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
Aug 25, 2015	2015_333577_0011	S-000865-15	Resident Quality Inspection

Licensee/Titulaire de permis

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

DEBBIE WARPULA (577), BEVERLEY GELLERT (597)

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): May 25, 26, 27, 28, 29 & June 1, 2, 3, 4, 5, 2015

During the course of the inspection, the inspector(s) spoke with Nurse Manager, RAI Coordinator, Occupational Therapist (OT), Physiotherapist (PT), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members and Residents

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
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
Pain
Personal Support Services
Quality Improvement
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

17 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (1)	CO #001	2014_333577_0010	577

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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On May 28, 29, & June 2, 2015, resident #003 was observed to be sleeping in bed with bed rails raised.

The current plan of care indicated that the resident is to have rails raised.

S#100 and S#101 both reported that the resident is to have bed rails raised during the day and raised at night when they are in bed. The Nursing Manager was interviewed on June 3, 2015, by Inspector #597 and they reported that a formal process of assessing the resident and the bed system is not done. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

Resident #012 was observed to have bed rails in use on June 2, 3 & 4, 2015, while lying in bed. Review of the residents care plan in May 2015, indicated the use of bed rails. On May 29, 2015, Inspector #577 spoke with S#100, who reported that when resident #012 is in bed, bed rails are elevated. Inspector could not find a completed bed rail

assessment form for resident #012.

Inspector #577 spoke with the Nurse Manager on June 2, 2015, and asked about bed rail assessments. They reported that there isn't a specific bed rail assessment form and that bed rails are discussed between nursing and rehabilitation staff. On June 3, 2015, Inspector spoke with S#103, who reported that they assess for bed mobility and fall risk. Reports they did not assess resident #012 for bed rails.
[s. 15. (1) (a)]

3. The licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

Resident #015 was observed to have bed rails in use on May 29, June 2 & 4, 2015, while lying in bed. Review of the residents care plan in June 2015, indicated the use of bed rails for bed mobility. On June 3, 2015, Inspector #577 spoke with S#104 who reported that resident #015 had elevated bed rails. Inspector could not find a completed bed rail assessment form for resident #015.

Inspector #577 spoke with the Nurse Manager in June 2015, and asked about bed rail assessments. They reported that there isn't a specific bed rail assessment form and that bed rails are discussed between nursing and rehabilitation staff. On June 3, 2015, Inspector spoke with S#103, who reported that they assess for bed mobility and fall risk. Reports they did not assess resident #015 for bed rails.
[s. 15. (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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #2: 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 when the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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

The presence of altered skin integrity was flagged during Stage 1 based on MDS data for resident #002.

The health care record of resident #002 was reviewed and orders for treatment were written in February 2015. The progress notes were reviewed and inspector #597 was unable to locate a skin assessment completed by registered staff using a clinically appropriate assessment tool. S#102 also reported that they were not able to locate weekly skin assessment's in the health care record for resident #002.

S#105 was interviewed regarding skin assessments and reported that the Wound Care Nurse assesses and documents electronically in the progress notes. They further

reported that resident #002's skin condition is now healed.

The Nurse Manager was interviewed and reported that weekly assessments are documented in the electronic health care record by the wound care nurse. Braden scale assessments are done on admission and quarterly by staff.

Policy N-W5, Wound Care Team Assessment Guideline for Inpatient and Outpatient referral was reviewed by the inspector. This document states that wound assessment documentation consists of two parts: 1) Skin Care Management Program Booklet which is utilized as an assessment instrument and as a care plan for the team and 2) PUSH tool for evaluating the effectiveness of the treatment plan. The Nurse Manager was interviewed regarding policy N-W5 and was unable to clarify what assessment instrument is used and where to find it. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that when the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

The presence of altered skin integrity was flagged during Stage 1 based on MDS data from October 2015, for resident #004.

The health care record of resident #004 was reviewed and the latest orders for treatment were written in May 2015. The progress notes were reviewed and the inspector was unable to locate a skin assessment completed by registered staff using a clinically appropriate assessment tool. Only three entries by the wound care nurse were made in the progress notes of resident #004 since October 2015.

S#105 was interviewed regarding skin assessments and reported that the Wound Care Nurse assesses and documents electronically in the progress notes.

The Nurse Manager was interviewed and reported that weekly assessments are documented in the electronic health care record by the wound care nurse. Braden scale assessments are done on admission and quarterly by staff. The Nurse Manager further reported that the home used to use electronic wound tracker but was not consistently completed by staff. They reported that the current expectations is that wound assessments be charted in the electronic progress notes.

Policy N-W5, Wound Care Team Assessment Guideline for Inpatient and Outpatient referral was reviewed by the inspector. This document states that wound assessment documentation consists of two parts 1) Skin Care Management Program Booklet which is utilized as an assessment instrument and as a care plan for the team and 2) PUSH tool for evaluating the effectiveness of the treatment plan. The Nurse Manager was interviewed regarding policy N-W5 and was unable to clarify what assessment instrument is used and where to find it [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.

Upon record review of MDS data for resident #012, dated for February 2015 quarter, Inspector #577 found that resident had altered skin integrity. Most recent physician orders indicated that resident was to receive special treatment. Upon further record review, Inspector was unable to locate a skin assessment completed by registered staff using a clinically appropriate assessment tool.

On June 2, 2015, Inspector #577 spoke with S#102 and S#107, who both reported that resident #012's skin condition is now healed.

On June 4, 2015, Inspector spoke with the Nurse Manager, who reported that the PUSH Tool is considered their clinical skin assessment tool and their wound care specialist utilizes the weekly skin integrity assessment. They further reported that the braden scale is done on admission, quarterly, prn and annually. The Nurse Manager was unable to provide documentation using the PUSH Tool for resident #012.

Inspector reviewed the home's policy N-W5, "Wound Care Team Assessment Guideline for Inpatient and Outpatient referral". The document indicated that wound assessment documentation consists of two parts 1) Skin Care Management Program Booklet which is utilized as an assessment instrument and as a care plan for the team and 2) PUSH tool for evaluating the effectiveness of the treatment plan. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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, specifically in regards to residents #002, #004 & #012, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible;

On May 27, 2015, Inspector #577 was conducting a family interview regarding resident #015. During the interview, the family member reported an incident that occurred a few months ago, where the home had notified them of a resident to resident interaction between resident #015 and #016. They further reported that the home had resolved it.

On June 2, 2015, Inspector spoke with Nurse Manager who reported that in February 2015, resident #016 was found by staff interacting with resident #015 in an intimate manner. The Nurse Manager reported that they consulted with S#108, Psychogeriatric Resource Consultant and spoke with resident #015's and #016's families. Inspector reviewed the investigative notes, which indicated that they consulted with S #108, notified the residents' physicians and families. The Nurse Manager determined that the interaction was consensual.

Inspector #577 reviewed the progress notes for resident #016 which indicated that in February 2015, resident #016 was observed to be interacting with resident #015. Staff intervened and resident #015 was brought to their room and settled to bed, in no distress. Resident #016 redirected to their room.
-May 2015: On rounds, pc am care of other residents, noted that resident #016 was not in their room, writer and co-worker started searching the unit. Resident #016 was found in resident #011's room, exhibiting specific responsive behaviours towards resident #011 who was asleep. The progress note indicated that staff asked resident #016 to leave the room and they refused. Resident #016 did eventually leave the room but required additional persuasion from staff, before they left to return to their own bed.

On June 3, 2015, Inspector #577 spoke with S#105, who witnessed the incident in February 2015. They reported that resident #015 & #016 had not developed a relationship prior to February 2015 incident and is unsure whether incident was consensual. They further reported that they do not recall whether resident #015 was awake during the incident and that resident #015 didn't appear startled.

Inspector reviewed resident #016's care plan in place for December 2014-June 2015. Inspector could not find any strategies developed for this resident to respond to their specific responsive behaviours towards other residents. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, ther are strategies developed and implemented to respond to these behaviours, specifically for resident #016, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident’s condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident’s condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident’s response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that that where a resident is being restrained by a physical device, the resident is released from the physical device and repositioned at least once every two hours.

Inspector #577 reviewed resident #012's care plan on May 28, 2015, which indicated that the resident uses a safety device for positioning and it is easily removed by the resident. On June 2, 2015, Inspector reviewed resident #012's chart and found a consent for restraint dated March 2015, for the safety device while in their chair. The consent indicated that the safety device was used as a mechanical restraint to avoid injury, which was signed by staff and a family member. Inspector also reviewed a restraint monitoring record used by staff to document for the safety device.

On May 29 & June 3, 2015, Inspector observed resident #012 sitting in their chair with the safety device applied. Inspector asked the resident to undo the device and the resident could not unfasten it. Inspector spoke with S#105 on June 3, 2015, who reported that the safety device is considered a restraint when a resident cannot undo it.

On June 3, 2015, Inspector #577 made frequent observations of resident #012 in their chair with the safety device/restraint applied. Inspector observed the resident up in their chair from 1000hr until after 1630hr, with no repositioning by staff. Inspector spoke with S#109 who reported they did not reposition resident in their chair. [s. 110. (2) 4.]

2. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Resident #001 was observed to be sitting in a chair with a restraint in place on five occasions in May and four occasions in June 2015.

The current care plan for resident #001 with a printed date of May 26, 2015, indicated the resident is to use a chair and restraint for their safety.

The health care record for resident #001 was reviewed by Inspector #597 and a physician order for the resident to use a chair with restraint as necessary was written in

March 2015. A consent signed by the SDM was also found on the health care record. Restraint monitoring records were reviewed and there wasn't documentation completed for monitoring every eight hours by RPN staff.

Registered staff were interviewed regarding their responsibilities regarding the evaluation of reassessing the resident and the effectiveness of the restraint every eight hours. Staff were not able to identify their responsibility.

The Nurse Manager was interviewed on June 3, 2015, regarding the home's restraint policy. The Nurse Manager indicated that staff were required to monitor the resident and the response to the restraint hourly while the restraint was applied, however they were not aware that an evaluation of the condition of the resident and the effectiveness of the restraint was required by a physician or registered staff every eight hours or any other time based on the resident's condition or circumstances. [s. 110. (2) 6.]

3. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

The current care plan for resident #003 with a printed date of April 28, 2015, indicates that resident is to have bed rails raised while resident is in bed.

The health care record for resident #003 was reviewed by Inspector #597 and a physician orders, which indicated that resident #003 is to have bed rails up while in bed, written in March 2015. A consent signed by the SDM was also found on the health care record.

S#100, S#101 and S#105 were interviewed and all reported that the resident is to have bed rails elevated at night. They further confirmed that bed rails raised were considered a restraint in the home.

Registered staff were interviewed regarding their responsibilities regarding the evaluation of reassessing the resident and the effectiveness of the restraint every eight hours. Staff were not able to identify this responsibility.

The Nurse Manager was interviewed on June 3, 2015, regarding the home's restraint

policy. The Nurse Manager confirmed that the use of specific bed rails was considered a restraint in the home and indicated that staff were required to monitor the resident and the response to the restraint hourly while the restraint was applied, however the they were not aware that an evaluation of the condition of the resident and the effectiveness of the restraint was required by a physician or registered staff every eight hours or any other time based on the resident's condition or circumstances. [s. 110. (2) 6.]

4. The licensee has failed to ensure that every use of a physical device to restrain a resident is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented, all assessment, reassessment and monitoring, including the resident's response.

The current care plan for resident #003 with a printed date of April 28, 2015, indicates that resident #003 is to have bed rails raised while resident is in bed.

The health care record for resident #003 was reviewed by Inspector #597 and a physician order for the resident to have bed rails up while in bed was written in March 2015. A consent signed by the SDM was also found on the health care record.

S#100, S#101 and S#105 were interviewed and all reported that the resident is to have bed rails elevated at night. They further confirmed that bed rails raised is considered a restraint in the home.

The restraint monitoring records for resident #003 were reviewed. It was noted that on four occasions in May and and one occasion in June 2015, staff completed the hourly monitoring record only twice. In June 2015, the hourly monitoring record had no entries.

The Nurse Manager was interviewed on June 3, 2015, regarding the home's restraint policy. The Nurse Manager confirmed that the use of specific bed rails was considered a restraint in the home and indicated that staff were required to monitor the resident and monitor the response to the restraint hourly while the restraint was applied. [s. 110. (7) 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 that the following requirements are met where a resident is being restrained by a physical device that the resident is released from the physical device and repositioned at least once every two hours, specifically in regards to resident #012;
resident’s condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident’s condition or circumstances, specifically in regards to resident's #001 & #003; and the use of restraints including all assessment, reassessment and monitoring, including the resident’s response, specifically in regards to resident #003, to be implemented voluntarily.

WN #5: 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 that 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,

On June 2, 2015, during the medication administration observation, it was noted by the inspector that the narcotics and controlled substances were kept in a locked cabinet within the medication cart, however the registered nursing staff left the keys hanging in the lock of the medication cart and the cart was left unlocked.

On June 3 and 4, 2015, the medication cart keys were also observed to be hanging from the medication carts and the carts left unattended in the medication room.

The medications were stored in an unlocked medication cart, not in a locked area of a locked medication cart or in a double locked cupboard in a locked room. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #6: 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 ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On June 2, 3, and 4, 2015, Inspector #597 observed the ward clerk, stores clerk and housekeepers to have access to the medication room. The medication carts, stock medication and narcotic storage are located in the medication room. The keys for the medication carts and medication storage were observed to be left hanging from the carts and not carried by the registered nursing staff. The registered staff had the keys for the medication room, and would unlock the door to the medication room for unregistered staff access.

The Nurse Manager was interviewed on June 3, 2015 and they confirmed that the ward clerk, stores person and housekeeping staff had access to the medication room. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #7: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents must receive annual training in Responsive Behaviours.

Inspector #577 spoke with the Nurse Manager on June 5, 2015, concerning the home's responsive behavior program. They reported that the program was put into place in December 2014. They further reported that all staff have not had any training on responsive behaviors. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents must receive annual training in Responsive Behaviours, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

1. 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.

The current care plan for resident #001 with printed date of May 26, 2105, was reviewed by Inspector #597.

Under a heading, the interventions indicated that no assistance from staff is required and other interventions indicated that resident required staff to assist with ambulation.

Under another heading, the interventions indicated that staff is required to supervise at all times while ambulating and that the resident is independent with ambulation but requires continuous supervision due to a condition.

S#105 was interviewed on June 3, 2015, and reported that the resident participated in the ambulation program and required the assistance of two staff.

S#100 was interviewed on June 4, 2015, and reported that the resident requires the assistance of one or two staff.

On June 02, 2015 at 1013hr, resident #001 was observed walking from bathroom a chair with the assistance of two staff. S#104 and S#101 reported that
staff assist to them walk a couple of times per day.

The monthly resident nursing rehabilitation and restorative care evaluation for May 2015, was reviewed and indicated that the resident was unable to walk without assistance.

The care plan for resident #001 does not provide clear direction to staff regarding their ability to ambulate. [s. 6. (1) (c)]

2. The licensee has failed to ensure that 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.

During Stage 1 observations, the call bell for resident #001 was observed to be clipped to the cord on the wall and not accessible to the resident.

The current care plan with printed date of May 26, 2015, listed the intervention of 'call bell within reach' at all times under four different nursing focuses.

S#105 was interviewed on June 3, 2015, and reported that the resident was not cognitively able to call for assistance using the call bell. S#110 was interviewed on June 4, 2015, and also reported that resident was not capable of using the call bell.

The care plan for resident #001 did not provide clear direction regarding the resident's ability to call for assistance. [s. 6. (1) (c)]

3. 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.

The current plan of care for resident #004 with printed date of March 13, 2015, indicated under a heading, that a treatment was to be completed every seven days and as required. There is also an entry in hand writing beside this intervention, which indicated that the treatment was no longer required. This entry is not dated.

The physician's orders for resident #004 were reviewed and that the physician had ordered daily treatment changes.

On June 4, 2015, S#111 and S#107 reported to the inspector that the treatment was ordered to be completed daily for this resident.

In conclusion, the interventions related to skin integrity in the care plan of resident #004 did not provide clear direction for staff. [s. 6. (1) (c)]

4. 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.

Inspector #577 reviewed resident #012's care plan on May 28, 2015, which indicated that resident uses a safety device that is easily removed by the resident. On June 2, 2015, Inspector reviewed resident #012's chart and found a consent for restraint dated March 2015, for the safety device. The consent indicated that the safety device was used as a mechanical restraint to avoid injury, which was signed by staff and a family member. Inspector also reviewed a restraint monitoring record used by staff to document for the safety device.

On May 29 & June 3, 2015, Inspector observed resident #012 sitting in their chair with the safety device applied. Inspector asked resident to undo the safety device and resident could not. Inspector spoke with S#105 on June 3, 2015, who reported that the type of safety device used by the resident is considered a restraint when a resident cannot unfasten the safety device.

The care plan was unclear concerning the use of the lap belt, as it indicated that resident #012 can easily remove it and further documentation indicates that it's being utilized as a restraint, and resident cannot unfasten the safety device. [s. 6. (1) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written staffing plan for nursing and support services.

On June 3, 2015, Inspector #577 spoke with the Nurse Manager about staffing for the home and they reported that they are considered the Registered Nurse on a day shift, Monday through Friday. They reported the following staffing complement: 12 hour day shift: 2 Registered Practical Nurses, 2 Personal Support Workers and 1 four hour PSW, 12 hour night shift: 2 RPN's. They further reported that they do not have a written staffing plan that provides a staffing mix that is consistent with residents' assessed care and safety needs. Nor do they have a written back up plan that addresses situations when staff cannot come to work. [s. 31. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents’ families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that they convene semi-annual meetings to advise family members and persons of importance to residents of their right to establish a Family Council.

On June 2, 2015, Inspector #577 spoke with the Nurse Manager who reported that the home doesn't have a Family Council. They reported that there isn't an interest right now and they send a letter to family twice a year. They further reported that they last met with families in March 2015, to advise about the family council. [s. 59. (7) (a)]

WN #11: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that weekly menu was communicated to residents.

During the dining observation on May 26, 2015, it was noted by Inspector #597 that the daily menus were posted in the dining room and the weekly menus were not located.

The Nurse Manager was interviewed on June 4, 2015, and they reported that the weekly menu was normally posted outside the dining room by the nursing station, however they were unable to locate the posted weekly menu. [s. 73. (1) 1.]

2. The licensee has failed to ensure that staff used proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During the lunch service on May 26, 2015, S#101 was observed to be standing beside Resident #026 assisting them to eat their soup.

During the lunch service on May 28, 2015, S#112 was observed feeding resident #026 while standing.

S#100 and S#101 were interviewed by inspector #597 and both reported that they received safe feeding training when they attended school only. Both staff reported that it is safer to feed residents while sitting down. [s. 73. (1) 10.]

WN #12: 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 has failed to ensure that the admission package of information included, at a minimum, the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide the home's policy to promote zero tolerance of abuse and neglect of residents. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide information on the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 78. (2) (c)]

2. The licensee has failed to ensure that the admission package of information included, at a minimum, an explanation of the duty under section 24 to make mandatory reports.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide an explanation of the duty to make mandatory reports. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide an explanation of the duty to make mandatory reports. [s. 78. (2) (d)]

3. The licensee has failed to ensure that the admission package of information included, at a minimum, 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.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide the home’s policy to minimize the restraining of residents and how a copy of the policy can be obtained.

Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide the home’s policy to minimize the restraining of residents and how a copy of the policy can be obtained. [s. 78. (2) (g)]

4. The licensee has failed to ensure that the admission package of information included, at a minimum, the name and telephone number of the licensee.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide information

that included the name and telephone number of the licensee. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide information that included the name and telephone number of the licensee. [s. 78. (2) (h)]

5. The licensee has failed to ensure that the package of information included, at a minimum, a statement of the maximum amount that a resident can be charged for each type of accommodation offered in the long-term care home.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide a statement of the maximum amount that a resident can be charged for each type of accommodation offered in the long-term care home. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide a statement of the maximum amount that a resident can be charged for each type of accommodation offered in the long-term care home. [s. 78. (2) (i)]

6. The licensee has failed to ensure that the admission package of information included, at a minimum, 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.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide information about what is paid for by funding or the payments that residents make for accommodation and for which residents do not have to pay additional charges. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide information about what is paid for by funding or the payments that residents make for accommodation and for which residents do not have to pay additional charges [s. 78. (2) (k)]

7. The licensee has failed to ensure that the admission package of information included, at a minimum, 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.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide 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. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide 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. [s. 78. (2) (m)]

8. The licensee has failed to ensure that the admission package of information included, at a minimum, 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.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide 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. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide 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. [s. 78. (2) (n)]

9. The licensee has failed to ensure that the admission package of information shall include, at a minimum, 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.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide information about the Family Council . Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide information about the Family Council. [s. 78. (2) (p)]

10. The licensee has failed to ensure that the admission package of information included, at a minimum, an explanation of the whistle-blowing protections related to retaliation.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation

Checklist-Admission Process" that indicated that the home did not provide information about whistle-blowing protections related to retaliation. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide information about whistle-blowing protections related to retaliation. [s. 78. (2) (q)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home's policy to promote

zero tolerance of abuse and neglect of residents was posted in the home, in a conspicuous and easily accessible location.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home had not posted all listed items required from the admission package in an accessible and conspicuous location for residents to read. Inspector spoke with the Nurse Manager who further confirmed that the home's policy to promote zero tolerance of abuse and neglect of residents was not posted in the home. [s. 79. (3) (c)]

2. The licensee has failed to ensure that the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained, was posted in the home, in a conspicuous and easily accessible location.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home had not posted all listed items required from the admission package in an accessible and conspicuous location for residents to read. Inspector spoke with the Nurse Manager who further confirmed that the home's policy to minimize the restraining of residents was not posted in the home. On June 3, 2015, Inspector toured the unit and could not find a posted policy to minimize the restraining of residents in the home. [s. 79. (3) (g)]

3. The licensee has failed to ensure that an explanation of the measures to be taken in case of fire, was posted in the home, in a conspicuous and easily accessible location.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home had not posted all listed items required in an accessible and conspicuous location for residents to read. Inspector spoke with the Nurse Manager who further confirmed that the home had not posted an explanation of measures to be taken in case of fire. On June 3, 2015, Inspector toured the unit and could not find a posting of an explanation of measures to be taken in case of fire in the home. [s. 79. (3) (i)]

4. The licensee has failed to ensure that an explanation of evacuation procedures, was posted in the home, in a conspicuous and easily accessible location.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home had not posted all listed items

required in an accessible and conspicuous location for residents to read. Inspector spoke with the Nurse Manager who further confirmed that the home had not posted an explanation of evacuation procedures. On June 3, 2015, Inspector toured the unit and could not find a posting of evacuation procedures in the home. [s. 79. (3) (j)]

5. The licensee has failed to ensure that an explanation of whistle-blowing protection related to retaliation, was posted in the home, in a conspicuous and easily accessible location.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home had not posted all listed items required in an accessible and conspicuous location for residents to read. Inspector spoke with the Nurse Manager who further confirmed that the home had not posted an explanation of whistle-blowing protections related to retaliation. On June 3, 2015, Inspector toured the unit and could not find a posting of an explanation of whistle-blowing protections related to retaliation in the home. [s. 79. (3) (p)]

WN #14: 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 ensure that they 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.

On May 26, 2015, Inspector #577 received the completed "LTCH Licensee Confirmation Checklist-Quality Improvement". The checklist indicated that the home did not seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that the licensee shall ensure that the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice.

On May 26, 2015, Inspector #577 received the completed "LTCH Licensee Confirmation Checklist-Quality Improvement". The checklist indicated that the home did not seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results. [s. 85. (4) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs.

According to MDS reviewed on June 3, 2015, resident #012 has a health condition and complains of pain on a daily basis.

On June 3, 2015, Inspector #577 reviewed residents medication records and noted that resident #012 had been given pain medication for complaints of pain on 2 occasions in May 2015.

On June 4, 2015, Inspector #577 reviewed resident #012's care plan related to pain which indicated specific pain interventions. Inspector #577 reviewed resident #012's progress notes relating to pain medication and found that the resident's response to the above pain medication was not documented. [s. 134. (a)]

2. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs.

On June 1, 2015, Inspector #577 reviewed the MDS data for May 2015, quarter for resident #015. The data indicated that resident has had complaints of severe pain.

On June 3, 2015, Inspector #577 reviewed residents medication records and noted that resident #015 had been given pain medication for complaints of pain on 2 occasions in May 2015.

On June 1, 2015, Inspector #577 reviewed resident #015's care plan related to pain. Care plan included specific pain interventions. Inspector #577 reviewed resident #015's progress notes relating to pain medication and found that the resident's response to the above pain medication was not documented in May 2015. [s. 134. (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
3. The obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
4. The method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident's Notice of Assessment issued under the Income Tax Act (Canada) for the resident's most recent taxation year. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
5. A list of the charges that a licensee is prohibited from charging a resident under subsection 91 (1) of the Act. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
6. The list of goods and services permitted under paragraph 3 of subsection 91 (1) of the Act that a resident may purchase from the licensee and the charges for those goods and services. O. Reg. 79/10, s. 224 (1).

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
7. The resident's ability to have money deposited in a trust account under section 241 of this Regulation. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package of information included information about the the obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence as set out in section 258 of this Regulation.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide information about the obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide information about the obligation of the resident to pay accommodation charges during a medical, psychiatric, vacation or casual absence. [s. 224. (1) 3.]

2. The licensee has failed to ensure that the admission package of information provided included information about the method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident’s Notice of Assessment issued under the Income Tax Act (Canada) for the resident’s most recent taxation year.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide information about the method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident’s Notice of Assessment issued under the Income Tax Act (Canada) for the resident’s most recent taxation year. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide information about the method to apply to the Director for a reduction in the charge for basic accommodation and the supporting documentation that may be required, including the resident’s Notice of Assessment issued under the Income Tax Act (Canada) for the resident’s most recent taxation year. [s. 224. (1) 4.]

3. The licensee has failed to ensure that that the package of information provided included information about a list of the charges that a licensee is prohibited from charging a resident under subsection 91 (1) of the Act.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide a list of the charges that a licensee is prohibited from charging a resident. Inspector spoke with the

Nurse Manager who further confirmed that the admission package did not provide a list of the charges that a licensee is prohibited from charging a resident. [s. 224. (1) 5.]

4. The licensee has failed to ensure that the admission package of information included a list of goods and services permitted under paragraph 3 of subsection 91 (1) of the Act that a resident may purchase from the licensee and the charges for those goods and services.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide the list of goods and services that a resident may purchase from the licensee and the charges for those goods and services. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide the list of goods and services that a resident may purchase from the licensee and the charges for those goods and services. [s. 224. (1) 6.]

5. The licensee has failed to ensure that that the admission package of information included the resident’s ability to have money deposited in a trust account under section 241 of this Regulation.

On June 2, 2015, Inspector #577 reviewed the completed "LTCH Licensee Confirmation Checklist-Admission Process" that indicated that the home did not provide information about the resident’s ability to have money deposited in a trust account. Inspector spoke with the Nurse Manager who further confirmed that the admission package did not provide information about the resident’s ability to have money deposited in a trust account. [s. 224. (1) 7.]

WN #17: 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 has failed to ensure that the quality improvement and utilization review system communicates the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents is communicated to the Residents’ Council, Family Council and the staff of the home on an ongoing basis.

On May 26, 2015, Inspector #577 received the completed "LTCH Licensee Confirmation Checklist-Quality Improvement". The checklist indicated that the home did not communicate to the Residents' Council, any improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents. [s. 228. 3.]

Issued on this 28th day of August, 2015

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

Original report signed by the inspector.