Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 31, Jun 1, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 2012	2012_030150_0010	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

CAROLE BARIL (150), LINDA HARKINS (126), LYNE DUCHESNE (117), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Medical Director, several Registered Nurses (RN), several Registered Practical Nurses (RPN), Registered Dietitian (RD), Nutritional Care Manager, Infection Control Nurse (ICN), Maintenance Staff member, a housekeeping staff, several Food Service Workers, Activity Director, Restorative Care staff, several Personal Support Workers (PSWs), residents, family members, the President of the Resident Council, and the President of the Family Council.

During the course of the inspection, the inspector(s) reviewed several residents health care records, observed several meal services, examined several resident rooms and common areas, examined resident furniture, observed resident activities, reviewed the staffing nursing staffing schedule, the admission process, several of the home's policies and procedures, and the Resident and Family Council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s.8.(3) in that the home does not have a registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

The registered nurses schedule was reviewed for the period of May 6, 2012 to June 30, 2012 and it was noted that there was no registered nurse for the following days:
May 12-13, 2012 on day shift
May 20, 2012 on evening shift
June 9-10-11, 24 and 27, 2012 on evening shift.

The registered nurse schedule for the period of May 6-June 30, 2012 was reviewed and the Director of Care (DOC) confirmed the identified missing 24/7 hours coverage of Registered Nurses.

It was noted that the DOC shifts was included as a registered nurse on several day shifts.

The ADOC stated that if there are no available registered nurse to work a shift, the home's practice is to replace the RN by an RPN with the DOC acting as the RN on call.

It is noted that under O.Reg 79/10, s.45 (1) (1) (ii) (B) it is only in the case of an emergency (means an unforseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home) that an RPN can replace an RN, as long an RN who is a regular staff member is available by phone.

A discussion was held on June 11, 2012, between the DOC and inspector #150. The DOC confirmed an RN wanting a day off, was automatically replaced by an RPN on the registered nurse staffing schedule. This was not and emergency as defined in the Regulations.

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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, section 16 in that the home has not ensured that every window in the home that opens to the outdoors and is accessible to the residents cannot be opened more then 15 centimeters (cm).

On June 05, it was noted that several windows in the resident rooms open more then 15 cm. The home is a large bungalow style building, whose main entrance opens to a rural highway. On June 14 and 15, inspector #117 spoke with the home's DOC and maintenance staff who confirmed that all of the windows in the home are the same type of crank windows. The maintenance staff measured a window: the dimensions are 50cm wide by 147.4 cm in height. The window opens to 37.5 cm wide.

On June14 and 15, 2012 discussions were held with the home's DOC regarding window openings, elopement risks and need to ensure that windows do not open more then 15 cm. On June 15, the DOC stated that she would communicate the need for immediate action to home's maintenance staff and administrator to ensure that windows do not open more then 15 cm. The home's DOC stated that the home did not have any recent incidents of resident elopement. A revision of the Ministry of Health Critical Incident System found no incidents of resident elopement.

On June 20, 2012, inspector # 150 communicated with the home's administrator and he stated that the home's windows still opened more then 15cm but that a plan was in place to ensure that windows do not open more then 15 cm by June 21, 2012.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.3. (1)11 (iv) in that the resident's personal health information was not protected as evidenced by the following findings.

It was observed on June 11, 12 and 13, 2012, by inspectors #117, #126 and #150 during the course the inspection, that the Registered Practical Nurses placed multi-dose medication packages for residents which identified resident personal health information inclusive of names of the resident and the medications into a garbage bag attached to the medication cart, during medication passes.

The Registered Practical Nurse and the maintenance staff were interviewed and confirm that the medication packages for residents discarded in the garbage bags were disposed of with the regular garbage which is pick-up by a private disposal company.

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 proper disposal of personal health information to protect residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

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

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c) as the plan of care does not set out clear direction to staff and others who provide direct care to the resident.

The Registered Dietitian confirmed that she maintains the Nutritional Kardex, it is current, it reflects the residents' nutritional care needs, and it is to be used by the food service staff and nursing staff to ensure nutritional care is provided according to the residents' nutritional needs.
On June 14, 2012 the Nutritional Kardex indicated that Resident #502 was to receive a low fat/salt diet but the Registered Dietitian's current assessment of May 4, 2012 indicated the resident was to receive a regular diet. There was no other documentation in the resident health record indicating that the resident's diet was anything other than regular. (138)

The care plan for Resident # 119 does not provide clear direction to the staff regarding resident's toileting needs. The document "Resident Care Plan" in the resident's health care record dated May 29, 2012 indicates that the resident was to be toileted every 2 hours with mechanical lift. Two PSW, S# 119 and S#120, stated the resident plan of care changed over a year ago and resident is no longer toileted. (138)

Resident #180's plan of care identifies the resident as being at risk for falls. The resident's health care record notes that on April 7, 2012, resident #180 unbuckled his/her wheelchair safety lap belt and fell to the floor. The resident did not sustain any injuries. Notes indicate that on April 9, 2012, a motion sensor posey mat was applied to the resident's wheelchair. On June 12, the interviewed restorative care staff states that she applied the posey mat as a fall prevention intervention on April 9, 2012. The resident's plan of care does not identify that resident #180 mobilizes with a wheelchair, that a there is a front clip safety belt and that there is a motion sensor posey mat as fall prevention interventions. It is noted that since the interventions, the resident has had no falls.(117)

The care plan for resident #134 indicates "training and skill practice in; walking 2 days in a week resident did walking program with 2 staff side by side. (30 minutes)".April 12, 2012, progress note's done by Physiotherapy Assistant documented treatments given to resident and does not include mobility walking program. The restorative care staff confirmed that resident is no longer able to walk. The plan of care reviewed by the home on June 8, 2012 indicate that the resident is still walking when it is documented and confirmed by staff that the resident is no longer participating in the walking program.

2. The licensee failed to comply with LTCHA 2007, S.O.2007, c.8, s.6 (7) in that care set out in the plan of care is not provided to the resident as specified in the plan.

Residents # 180 and #150's plan of care specifies that the residents are to receive protein powder three times daily at mealtime. Interviewed RPNs S#118 and S#102 state that the protein powder is not given to the resident by registered staff. They state that the protein powder is prepared and given to the residents by the dietary service department. They also state that they initial the Medication Administration Sheet (MAR) but do not verify the resident's consumption of the protein powder.

3. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (10) (b) in that residents plan of care are not reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident # 155 April 30, 2012, skin assessment progress note written by DOC noted that resident had open area outer aspect of left foot- open sore between 3 and 4th toe area to be cleaned with proviodine applied twice day. On June 14, 2012, discussion held with ADOC and she stated that when resident's wound does not heal the physician is usually notified of resident impaired skin integrity. As of June 14, 2012, there has not been a reassessment of the wound by the multidisciplinary team.(126)

Resident # 180 's attending physician ordered protein powder 1 scoop three times daily at mealtime, as part of treatment for open wound to the left 3rd toe amputation site. A review of the resident's health care record notes that the home's

Registered Dietitian did not review and reassess the ordered protein powder during her quarterly reassessments of the resident. The Registered Dietitian stated that she was not aware that the resident was receiving protein powder and the intervention was not reassessed during the revision of the resident's plan of care.

Resident #150 attending physician ordered protein powder 2 scoops three times daily at mealtime. A review of the resident's health care record notes that the home's Registered Dietitian did not review and reassess the ordered protein powder during her quarterly reassessments of the resident. The Registered Dietitian stated that she was not aware that the resident was receiving protein powder and the intervention was not reassessed during the revision of the resident's plan of care.

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 accurate documentation of the residents plan of care sets out clear direction to staff and others who provide care to the residents as well the plan must be revised when the residents care needs change, to be implemented voluntarily.

WN #5: 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 subsections:

s. 78. (1) Every licensee of a long-term care home shall ensure that,
(a) a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted;
(b) the package of information is made available to family members of residents and persons of importance to residents;
(c) the package of information is revised as necessary;
(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or substitute decision-maker of a resident; and
(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78. (1).

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) 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;
(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;
(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;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(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;
(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;
(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;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s. 78(1)(a) and (2)(a)(b)(c)(d)(f)(g)(i)(n)(m)(o)(p)(q)(r) in that the licensee failed to provide a package of information to residents/SDM upon admission.

The admission process was reviewed with the Director of Care, the Assistant Director of Care, and the Administrator and it was confirmed that forms were initiated on admission to build the resident's health record but a package of information was not provided to the resident.

The SDM and another daughter of resident #501 and resident #502, who were recently admitted in May 2012, confirmed that they were not provided a package upon admission.
The information not provided to residents/SDM on admission including:
- Resident Bill of Rights,
- the long-term care home's mission statement,
- the long-term care home's policy to promote zero tolerance of abuse and neglect of residents,
- an explanation of the duty under section 24 to make mandatory reports,
- the correct person designated by the Director to receive complaints,
- notification of the long-term care home's policy to minimize restraints,
- a statement of the maximum amount that a resident can be charged for basic accommodation,
- a statement that residents are not required to purchase care, services, programs or goods from the licensee,
- a disclosure of non-arm's length relationships between the licensee and other providers of care, services, programs, or goods,
- information about the Resident's Council,
- information about the Family Council,
- information about whistle-blowing protection,
- the obligation of the resident to pay accommodation charges during medical, psychiatric, vacation, or casual absence,
- trust account information.

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 licensee develops and implements a package of information in keeping with the LTCHA 2007 to be provided to residents or SDM on admission, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s. 84 related to develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

On June 13, 2012, the Administrator states that the home did develop a Continuous Quality Improvement Program in 2010 for the purpose of the Accreditation.

The Administrator states that the home has not formerly implemented the Continuous Quality Improvement Program.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home develops and implements a quality improvement system, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

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,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(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 comply with O.Reg 79/10, s. 90 (1) (b) in that there are no schedules and procedures in place for routine, preventive and remedial maintenance.

The home's maintenance staff stated that the home does not have procedures or plans to ensure routine, preventive and remedial maintenance. The maintenance staff stated that maintenance issues are only addressed when they are reported in the home's maintenance log book, when there is a complaint or when there is an immediate issue that needs to be addressed. The maintenance issues identified below were identified in the home's maintenance log book. The home's Administrator stated that at this time, only immediate maintenance issues are being addressed by the home as there are plans to rebuild the home in approximately 8 years.

A- It was noted in the home's tub and shower room that the shower head cap is rusted and pock marked, the caulking at the based of the toilet is cracked, chipped, and stained yellowish brown. The toilet wall grab bar is loose and not securely attached to the wall. The sink drain is rusted and pock marked. The electric base boards in the tub room are rusted and pock marked.

It was also noted that the lower walls in tub room hallway (linking tub-shower and toilet areas) have exposed gyprock with some white primer paint. The walls are heavily chipped and scratched at lower and mid wall level. A white table in tub room has a heavily chipped surface on table top and along all edges of table surfaces. The home's maintenance staff stated that although the walls were primed, there is no immediate plan for painting the wall surfaces.

B- In two residents room, it was noted that the bathroom sink faucet is heavily stained with accumulated dried white matter and has a chipped uneven surface. The sink drain is rusted and chipped. It is also noted that the caulking at the base of both toilets is cracked and stained with yellowish brown matter. Similar issues were noted regarding the sinks, faucets and caulking around toilets in several residents' rooms.

C- It was also observed in one resident's room that the front door of bathroom has chipped paint and a damage edge from the door knob, approximately 6 inches down to bottom of the door. The room entrance wall, opposite the door, has wall damage from floor up to approximately 12 inches in height.

Inside the bathroom, there are 2 sections of the bottom wall, approximately 6 x 4 inches, that are damaged and not repaired. There are also black scrapes on the sink wall, approximately 20 inches long.

The tile flooring around the base of the toilet is uneven. The tile contour around the bottom of the toilet is discoloured brown-black. The tile grout lines are also discoloured brown-black. There is also an approximate 2-3 cm wide and 60 cm long flooring gap along the back wall, behind the toilet.

Similar issues were noted regarding wall and floor damage in several residents' rooms.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home establishes schedules and procedures to be in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 129 (1) (b) in that controlled substances are not stored in a separate, double locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart.

On June 11, 2012, it was noted that benzodiazepines were not double locked in the home's medication cart. Interviewed RPN S#108 and DOC state that the home does not double lock controlled substances such as benzodiazepines medication.

On June 13, 2012, it was noted that the home's discontinued narcotics are being kept in a covered bucket, on the floor, in the locked storage room #112. It was also noted that the home's discontinued medication including benzodiazepines are kept in a black garbage bag, on top of the covered bucket, in the locked storage room #112. The discontinued narcotics and benzodiazepines, both controlled substances are not kept in a double locked stationary cupboard in the locked area.

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 prescribed and discontinued controlled substances are stored in a separate, double area stationary cupboard or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 131 (2) in that drugs are not administered to two identified residents in accordance with the directions for use by the specified prescriber.

Resident #155 has a medicated treatment to be applied twice daily to an affected area. MAR reviewed for the period April 30, 2012 to June 13, 2012, treatment were not signed for 17/55 for day shift and 38/55 on evening shift. On June 14 2012, evening shift, two Registered Practical Nurses S#118 and S#105 and one RN S#119 confirmed that they don't always have time to do the evening treatment.

Resident #132 has a prescribed medicated cream to be applied to affected areas twice daily. MAR reviewed for the period April 1, 2012, to June 13, 2012. Application of the medicated cream on days was not signed for 7/75 day shifts and 51/75 evening shifts. On June 14, 2012, evening shift, two Registered Practical Nurses S#118 and S#105 and one RN S#119 confirmed that they don't always have time to do the evening treatment.

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 prescribed medicated treatments are administered on evenings, to residents in accordance with the directions for use by the specified prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following subsections:

s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs;
(b) all drugs with illegible labels;
(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).

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.
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. That drugs that are to be destroyed are destroyed in accordance with subsection (3). O. Reg. 79/10, s. 136 (2).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

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.
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 members of the team who destroyed the drug.
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

s. 136. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's

procedures are being followed and are effective;
(b) that any changes identified in the audit are implemented; and
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

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 comply with O.Reg 79/10, s. 136 in that the homes does not have a drug destruction and disposal policies and procedures that are implemented in the home as per the Regulation section 136.

The home's policy Medical and Nursing Administration Medication Orders, " Disposal of Surplus prescribed drugs in the Nursing Home" is dated January 1992, and was last revised in May 2007.

The policy does not provide for the ongoing identification, destruction and disposal of all expired drugs, discontinued medications and discontinued controlled substances. It was noted on June 13 and 14, 2012, that there were four bottles of Novasen 325mg with an expiry date of March 2012 in the medication room. It was also noted that in the home's Emergency Drug Box, the vial of Vitamin K had an expiry date May 2012. The RPN S#108 and the DOC stated that the home's pharmacy is responsible for the revision of medication expiry dates and that this review has not been recently done. [section 136 (1) (a,b,c,d)]

The licensee has failed to ensure that discontinued medication are stored safely and securely within the home, that discontinued controlled substances are stored in a double locked storage area within the home, separate from those available for administration to a resident, that the drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence based practice. [section 136 (2) (1,2,3,4)]

The policy does not identify that controlled substances and every other medication must be destroyed by a team acting together and composed of designated persons as per this Regulation. [section 136 (3) (a,b)]
The home's DOC stated during June 14 , 2012, that the home's discontinued medication and discontinued controlled substances scheduled for destruction are verified by herself and the pharmacist. Once this is done, the pharmacist removed the medication and controlled substances scheduled for destruction from the home to dispose of them outside of the home. She confirms that she does not see and is not part of the team that ensures actual destruction of the discontinued medication and controlled substances.

The home's policy " Disposal of Surplus prescribed drugs in the Nursing Home", states that " Surplus prescribed drugs are destroyed on site at St-Viateur Nursing Home by the Pharmacist and the Director of Care every two months or as need occurs".The home's discontinued medication and discontinued controlled substances are not destroyed by a team acting together as per O.Reg 136 (3) (a-b), nor are they destroyed in the home as per the home's policy.

The home's drug and disposal policy must provide information related to the required information for the drug record document of the disposal and destruction of controlled substances as identified in the Regulation. [section 136 (4) (1-7)]

The licensee shall ensure that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective, that any changes are identified in the audit are implemented, and that a written record is kept. [section 136 (5) (a,b,c)]

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. On June 14, 2012, the DOC stated , that the home's discontinued medication and discontinued controlled substances scheduled for destruction are verified by herself and the pharmacist. Once this is done, the pharmacist removed the medication and controlled substances scheduled for destruction from the home to dispose of them outside of the home. She confirms that she does not see and is not part of the team that ensures actual destruction of the discontinued medication and controlled substances. [section 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 in that the home needs to ensure that Drug destruction and disposal policies and procedures are implemented in the home as per the Regulation section 136, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (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).

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;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols; and
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.229.(2)(c) in that the Local Medical Officer of Health (LMOH) as not been invited to the quarterly infection and prevention control team meeting.
The Infection Control Nurse (ICN) stated that she was not aware that the LMOH should be invited. During last year, the LMOH was not invited to the quarterly infection and prevention control team meeting.

The licensee has failed to comply with O.Reg 79/10 s.229.(3)(b)(c) in that the designate staff member for infection control did not receive formal education and experience in infection prevention and control practices. The ICN stated that she did not have education on cleaning and disinfection, on data collection and trend analysis other that her basic nursing training (Registered Practical Nurse).

The licensee has failed to comply with O.Reg 79/10 s.229. (6) in that the home have not reviewed the gathered information on a monthly basis for the presence of infection control trends.
The ICN stated that the revision is done on a quarterly basis not a monthly basis.

The licensee has failed to comply with O.Reg 79/10 s.229. (10)1. in that resident admitted to the home are not screened for tuberculosis within 14 days of admission.
- Resident # 155 was screened for tuberculosis step 1, 29 days post admission.
- Resident #178 was screened for tuberculosis step 1, 20 days post admission.
- Resident # 173 was screened for tuberculosis step 1, 16 days post admission.

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 there is education for the home's Infection Control Nurse on cleaning and disinfection, data collection and trend analysis; that the local medical officer of health is invited to the home's infection control quarterly meetings and that the screening for Tuberculosis is done withing 14 days of resident admission, to be implemented voluntarily.

WN #12: 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 subsections:

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).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, S.O., c.8, s.15 (2) (c) in that the home, furnishings and equipment are not maintained in a safe condition and in a good state of repair.

The home's maintenance staff stated to inspector #117 that the home does not have procedures or plans to ensure that the home's equipment is maintained in safe condition and good state of repair. He states that any issues related to safety items has to be documented in the home's maintenance log for revision and repairs to occur.

In one resident's room, metal support arms bolted to the back of the toilet are rusted and have an accumulation of yellow matter at the points of contact with the toilet. The arms are wobbly and not secure to touch. The home's housekeeper and maintenance staff state the metal support arms have been bolted to the toilet for several years.

In one resident's room, the unattached metal support arms, framing the toilet, have uneven footing on the ground and is unsteady. The support arms feet have rust and yellow matter debris. The home's restorative care and maintenance staff states that this is an old metal support arm that has not been in use for several years and was applied for this resident.

In the main tub/shower room, the toilet grab bar is loose and not properly secured and attached to the wall. The maintenance staff stated that this was not brought to his attention and therefore has not been addressed for safety and maintenance repairs.

During the inspection, it was observed by inspectors #117, #138 and #150 that the most of the home's chairs in the in the activity lounge and the main dining room as well as the staff feeding stools in the main dining room have cracked, chipped and torn vinyl covering surfaces.

In the main dining room:
- five of nine of the feeding stools had worn and split vinyl coverings,
- all seven dining room chairs had worn and split vinyl coverings,
- all four white u-shaped tables were scratched and paint was worn off showing the wood product underneath.

In the small dining room:
- one of two feeding stools had worn and split vinyl covering,
- all sixteen dining room chairs had worn and split vinyl coverings.

The home's maintenance staff and administrator stated that they have explored the possibility of having these chairs and seats recovered. They indicated that the re-upholstery costs were prohibitive and that there are no plans for replacing the existing chairs and stools.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's furnishings and equipment be clean, safe and in a good state of repair, as well,that the home does regular audits of the furnishings and equipment to ensure they are safe for use and are applied as per manufacturer instructions, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 130 (2)(i) in that all areas where drugs are stored are not restricted to persons who may dispense, prescribe or administer drugs in the home, (ii) and the Administrator.

On June 13, 2012, it was noted that the home's discontinued narcotics and discontinued medication are kept in a locked storage room. The discontinued narcotics are kept in a bucket with a lid, not double locked, and the discontinued medication are kept in a garbage bag. The home's DOC states that she and the home's maintenance man have a key to access this storage room.

On June 13, 2012 the home's Maintenance Manager confirmed and demonstrated to the inspector #117 that he had a key that opens the storage cupboard in which discontinued medication including discontinued narcotics are being stored.

On June 13, 2012 the home's DOC relocated the home's discontinued medication and narcotics into an empty cupboard, located in the home's medication room. A temporary lock was applied to the cupboard. The DOC confirmed that only registered nursing staff have access to the home's medication room.

On June 14, 2012, a permanent lock was applied to the cupboard where the discontinued medications and narcotics are now stored, in the locked medication room. The DOC confirms that only registered staff have access to these locked areas.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 117 in that no medical directive or order for the administration of a drug to a resident is to be used unless it is individualized to the resident's condition and needs.

It was noted that the home has a list of medical directives that were reviewed and implemented by the home's attending physicians, on May 9, 2012. The home's ADOC states these medical directives are used for all residents and that there are not individualized to the resident's conditions. Three interviewed registered staff members S#105, S#118 and S#119, confirm that they do use the generalized medical directives for all residents within the home.

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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 8 (1) in that the policy and procedure, Administrating Medications (Safe Medication Practices) reviewed July 2011 was not complied with.

O. Reg. 79/10, 114 (2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's Administrating Medications (Safe Medication Practices) policy dated July 2011, indicates that "the Nurses (RN/RPN) will sign Medication Administration Record (MAR) immediately after medications administration to prevent medication errors/or omission"

On June 11, 12 and 13, 2012, during medication administration passes, two RPNs S#102 and S#108 were observed by inspectors #126 and #150 to be signing there initial in the Medication Administration Record (MAR) before the administration of the medications for 6 residents. (150)

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the O.Reg 79/10, s. 73. (1)1 in that the licensee failed to communicate the seven day and daily menus to residents.

The home's Nutritional Care Manager confirmed that the home's method of communicating the menu to the residents is through posting of the menu.

The home's weekly menu was not posted upon commencement of inspection on June 5, 2012. The weekly menu was posted beginning June 6, 2012 in the main dining room however therapeutic diets and texture modified diets were not included. The weekly menu was only posted in the main dining and this area was not accessible to all residents in the home.

The home's daily menu was not consistently communicated to residents. It was observed that the daily lunch menu was not posted for residents in the small dining room on June 5, 11, 12, and 13, 2012. The daily breakfast menu was not posted in the home throughout the course of the inspection.

Further, menu substitutions and changes were not communicated to the residents.

The President of the Family Council confirmed that the menu is not always communicated to the residents and voiced this concern to inspector 126.

2. The licensee has failed to comply with the O.Reg 79/10, s 73. (1)9 in that assistive devices to eat and drink as comfortably and independently as possible were not provided to residents.

Eight residents were to receive assistive devices at meals times according to the Nutritional Kardex maintained by the home's dietitian but it was observed during two separate meal rounds that no assistive devices were distributed to any residents.

Resident #503, who was to receive an assistive device at meal times but did not, was observed to have difficulty self feeding and spilled much of the meal on herself/himself and the table.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s. 79 (1) in that not all the required information was posted in the home as identified during the tour through the home and verified by the Director of Care and Assistant Director of Care. The required information not posted includes the following:

- the fundamental principles set out in section 1 of the Act,
- the most recent audited report,
- an explanation of the duty to make mandatory reports,
- the current Bill of Resident Rights
- the home's mission statement,
- the policy to promote zero tolerances of abuse and neglect,
- the correct designate to receive complaints on behalf of the Director,
- notification of the long-term care home's policy to minimize restraining of residents,
- an explanation of whistle-blowing protection.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 80. Regulated documents for resident

Specifically failed to comply with the following subsections:

s. 80. (1) Every licensee of a long-term care home shall ensure that no regulated document is presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident, unless,
(a) the regulated document complies with all the requirements of the regulations; and
(b) the compliance has been certified by a lawyer. 2007, c. 8, s. 80. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 80 (1) (b) in that the regulated document(s) presented for signature to a resident or substitute decision-maker, complies with all the requirements of the regulations is certified by a lawyer.

The home's Administrator stated in interviews conducted on June 12 and 13, 2012 that the home's regulated document (s), as identified under O.Reg 79/10, section 227 Regulated Documents, have not been certified by a lawyer. These documents include the resident admission agreement and resident charges.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

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);
(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;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(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 comply with the LTCHA 2007, S.O. 2007, c. 8, s. 85 in that a survey taken , at least annually, of the residents and their families to measure their satisfaction with home and the care, services programs and goods provided at the home was not complied with.

On June 13, 2012, the home's Administrator confirmed that there was a survey done in 2010 and none for 2011 and 2012.

The President of Family Council for last 3 years states that the Council has never been consulted in developing a satisfaction survey or acting on its results

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Issued on this 21st day of June, 2012

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

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) :	CAROLE BARIL (150), LINDA HARKINS (126), LYNE DUCHESNE (117), PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2012_030150_0010
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	May 31, Jun 1, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 2012
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 :	RICHARD MARLEAU

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

This plan must be submitted to Carole Baril, Long Term Care Homes's Inspector, Ottawa SAO by June 29, 2012 via fax #(613) 569-9670.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s.8.(3) in that the home does not have a registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

The registered nurses schedule was reviewed for the period of May 6, 2012 to June 30, 2012 and it was noted that there was no registered nurse for the following days:
May 12-13, 2012 on day shift
May 20, 2012 on evening shift
June 9-10-11, 24 and 27, 2012 on evening shift.

The registered nurse schedule for the period of May 6-June 30, 2012 was reviewed and the Director of Care (DOC) confirmed the identified missing 24/7 hours coverage of Registered Nurses.

It was noted that the DOC shifts was included as a registered nurse on several day shifts.

The ADOC stated that if there are no available registered nurse to work a shift, the home's practice is to replace the RN by an RPN with the DOC acting as the RN on call.

It is noted that under O.Reg 79/10, s.45 (1) (1) (ii) (B) it is only in the case of an emergency (means an unforseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home) that an RPN can replace an RN, as long an RN who is a regular staff member is available by phone.

A discussion was held on June 11, 2012, between the DOC and inspector #150. The DOC confirmed an RN wanting a day off, was automatically replaced by an RPN on the registered nurse staffing schedule. This was not and emergency as defined in the Regulations. (126)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Order / Ordre :

The licensee shall ensure that every window in the home that opens to the outdoors and is accessible to residents has screen and cannot be opened more then 15 centimeters. That the home establish a regular window audit process to ensure windows do not open more then 15 centimeters.

Grounds / Motifs :

1. The licensee has failed to comply with O.Reg 79/10, section 16 in that the home has not ensured that every window in the home that opens to the outdoors and is accessible to the residents cannot be opened more then 15 centimeters (cm).

On June 05, it was noted that several windows in the resident rooms open more then 15 cm. The home is a large bungalow style building, whose main entrance opens to a rural highway. On June 14 and 15, inspector #117 spoke with the home's DOC and maintenance staff who confirmed that all of the windows in the home are the same type of crank windows. The maintenance staff measured a window: the dimensions are 50cm wide by 147.4 cm in height. The window opens to 37.5 cm wide.

On June14 and 15, 2012 discussions were held with the home's DOC regarding window openings, elopement risks and need to ensure that windows do not open more then 15 cm. On June 15, the DOC stated that she would communicate the need for immediate action to home's maintenance staff and administrator to ensure that windows do not open more then 15 cm. The home's DOC stated that the home did not have any recent incidents of resident elopement. A revision of the Ministry of Health Critical Incident System found no incidents of resident elopement.

On June 20, 2012, inspector # 150 communicated with the home's administrator and he stated that the home's windows still opened more then 15cm but that a plan was in place to ensure that windows do not open more then 15 cm by June 21, 2012. (117)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the

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

Director

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

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

Ontario

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Ministère de la Santé et des Soins de longue durée

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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 21st day of June, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : CAROLE BARIL

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