Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 8, 2014	2014_312503_0016	T-034-14	Resident Quality Inspection

Licensee/Titulaire de permis

GROVE PARK HOME FOR SENIOR CITIZENS
234 COOK STREET, BARRIE, ON, L4M-4H5

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

GROVE PARK HOME FOR SENIOR CITIZENS
234 COOK STREET, BARRIE, ON, L4M-4H5

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

LAURA BROWN-HUESKEN (503), ANN HENDERSON (559), ERIC TANG (529), JOANNE ZAHUR (589), NATASHA JONES (591), SOFIA DASILVA (567)

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): July 4, 7, 8, 9, 10, 11, 14, 15, 16 and 17, 2014.

During the course of the inspection, the following complaint and critical incident inspections were completed: T-651-13, T-263-14.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), assistant director of care (ADOC), nurse practitioner, human resources manager, nutrition manager (NM), environmental services manager (ESM), programs and volunteer manager, food services supervisor, registered dietitian (RD), physiotherapist, nursing rehabilitation coordinator (NRC), life enrichment coordinator, resident care administrative assistant (RCAA), family council co-chair, dietary aides (DA), administrative assistant, resident assessment instrument (RAI) coordinator, maintenance workers, environmental services workers, registered nurses (RN), registered practical nurses (RPN), housekeepers, and personal support workers (PSW).

During the course of the inspection, the inspector(s) conducted tour of all home areas, observed meal services, reviewed clinical records, observed provision of care,
reviewed Residents' Council minutes and Family Council minutes, home's policies related to food services, falls prevention, complaints, immunizations, infection control, restraints, abuse, accommodation services, pain, medication, continence, reviewed the complaint log, maintenance records, water temperature logs, housekeeping records, and education records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are kept closed and locked.

On July 4, 2014, at 10:15 a.m. a door on the Maple home area leading to an unmarked stairway was unlocked. The stairway contained steep, concrete steps that lead up to an upper floor. The upper floor had three rooms containing shelves with boxes, old toilets, wood slabs and other loose debris on the floor. A PSW was notified and confirmed that the door was not locked and that maintenance was required. The administrator arrived and confirmed that the maintenance staff would be notified immediately. On July 10, 2014, at 12:10 p.m. the identified door was confirmed to be locked. [s. 9. (1) 1. i.]

2. Record review revealed that resident 71 was exhibiting exit seeking behaviour on the evening of an identified date, and was self-propelling in a wheelchair on the home area. At 9:30 p.m. the resident was found at the bottom of stairway 1 in the basement and the resident's wheelchair was located on the landing of the first floor. Assessment by the registered staff revealed two reddened areas. The resident was transferred to hospital the next day for assessment.

Interview with an identified staff revealed that he/she had worked a double shift and felt tired. As such, he/she exited the home through the door to stairway 1 as he/she could gain quicker access to the staff parking lot. The identified staff further stated that he/she gained entry to stairway 1 without the use of a code as the door was unlocked. He/she has failed to ensure the door was locked after closing. An interview with a registered nursing staff that first discovered the incident found the resident laying on the floor at the bottom of stairway 1 in the basement. He/she took the same stairway and discovered the door leading to the stair was left on bypass as evidenced by a green indicator on the keypad, leaving unrestricted access to stairway 1.

An interview with the DOC and administrator confirmed that the door leading to stairway 1 was unlocked resulting in resident accessing stairway 1 and experiencing an unwitnessed fall. [s. 9. (1) 1. i.]

3. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when not supervised by staff.

On July 7, 2014, the door to the suction equipment room on Maple home area was observed to be propped open. The room housed four oxygen tanks, 2 oxygen compressors, a computer with cables. Posted on the wall were documents with personal health information for a resident. This door also led to the staff room where a toaster was located. The ADOC confirmed that this door should be kept closed and locked. [s. 9. (1) 2.]

4. On July 10, 2014, the door to the suction equipment room on Maple home area was observed to be propped open. A sign posted on the door stated, "This door is to remain closed and locked for resident safety". The ADOC confirmed that this door should be kept closed and locked. [s. 9. (1) 2.]

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee 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.

A review of clinical records for resident 65 revealed that the resident's family had expressed concerns regarding plaque build-up on the resident's teeth and dentures to the home. Interviews with direct care staff revealed that the resident was provided with variable amounts of assistance to clean dentures and teeth. The resident's written plan of care directs staff to provide total assistance with mouth care and the written plan of care also indicates that staff are to ensure that the resident brushes his/her

teeth. An interview with the DOC indicated that the resident's written plan of care did not provide clear directions to staff who provide direct care to the resident in relation to the frequency of oral care. [s. 6. (1) (c)]

2. The written plan of care for resident 60 directs staff to toilet resident at 6:30 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 4:30 p.m., 6:00 p.m. and before bed. The schedule outlined in point of care and the resident's nursing rehab plan directs the staff to toilet the resident at 7:00 a.m., 9:30 a.m., 1:30 p.m., 4:00 p.m., 7:30 p.m. and as needed. In an interview the NRC indicated that the written plan of care does not provide clear directions to staff who provide direct care to the resident. [s. 6. (1) (c)]

3. The written plan of care for resident 64 directs staff to provide the resident with an over night liner for incontinence. The continence product information card in the resident's bathroom indicated the resident requires a liner during the day and a pull-up product during the night. Interviews with the resident and PSWs revealed that the resident uses a pull-up product which the facility provides and the resident stores in his/her room. An interview with a RPN indicated that the written plan of care does not provide clear directions to the direct care staff. [s. 6. (1) (c)]

4. The written plan of care for resident 69 indicated that two persons are required for constant supervision/physical assistance with mechanical ceiling lift for all transfers, and three staff are required as needed for difficult maneuvers. An interview with a RPN confirmed that the transfer directions in the written plan of care were not clear and a definition of difficult maneuvers was not included. [s. 6. (1) (c)]

5. The written plan of care for resident 20 did not include a reference to the resident's continence status and the incontinence product requirements. Interviews with staff and record reviews for resident 20 indicate that the resident was incontinent of urine and that the resident required the use of a continence pad. Interview with a RPN and DOC confirmed that the written plan of care did not include information regarding continence status and the incontinence product requirements and did not provide enough direction to staff that provide direct care to the resident. [s. 6. (1) (c)]

6. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review for resident 61 revealed that the physiotherapist assessment on an

identified date, indicated that the resident did not have any falls in 2014. Nursing fall assessments on two identified dates revealed that the resident fell on these dates. Interview with the physiotherapist confirmed that the physiotherapy and nursing assessments were inconsistent. [s. 6. (4) (a)]

7. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Record review for resident 68 revealed that the resident fell on three identified dates. Interview with the registered staff revealed that after the falls, the registered staff did not refer the resident to the falls prevention program for the development and implementation of interventions related to falls. Interview with the restorative care program coordinator confirmed that resident 68 was not referred to the falls prevention program. The restorative care program coordinator confirmed that resident 68 was considered a high risk for falls and that a referral should have been made as a result of the resident's risk for continuous falls. The physiotherapist revealed he/she was not notified of the resident's falls and did not collaborate with nursing staff in development and implementation of the resident's plan of care. The nursing team, falls prevention program and physiotherapy did not collaborate with each other in development and implementation of the resident's plan of care. [s. 6. (4) (b)]

8. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan of care for resident 70 directs staff to clean the resident's dentures after meals and to soak the dentures nightly. The PSWs revealed in interviews that mouth care is provided to the resident in the morning and before bed. Record review further confirmed that the resident was provided mouth care during morning and evening care for an identified one month period. An interview with a RPN confirmed that the resident was not receiving mouth care after meals and was not receiving care as specified in the plan. [s. 6. (7)]

9. The plan of care for resident 71 directs staff to shave resident daily with morning care. Observations on July 11, 2014, revealed that the resident was not shaved. Record review and interviews with a PSW and RPN confirmed that the resident had not been shaved. An interview with the DOC confirmed that staff is expected to

provide care as per the care plan. [s. 6. (7)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's medication pass policy and procedure was complied with.

The home's medication pass policy and procedure, 04-02-10 reviewed June 9, 2009, directed the nurse or care provider to initial in the box indicating the date and time when a medication is given. An appropriate chart note must be used if a medication cannot be administered.

A review of the October 2013 medication administration record (MAR) for resident 65 revealed missing signatures for medications on three identified dates and times. Interviews with RPNs and the DOC confirmed that the medication pass policy and procedure was not followed for the aforementioned medications. [s. 8. (1) (b)]

2. The licensee failed to ensure that the home's Intake Tracking policy is complied

with.

The home's Intake Tracking policy, NS-18 revised July, 2013, directs staff to record in point of care (POC) all food and fluids consumed by residents during meals. Intake is to be recorded as a percentage of the whole amount of food provided. On July 17, 2014, during the lunch meal, resident 63 was observed to consume three bites of the main entrée. A review of the POC documentation for lunch on July 17, 2014, indicated that the resident had consumed 100% of the food. An interview with the DOC confirmed that resident intake is to be accurately documented as per the home's policy. [s. 8. (1) (b)]

3. The licensee failed to ensure that the Falls Prevention Program is complied with.

A review of the home's policy titled, Falls Prevention Program, NUR-03-16, revised May 2014, indicates that in follow up to a fall, a resident's progress notes will be reviewed, looking at the number of previous falls over the past thirty (30) day period. A falls referral, found in point click care under the assessment tab, will be opened and section 1 completed when a resident has had three or more falls over a thirty day period and/or staff identify a problem where a risk for continuous falls is predicted. An interview with the DOC confirmed that the requirement to refer residents, as per the current policy dated May 2014, is consistent with the previous version of the policy. Record review for resident 68 revealed that the resident had three falls. Record review and interview with a registered staff and restorative care program coordinator confirmed that a referral was not made for resident 68, following the falls, as per the home's policy. [s. 8. (1) (b)]

4. The licensee failed to ensure that the Best Practice Guidelines on Vaccine Storage and Handling Practice was complied with.

Best Practice Guidelines (BPG) on Vaccine Storage and Handling Practices issued by Simcoe Muskoka District Health Unit (SMHDU) 2012, directs staff to check and record vaccine refrigerator temperatures in the temperature log book twice daily. This will ensure the publicly funded vaccines have been stored at the right temperature.
The ADOC confirmed in an interview the home's practice is to check and record the vaccine refrigerator temperatures twice daily on Monday, Tuesday, Wednesday, Thursday and Friday's. The ADOC is in charge of the vaccine refrigerator checks and recordings and indicated when he/she is unable to check and make a recording the RCAA is the back-up person allocated to complete this task. The RCAA works

Monday, Wednesday and Friday. Review of the temperature logs for April, May, June and July 2014, revealed that the temperatures were not documented on the evening of April 30, 2014, May 21, 2014, days and evenings on May 22, June 12, and July 3, 2014. The RCAA confirmed that the temperatures were not taken on the aforementioned dates [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's medication pass policy and procedure, intake tracking policy, falls prevention program, and the Best Practice Guidelines on Vaccine Storage and Handling Practice are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The following was observed on July 9, and 10, 2014:
- resident 61's walker frame and seat were stained
- resident 66's wheelchair seat cushion was stained
- resident 71's wheelchair seat cushion and frame were soiled.

Interviews with PSWs, RPNs, and DOC confirmed the aforementioned mobility aids were dirty and required cleaning. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed:
- rust in the toilet bowls in rooms 1124, 1129, 1133, 1139, 1148, 1152, 1156, 1157, 1166, 1171 and 1180,
- room 1174a contained four stained ceiling tiles in the washroom, dry wall damage in the bedroom and washroom and scuff marks on the wall,
- tub room on the Aspen home area (room closest to the solarium) contained four damaged ceramic wall tiles,
- room 1012a contained dry wall damage and a hole noted in the ceiling,
- room 1031a contained unpainted patched wall and paint chips,
- room 2011a contained three stained ceiling tiles,
- room 2015a contained dry wall damage and scuff marks.

Interviews with an environmental services worker and ESM confirmed the aforementioned observations are not in a good state of repair and follow-up is required to address the issues. [s. 15. (2) (c)]

3. On July 10, 2014, during breakfast in the Maple home area dining room a feeding stool was observed to have tears in the seat cover exposing the foam in the seat. An interview with the RPN on the unit revealed that the stool was in disrepair and should be removed from the dining room. Interviews with the NM and the ESM revealed that the stool was in disrepair and was subsequently removed from the dining room and disposed of. [s. 15. (2) (c)]

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, furnishings and equipment are kept clean and sanitary as well as maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of clinical records and interviews revealed that on an identified date, resident 03 reported to an identified PSW working the evening shift that he/she was very upset about a conversation with an identified PSW that occurred after lunch that day. The resident indicated to the PSW that he/she felt demeaned by the loud and brusque manner the PSW had spoken to him/her. An identified RPN entered the room and the resident repeated this statement. An interview with the DOC and a review of the internal investigation notes revealed the DOC had been informed of the allegation of suspected verbal abuse and it was not investigated until 39 days later. The DOC further revealed that an email was received from the resident's family member regarding the alleged verbal abuse and this initiated an internal investigation. The DOC confirmed that there had been an incident and it was not immediately investigated. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reports the suspicion to the Director.

Review of clinical records and interviews revealed that on an identified date, resident 03 reported to an identified PSW working the evening shift that she was very upset about a conversation with an identified PSW that occurred after lunch that day. The resident indicated to the PSW that he/she felt demeaned by the loud and brusque manner the PSW had spoken to him/her. An identified RPN entered the room and the resident repeated this statement. An interview with the DOC and a review of the internal investigation notes revealed the DOC had been informed of the allegation of suspected verbal abuse on an identified date. The DOC further revealed that an email was received from the resident's family member regarding the alleged verbal abuse and this initiated an internal investigation. The DOC confirmed that there had been an incident, it was not immediately investigated and it was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reports the suspicion to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the continence care and bowel management program has a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referrals of residents to specialized resources where required.

Review of the home's continence care bowel policy, NUR-03-26 revised March 2011, and continence care bladder, NUR-03-31 revised March 2011, revealed the continence care and bowel management program lacked a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referrals of residents to specialized resources where required.
The DOC confirmed in an interview that the home's continence care bowel and continence care bladder policies are a work in progress, and do not provide a written description of the program as required under the Act and Regulations. [s. 30. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the continence care and bowel management program has a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referrals of residents to specialized resources where required, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who are incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the residents require.

Review of the resident assessment instrument, minimum data set (RAI-MDS) completed on admission for resident 20 indicates that the resident is frequently incontinent of bladder. Interview with the registered staff revealed that resident 20 was incontinent on admission and that he/she required the use of a continence product throughout the day. Staff also confirmed that the resident continues to require assistance with toileting and continence product changes, when required.

Review of the resident assessment instrument, minimum data set (RAI-MDS) completed on admission for resident 21 indicates that the resident is frequently incontinent of bladder. Interview with the registered staff revealed that resident 21 was incontinent of bladder on admission. Interview with the registered staff confirmed that the resident requires assistance with toileting and that he/she continues to require the use of a continence product throughout the day.

Interviews with the NRC and DOC indicated that residents 20 and 21 did not receive an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the residents require, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

During a lunch observation on July 4, 2014, resident 17 was observed to arrive late to the Pine home area dining room. The resident was provided a soup and when that was not consumed, he/she was provided a dessert. Resident 17 confirmed that he/she had not been offered an entrée. An interview with an identified PSW confirmed that the resident was not offered or provided an entrée. The resident was then provided a choice of entrée and the DA brought the resident a hot dog and indicated that the resident was not provided a vegetable side as he/she does not usually consume vegetables. An interview with the NM confirmed that resident 17 should have been offered all courses as per the planned menu. [s. 71. (4)]

2. During a dinner observation on July 15, 2014, resident 18 was observed to indicate his/her meal choice as the lamb, mint jelly, mashed potatoes and PEI vegetable blend. The DA indicated that there were no more servings of lamb available and resident 18 was asked if he/she would take the pork chop instead. The resident was then provided a pork chop, rice pilaf and squash. An interview with the NM confirmed that the planned menu item was not available for resident 18 and further indicated that all efforts should have been made to provide the resident with his/her choice including calling the cook to request additional servings. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff were provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining as set out in the Act and Regulations.

The education records of five identified direct care staff including two RPNs and three PSWs were reviewed and revealed that education of minimizing restraints had not been provided to these staff in the previous 18 months. The DOC confirmed that no education had been provided related to the minimizing of restraints and how to restrain residents in accordance with the requirements for restraining as set out in the Act and Regulations for 2013 onwards. [s. 76. (7) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that direct care staff were provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining as set out in the Act and Regulations, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

Hot water temperatures were taken on the following occasions from a tub room in the Aspen Unit using a calibrated thermometer:
- July 11, 2014 at 9:01 a.m. 31.5 degrees Celsius
- July 11, 2014 at 1:13 p.m. 33.2 degrees Celsius
- July 14, 2014 at 11:15 a.m. 34.1 degrees Celsius
- July 14, 2014 at 2:09 p.m. 31.2 degrees Celsius
- July 15, 2014 at 9:05 a.m. 34.3 degrees Celsius

On July 15, 2014, at 10:20 a.m. the water temperature in the identified tub room was recorded at 26.1 degrees Celsius, using a calibrated thermometer. The ESM and a maintenance worker confirmed that the water temperature did not meet the legislated requirement of 40 degrees Celsius and that repair work was required to address the issue. [s. 90. (2) (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 procedures are developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During an interview resident 05 revealed that he/she keeps identified drugs at his/her bedside and self-administers these medications. A review of the physician's orders indicated that there is no physician's order to self-administer one of the identified medications. The home area RPNs confirmed the above. [s. 131. (5)]

2. The licensee failed to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

On July 8, 2014, during an interview resident 01 revealed that he/she keeps identified drugs in his/her bedside drawer and this was confirmed by an identified RPN. A review of the resident's physician orders indicated that the resident may self-administer the identified medications, however, there is no physician order to keep them at the bedside.
During an interview resident 05 revealed that he/she keeps an identified drug at his/her bedside and self-administers this drug. A review of the physician's orders indicated that the resident may self-administer the drug, however, there is no physician's order to keep the medication at the bedside.
The home area RPNs confirmed the above. [s. 131. (7) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident and that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

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

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

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

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

Findings/Faits saillants :

1. The licensee failed to provide training related to continence care and bowel management to all staff who provide direct care to residents.

The education records of five identified direct care staff including two RPNs and three PSWs were reviewed and revealed that education related to continence care and bowel management had not been provided to these staff in the previous 18 months. The DOC confirmed that no education had been provided related to continence care and bowel management for 2013 onwards for the identified staff members. [s. 221. (1) 3.]

2. The licensee failed to 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.

An interview with the DOC and human resources manager confirmed that the annual training for abuse recognition and prevention for all direct care staff was last provided on June 12, 2012. [s. 221. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to provide training related to continence care and bowel management to all staff who provide direct care to residents and to provide annual training for abuse recognition and prevention to all staff who provide direct care to residents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interview with the ADOC confirmed that the home's infection prevention and control program was not evaluated in 2013. [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

The inspector observed the following:
- On July 7, 2014, at 2:15 p.m. a plastic container with two unlabeled nail clippers and one unlabeled hairbrush containing hair were located in the Willow spa room,
- On July 7, 2014, at 1:45 p.m. a plastic container with multiple unlabeled nail clippers in a plastic container, one bath tub scrub brush on the floor, and one toilet scrub brush on the floor in the Spruce spa room,
- On July 7, 2014, at 1:50 p.m. one unlabeled roho cushion without a cover on the floor beside the sink, and a bedpan placed on the seat of the shower chair in Spruce shower room.
An interview with a RPN on Willow, confirmed the above noted items should have been labeled. An interview with a PSW on Spruce confirmed that the above unlabelled items should have been labeled and that the bathtub and toilet scrub brushes should not have been on the floor. [s. 229. (4)]

3. During a lunch observation on July 4, 2014, an identified PSW was observed to remove soiled dishes and to serve the following course to different residents with no hand hygiene completed in between. An interview with the NM revealed that during meal service all staff are expected to utilize the hand sanitizer or wash their hands after they have touched soiled dishes. [s. 229. (4)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the pain management program provided strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

A review of the home's pain management program revealed that the program does not have non-pharmacologic interventions for pain management and the DOC confirmed that the pain management program did not include non-pharmacological aspects of pain management. [s. 52. (1) 2.]

2. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of clinical documentation revealed that resident 72 intermittently complained of mouth/tooth pain during an identified time period, and was treated with an as needed dosage of pain medication on four identified dates. On an identified date a family member of resident 72 indicated to staff that resident was expressing that he/she was experiencing mouth/tooth pain. On an identified date a family member expressed concern to staff that the resident's mouth pain was impacting his/her ability to eat and requested that the resident's pain medication be reassessed.
An interview with the charge nurse confirmed that the resident was experiencing mouth pain during the identified time period and the pain was impacting the resident's meal intake. The home's physician noted that staff reported dental pain with meals and a prescription for a topical product was written for application to affected area of teeth before meals and at bedtime when needed.
Record reviews and an interview with the DOC confirmed that the resident exhibited a change in health status related to pain and that the resident's pain had not been assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Family Council concerns or recommendations.

A review of the Family Council minutes from January 15, 2014, identified the following concerns and recommendations:
- visibility of name tags used by staff,
- identification of staff member when answering telephone,
- addition of a staff picture gallery to home areas,
- Family Council minutes be posted in a prominent location and emailed to family members,
- emails sent to family members to have names and addresses blind carbon copied,
- the use of "voice-blast" to remind family members of future meetings.

An interview with the program and volunteer manager revealed that the meeting minutes from the January 15, 2014, Family Council meeting were not forwarded to the home until the end of March 2014. The exact date could not be confirmed. An interview with the administrator confirmed that a written response was not provided to the Family Council within 10 days. [s. 60. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that menu substitutions are comparable to the planned menu.

On July 4, 2014, the planned lunch menu included fish cakes, sweet potato fries and zucchini. The fish cakes and sweet potato fries were substituted for hot dogs on a bun. The home's menu substitutions policy, NS-9, reviewed July 2013, indicated that substitutions may only be made within the food groups. The home's RD confirmed that a vegetable component of the meal being substituted with a grain product was not comparable. [s. 72. (2) (e)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (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:
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. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

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

During a lunch observation on July 4, 2014, resident 17 was observed to arrive late to the Pine home area dining room. The resident was provided soup and when that was not consumed, he/she was provided a dessert. The resident was subsequently provided an entrée and had all three meal courses at one time. The resident was not observed to indicate this as a preference. Review of the clinical records for the resident revealed that the resident had not been assessed to required service of multiple courses at one time. The home's dining experience policy, NS-24 reviewed July 2013, directs staff to serve residents course by course unless otherwise indicated by the resident or by the resident's assessed needs. An interview with the NM confirmed that resident 17 should have been provided course by course meal service. [s. 73. (1) 8.]

2. The licensee failed to ensure that the home has a dining service that provides residents with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Review of the written plan of care for resident 63 directed staff to provide supervision with minimal set-up or assistance for meals. An interview with an identified PSW indicated the resident requires supervision, cueing, and minimal assistance with feeding. On July 16, 2014, in the Aspen dining room, resident 63 was served the main entrée at 12:26 p.m. The resident was observed to have difficulty affixing the food to the fork, and placing into his/her mouth. The plate was removed at 12:50 p.m. No assistance was provided during this time. The resident's intake was observed to be minimal.
On July 17, 2014, in the Aspen dining room, resident 63 was served the main entrée at 12:23 p.m. At 12:40 p.m. a PSW assisted the resident with one forkful of food. The resident was observed to use one hand to put two portions of food into his/her mouth. The plate was removed from the resident at 1:16 p.m. The PSW confirmed that he/she did not provide the resident with assistance on July 17, 2014, during lunch. [s. 73. (1) 9.]

3. The licensee failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

During a lunch observation on July 4, 2014, resident 19 was observed to be served soup for which he/she was provided no assistance or encouragement to consume for

19 minutes. The resident did not consume any soup during this time. A review of the plan of care for the resident revealed that the resident requires intermittent encouragement and physical assistance for eating. An interview with the NM indicated that the resident should not have been provided the soup until someone was available to provide the assistance required by the resident. [s. 73. (2) (b)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the copies of the inspection reports from the past two years are posted in the home.

On July 4, 2014, the public inspection report number 2013-168202-0028 dated May 27, 2013, was not posted in the home. An interview with the administrator confirmed that the report was not posted in the home. [s. 79. (3) (k)]

WN #20: 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).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interviews with the co-chair of the Family Council and the Programs and Volunteer Manager revealed that the licensee did not seek the advice of the Family Council in developing and completing the satisfaction survey and acting on its results. [s. 85. (3)]

Issued on this 11th day of September, 2014

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) :	LAURA BROWN-HUESKEN (503), ANN HENDERSON (559), ERIC TANG (529), JOANNE ZAHUR (589), NATASHA JONES (591), SOFIA DASILVA (567)
Inspection No. / No de l'inspection :	2014_312503_0016
Log No. / Registre no:	T-034-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 8, 2014
Licensee / Titulaire de permis :	GROVE PARK HOME FOR SENIOR CITIZENS 234 COOK STREET, BARRIE, ON, L4M-4H5
LTC Home / Foyer de SLD :	GROVE PARK HOME FOR SENIOR CITIZENS 234 COOK STREET, BARRIE, ON, L4M-4H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Taylor

To GROVE PARK HOME FOR SENIOR CITIZENS, 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 :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, are kept closed and locked and equipped with a door access control system that is kept on at all times. The plan should include short and long-term actions to ensure compliance. Please submit plan to Laura.Brown-Huesken@ontario.ca by September 26, 2014.

Grounds / Motifs :

1. Record review revealed that resident 71 was exhibiting exit seeking behaviour on the evening of an identified date, and was self-propelling in a wheelchair on the home area. At 9:30 p.m. the resident was found at the bottom of stairway 1 in the basement and the resident's wheelchair was located on the landing of the first floor. Assessment by the registered staff revealed two reddened areas. The resident was transferred to hospital the next day for assessment.

Interview with an identified staff revealed that he/she had worked a double shift and felt tired. As such, he/she exited the home through the door to stairway 1 as he/she could gain quicker access to the staff parking lot. The identified staff further stated that he/she gained entry to stairway 1 without the use of a code as the door was unlocked. He/she has failed to ensure the door was locked after closing. An interview with a registered nursing staff that first discovered the incident found the resident laying on the floor at the bottom of stairway 1 in the basement. He/she took the same stairway and discovered the door leading to the stair was left on bypass as evidenced by a green indicator on the keypad, leaving unrestricted access to stairway 1.

An interview with the DOC and administrator confirmed that the door leading to stairway 1 was unlocked resulting in resident accessing stairway 1 and experiencing an unwitnessed fall. (529)

2. On July 4, 2014, at 10:15 a.m. a door on the Maple home area leading to an unmarked stairway was unlocked. The stairway contained steep, concrete steps that lead up to an upper floor. The upper floor had three rooms containing shelves with boxes, old toilets, wood slabs and other loose debris on the floor. A PSW was notified and confirmed that the door was not locked and that maintenance was required. The administrator arrived and confirmed that the maintenance staff would be notified immediately. On July 10, 2014, at 12:10 p.m. the identified door was confirmed to be locked. (591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 17, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 8th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Laura Brown-Huesken

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