moved the other resident out of reach of Resident #010. On September 10, 2014 at 14:52 Resident #30 who was sitting in his/her wheelchair by the nursing station, touched inspector #545's arm wanting attention; resident #010 yelled out at Resident #030 to "stop listening in on conversation between Inspector and DOC". A PSW came by within a few minutes, and removed Resident #010 from area.

During interviews with PSW #S113, PSW #S111, RN #S112, Physiotherapy Assistant #S110 and the RAI Coordinator they identified the following responsive behaviours exhibited daily by Resident #010:
•Frequent daily outbursts at staff and visitors
•Yelling and swearing at other residents ordering them to move out of the way
•Displaying impatience and often screaming out that "no one helped him/her around here".
•Frequent outbursts at meal time demanding to be served first; indicating that Resident #010 was moved to the Main Dining Room because even though he/she was eating independently, he/she required staff intervention to manage his/her behaviour

PSW #S113 indicated on September 8, 2014 that Resident #010 reacted with anger outbursts and identified the following triggers:
•resident couldn't pass in the hallways with his/her wheelchair or with the walker during the walking program,
•wandering Resident entered his/her room
•the food was not served as soon as resident arrived in the dining room
•resident rang the bell and staff didn't come fast enough
•staff pushed resident to be independent like dressing or propelling his/her own w/c when he/she didn't want

PSW #S111 indicated on September 8, 2014 that Resident #010 reacted in outbursts of yelling and screaming and becoming upset and identified the following triggers:
•not getting attention from staff, indicating that Resident reacted positively to one-on-one interaction with staff and enjoyed hugs as he/she got to know you
•not getting the assistance with care immediately when asked
•others residents won at Bingo while he/she didn't
•others are in his/her way in the corridor, added that Resident seem to own the corridor in the home, not want other residents in his/her space

RN #S112 indicated on September 8, 2014 that Resident #010 was verbally abusive on a daily basis, swearing at staff and residents when and identified the following triggers:
•pain in his/her legs
•high need of attention
•low intolerance to other Residents around him/her
•impatience, unable to wait, need to be served first

The RAI Coordinator indicated on September 9, 2014 some staff were a little rough with resident, added that staff should not joke with Resident #010, and always approach resident slowly and be attentive to his/her mood.

On September 10, 2014 BSO staff #117 indicated that the Behavioural Support staff were not involved with Resident #010 because he/she was already followed by the psychogeriatric services and that the home's staff knew how to manage the resident's responsive behaviours.

The RAI Coordinator indicated she was responsible in updating the plan of care, and to ensure it was printed and placed in the residents' paper chart as

registered staff and direct care staff did not have access to the electronic records. She indicated that Resident #010's responsive behaviour plan of care dated a specific date in June 2014 did not include any mood and behaviour patterns, any identified responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day but that she would individualized the resident's plan of care to reflect his/her responsive behaviour as identified by staff, including herself.

During an interview with the Director of Care on September 11, 2014 she indicated that she was aware that Resident's #10's plan of care needed some work in order to include any mood and behaviour patterns, any identified responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day. (545)

2. The most recent care plan for Resident #001 dated a specific date in July 2014 indicated this resident is incontinent of urine and wears incontinence products.

During an interview, the Assistant Director of Care indicated to Inspector # 550 Resident #001 is no longer incontinent of urine, resident now has a foley catheter in place because of a pressure ulcer.

PSW staff #S101 who was the PSW assigned to Resident #001 was aware that the resident had a foley catheter in place.

The Assistant Director of Care indicated to Inspector #550 being aware that the care provided to Resident #001 does not reflect what is in the written care plan. She indicated the care and interventions are updated in the written care plan only when the staffs complete the quarterly assessments. She indicated the care plan should be updated when the resident's care changes and they should not wait until the quarterly assessment is done. She indicated to inspector the changes in the care of a resident are communicated to staff at the report in the morning. (550)

3. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c) in that the licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #010 was reassessed on a specific date in August 2014, and it was

documented that resident had inadequate bladder control with multiple daily episodes of incontinence, which was a change from the last assessment dated a specific date in May 2014. At that time Resident #010 had bladder incontinence two or more times per week but not daily.

Upon review of the Plan of Care dated a specific date in May 2014 it was indicated that Resident #010 was occasionally incontinent of bladder, two or more times per week, and interventions included provision of disposable/reusable diapers - small medium large, toileting every 2 hours or before and after meals and as needed. It was also documented that Resident had complete bowel control and needed to be toileted daily at the same time to prevent incontinence.

During an interview on September 8, 2014, PSW #S113 indicated that Resident used a specific type of incontinence product on days and evenings and a specific type of incontinence product at night time. PSW indicated that Resident required daily encouragement to be reminded he/she is capable of being continent, added that Resident was capable of ringing the call bell when needed to go to the bathroom. PSW #113 indicated that he/she needed to respond to the call bell quickly as Resident is not able to wait.

During interview with RN #S112 on September 8, 2014, he/she indicated that he/she was surprised that Resident was incontinent of bladder as Resident was capable of ringing the call bell for assistance, added that Resident regularly asked for assistance. The RN indicated that Resident was incontinent of bowels following administration of a laxative. The Plan of Care did not mention that Resident had frequent bowel incontinence following administration of laxative.

During an interview with the RAI Coordinator on September 9, 2014 she indicated that Resident #010's bladder and bowel continence was assessed as part of the completion of the RAI-MDS 2.0 assessment on a specific date in August 2014 but that she had not yet had time to revise and update the Resident's plan of care. She indicated that the printed plan of care last revised on a specific date in June 2014 was the only plan of care available and accessible to direct care staff and registered staff.

As such, Resident #010's plan of care did not set out clear directions to staff and others who provided direct care to the resident.
(545)

4. The licensee has failed to ensure that Resident #005's plan of care includes the restraint by a physical device used with the resident.

On September 12, 2014 the Director of Care provided Inspector #547 with a copy of the resident's plan of care dated a specific date in December 2013. This plan of care only indicated that the resident requires a specific type of restraint when in bed. No indication of the resident's trunk restraint, or the two other limb restraint were noted in the resident's care plan.

On September 12, 2014 Staff #106 and Staff#130 indicated that Resident #005 has a trunk restraint applied when seated in his/her chair. These same staff members also indicated that Resident #005 had two other limb restraints to a specific body part when staff were providing personal care or feeding also when the resident is seated in his/her chair when other residents are present. Staff #106 and Staff #130 confirmed that the resident cannot remove these restraints on his/her own.

On September 12, 2014 Staff #132 indicated to Inspector #547 he/she knows the trunk restraint is considered a restraint, but that it was not in the care plan. The Resident's two limb restraints are also not in the care plan.

During an interview with Inspector #547 on September 12, 2014, the Director of Care indicated that all Resident #005's restraints should have been in the care plan and the restraint record should also provide clear directions to staff and others who provide direct care to Resident #005 including the proper documentation and supervision of these restraints.

The Director of Care confirmed that the plan of care for Resident #005 did not set out clear directions to staff and others who provide direct care to this resident regarding his restraints.

The plan of care does not provide directions related to the application and monitoring of the restraint. (547)

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 : Dec 15, 2014

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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:

The development and establishment of schedules and procedures for routine, preventative and remedial maintenance to ensure ongoing maintenance for home repairs.

The plan shall identify the time line for completing the tasks and who will be responsible
for completing those tasks.

The plan is to be submitted to Joanne Henrie by November 21, 2014 via e-mail to
joanne.henrie@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that the home and furnishings are maintained in a good state of repair.

Inspector #547 interviewed the home's Janitor on September 10, 2014 who indicated that the home does not have procedures or plans to ensure ongoing maintenance for preventative home repairs. The Janitor indicated that staff will report any repair issues to him verbally or via the housekeeping/maintenance log

book that he verifies daily. The janitor further indicated that he will repair any safety issues immediately as they are brought to his attention. The Janitor does not keep any log of areas repaired, unless they were logged in the housekeeping/maintenance log book, as verbal items do not get added to this book. The following observations were made by Inspector #550, #592, #545 and #547 during the Resident Quality Inspection:

-On September 4, 2014 Inspector #550 noted in a specific resident room that the wall under the window was cracked exposing the dry wall beneath. The bumper pads on each bed rail were noted to be ripped exposing the foam beneath. The walls in this shared washroom were gouged with paint chipped exposing drywall. Screw holes observed above the soap dispenser and under the paper towel dispenser exposing the drywall beneath. The bottom corner wall next to the sink is damaged, with paint chipped exposing the drywall.

-On September 2, 2014. Inspector #592 noted in a specific resident room to have three broken floor tiles underneath the electric heater box to be broken exposing cement. 2 inches wide, 6 feet long. There were also three dry wall patches in the bathroom walls and chipped paint exposing the drywall under that soap dispenser and three areas where caulking missing around the toilet exposing brownish and yellowish matter.

-On September 3, 2014. Inspector #545 noted in a specific resident room shared bathroom that the caulking around the toilet covered with yellow/brownish matter and areas of caulking removed all together. Floor tiles around this toilet were stained with yellow/brownish colour. Paint on the bottom of the walls was noted to be chipped with black marks and the baseboards were unglued in 2 areas exposing the drywall behind with an accumulation of dust and debris.

It was further noted during September 2nd and 4th, 2014 these common areas in disrepair:
- On September 4, 2014 Inspector #550 noted TV lounge had indentations in the walls,with chipped paint exposing the drywall as well as the wall under the windows was damaged with chipped paint and drywall. Floor tiles under the baseboard heaters in this same area are damaged exposing the sub floor beneath.
-On September 3, 2014 Inspector #545 noted in the small dining Room (RM 147) to have 8 metal chairs and 1 wooden chair with maroon leatherette exposing material beneath. Four white circular tables have lost painting on the

edges exposing porous wood grain. The Lounge/TV Room/Dining Room Area had 14/14 metal chairs with maroon leatherette where several slits exposed material. The wooden railing in the hallways had well worn varnish on the wooden railings on walls is well used, exposing the porous wood grain. Inspector #545 also noted the Spa/Tub Room #113 (West Wing) had paint chips on walls/doors throughout exposing the porous drywall. Caulking was noted to be missing around toilet and covered with yellow/brownish matter with floor tiles stained around the toilet.
-On September 10, 2014 Inspector #547 noted a specific room had a bent baseboard heater box under the window, with paint chipped exposing a sharp edge in this shared resident room. Floor tiles under this heater box was broken where the sub floor raises up exposing the cement sub floor, with dust and debris. Interview with the Janitor on this same date indicated that this floor was repaired 4-5 years ago and continues to crack as the cement sub floor has lowered in areas. They are unable to properly seal this area and they decided to not repair area again. No other solutions to seal this area under the baseboard heater to this date.
-Inspector #547 further noted on September 11, 2014 that the small dining room (RM147) had 3 baseboard heater boxes and the large dining/living room had 5 baseboard heater boxes that have been dented, with paint scuffed in several areas. The large dining/living room had 2/4 vinyl lazy boy chairs with ripped vinyl in several areas to each chair exposing the material and foam underneath. Both dining rooms had vinyl baseboard that has become unglued and broken in several areas, exposing the sub floor where dust and food debris has accumulated.
- On September 10, 2014 Inspector #547 noted walls in 7/11 resident rooms in the West wing, and 6/14 resident rooms in the East wing, where the corner of walls near the resident's closets were gouged with paint and drywall removed exposing the metal drywall strapping beneath. Metal doorway to every resident room had paint scuffed exposing the metal base beneath.

-On September 10, 2014 Inspector #547 interviewed the Administrator regarding the home and furnishings that have not been maintained in a good state of repair, and he indicated that the home has ongoing repairs required and will be rectified when the home rebuilds their new building. The Administrator indicated that the chairs could be recovered versus replaced to minimize costs, however they remain not done since the were also noted at the last Resident Quality Inspection in May 2012.

At this point and time, there is no building plans in place to rebuild the home.

Non-compliance was previously issued as a voluntary plan of correction on May 31st, 2012. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:

A process to ensure that all staff receives education on reporting obligations of any person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident is immediately reported to the Director.

Development of a monitoring process to ensure that all incidents of suspected abuse of a resident by anyone is immediately investigated, documented and acted upon.

Revision of the home's policy ''Zero tolerance and non-abuse of residents & employees'' to include all requirements as indicated in the LTCHA, 2007 S.O. 2007, c.8, s. 20. and be communicated to all staff and all department managers. Education should include what constitute abuse.

A process to ensure all staff shall receive retraining annually on Resident's Bill of Rights, duty to make mandatory reports and whistle blowing protection.

A process to ensure that the admission package contains all the required information as per LTCHA s. 78 and O. Reg. 79/10 s. 224.

The plan shall identify the time line for completing the tasks and who will be responsible
for completing those tasks.

The plan is to be submitted to Joanne Henrie by November 21, 2014 via e-mail to
joanne.henrie@ontario.ca

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

During a review of Resident #004's health record, Inspector # 126 observed that it was documented in the progress notes on a specific date in August 2014 Resident #004 was pinched by another resident which resulted in a small bruise to a specific body part. The incident was witnessed by RPN staff #S131 and it

was documented by RN staff #S112. No other documentation in the progress notes was found related to that incident.

On September 11, 2014, Inspector #126 interviewed RN staff #S112 who was the RN in charge of the building when the incident of August 2014 occurred. RN staff #S112 indicated that he/she had not followed up on the incident because the resident who pinched Resident #004 does that occasionally to other residents in the home. RN staff #S112 also indicated that he/she did not complete an incident report, notify the resident's family of the incident or investigate the incident further as he/she had not perceived that incident as an incident of physical abuse.

The Director of Care was in the medication room when Inspector #126 interviewed RN staff #S112. The Director of Care asked Inspector #126 if the police needed to be called for such an incident. Inspector #126 indicated that the home is required to follow the legislation related to abuse. Inspector #126 asked both registered staff if they were aware of the abuse decision tree and they did not know what the Inspector was taking about.

There was no evidence that the alleged incidents of physical abuse involving the resident was immediately investigated as identified in WN #6.

The incident of physical abuse to Resident #004 was not reported to the Director as identified in WN #18.

Resident #004's substitute decision maker was not notified immediately upon the licensee becoming aware of the incident of abuse that resulted in a physical injury to the resident as indicated in WN #24.

The appropriate police force was not immediately notified of the witnessed incident of abuse to Resident #004 as indicated in WN #25.

During an interview, staff #S115 (RAI Coordinator and Educator) indicated to Inspector #126 that the home provided education in November 2013, on the home's policy ''Zero tolerance and non-abuse of residents & employees''. The attendance sheet dated November 2013 was reviewed and it was observed that out of 89 employees, 24 employees participated in the training on abuse. Staff #S112 indicated that he/she did not have training in the last year related to abuse.

The licensee has failed to ensure that all staff have receive retraining annually on Resident's Bill or Rights, duty to make mandatory reports under section 24 of the Act and the whistle blowing protection as identified in WN #20.

The home's package of information does not include an explanation of the duty under section 24 to make mandatory reports as identified in WN #21.

The home's ''Zero tolerance non abuse of residents and employees'' policy does not include all the requirements in the LTCHA, s. 20. (2) as identified in WN #17. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:

All residents who receive physiotherapy services, shall have their plan of care revised to ensure the provision of physiotherapy services is documented.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Joanne Henrie by November 21, 2014 via e-mail to
Joanne.Henrie@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

On a specific date in the fall of 2014, Resident #4 was transferred to another Long Term Care Home. Resident # 004's care plan dated a specific date in July 2014, was reviewed. It is noted in the care plan that Resident # 004 will "maintain mobility and will exercise and prevent contractures. Resident # 4 was to receive physical therapy 15 minutes total in 1 day per week, time 75 minutes".

On September 9, 2014, Inspector # 126 interviewed Physiotherapy Assistant S# 110 indicated that resident # 004 was not receiving any type of physiotherapy treatment since a specific date in March 2014. Staff #S110 is not aware of the criteria to ensure physiotherapy treatment continues or when to discharge a resident. Staff #S110 indicated he/she follows the instruction of the physiotherapist and usually discharge the resident after a visit from the physiotherapist.
. (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 7th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

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